

# Sampling of Responses to the CDF Statement on Nutrition and Hydration

The recent statement from the Vatican's Congregation for the Doctrine of the Faith (issued Sept. 14, 2007), concerning artificially administered nutrition and hydration to patients in a persistent vegetative state, has generated a lot of discussion within Catholic health care, resulting in a range of perspectives and interpretations. Following is a sampling of those interpretations and perspectives on the CDF statement.

**Carol Bayley, PhD, Vice President, Ethics and Justice Education, Catholic Healthcare West, San Francisco**

On Friday, Sept. 14, 2007, the Congregation for the Doctrine of the Faith (CDF) issued a response to certain questions that had been posed to it by some United States bishops regarding the administration of artificial nutrition and hydration to patients in a permanent vegetative state (PVS). I understand the CDF's statement as an answer to questions regarding

1. patients diagnosed to be in PVS
2. who are not ventilator dependent
3. who have artificial nutrition and hydration and
4. for whom the cessation of the artificial nutrition and hydration is being considered

The statement itself is short: two questions, two answers, one page. The commentary that came along with it is considerably longer.

In spite of the commentary, apparently sent along to help address questions about the meaning of the statement, I'm left with more questions than answers. I will share two of them here. First, neither the statement nor the commentary puts the current questions and answers in the rich context of the rest of the church's teaching on care at the end of life, specifically on the withdrawal of treatment. For somewhere close to 500 years, the Catholic Church has taught that some medical treatment could be burdensome to a

patient, and if it is too burdensome, the patient is not obligated to undergo it. This patient-centeredness contrasted with our more contemporary focus on a specific *kind* of treatment. Indeed, in some traditional examples, two persons with the same diagnosis and prognosis might legitimately decide differently about the value of life-sustaining treatment, causing one person to undergo the treatment and the other to allow the disease to overtake him. The difference was not in the treatment; it was in the person.

By focusing the answers to the questions about PVS on one particular treatment, the authors of the statement neglected to mention anything about the meaning or value of the treatment to the person, a key feature in all the church's other teaching on end-of-life care. So my first question is exactly how this teaching fits into the much older tradition on end-of-life care. My tentative answer is that since the Catholic Church rarely produces a 180-degree reversal, and since the 500-year-old person-centered tradition is not mentioned, it must be presumed. If that is the case, the statement is not very different from the current Directive 58, the ambiguities of which we have managed for a long time.

My second question has to do with the church's response to the average layperson's reading of the statement. To date, I am aware only of the lay press carrying the story in *Modern Healthcare* and the *Chicago Tribune*. I have had conversations, however, with administrators, ethicists and lawyers, within and outside of my system, suggesting that an honest (and by that they mean literal) interpretation of the statement will put Catholic hospitals and long-term care facilities squarely in conflict with California law, which specifically has found that nutrition and hydration are medical treatments that, like other medical treatments, may be forgone when they are too burdensome or without value to the patient. To lawyers especially, who are primed for conflict by matters such as abortion and contraception, this appearance of direct conflict, in which people's rights to refuse

treatment may be overpowered by the monolithic Catholic Church, is unmistakable. It would not surprise me if an enterprising rights lawyer sought a test case, or if a well-meaning administrator found it necessary to discharge a PVS patient whose family sought discontinuation of nutrition and hydration. How the church responds to such cases may affect the credibility of Catholic hospitals throughout the United States.

Because some of the ideas contained in the statement are not obviously just a reiteration of other teachings on the same subject, American bishops and theologians will have to take some time to unpack the meanings and messages contained in the statement before its impact is clear. They will certainly take into consideration, for example, developing American attitudes toward assisted suicide and euthanasia, fueled in many cases by people's fears that unwanted treatment will not be withdrawn. As we know, the ordinary pace of change in the Catholic Church is not . . . sudden. Until the statement finds its place in the settled, and long-held tradition on care of patients at the end of life, we should probably look at it more for what it restates: that every human person, no matter how diminished, possesses a dignity we must respect.

**Fr. Joseph Cardone, PhD, Vice President, Mission and Values, St. Vincent Mercy Medical Center, Toledo, Ohio**

The recent CDF statement *Responses to Certain Questions Concerning Artificial Nutrition and Hydration* has generated a great deal of discussion. The statement constitutes ordinary authentic teaching, and deserves respect. However, this respect is not simply blind unquestioning acceptance. Because it will impact families and Catholic health care institutions that care for this vulnerable population, we are obligated to engage in critical dialogue and thoughtful questioning.

Recently, I stood in an operating room and observed a surgeon perform a percutaneous endoscopic gastrostomy (PEG). He described this medical procedure in the following way: The PEG tube is placed in the endoscopy unit or, less commonly, in the operating room. The procedure requires intravenous sedatives and narcotics. Cardiac and oxygen saturation monitoring are routine. A topical anes-

thetic is sprayed into the pharynx and an endoscope is passed via the mouth into the esophagus and stomach. While transilluminating the light from the scope through the abdominal wall, a site is selected for the incision. And it went on from there.

To argue that this is not a medical treatment is confused and confusing. In some cases, a PEG may be an ordinary and proportionate means of preserving life. But, as is taught in the *Ethical and Religious Directives for Catholic Health Care Services*, that determination is made by the patient or the patient's health care proxy after weighing the benefits and burdens of the procedure (Directives 25, 32, 56 and 57). To declare that *a particular medical treatment* is ordinary, proportionate and obligatory is not in keeping with the centuries-old Catholic medical moral tradition.

The possible negative impact of the CDF statement on the Catholic health care ministry deeply concerns me. I fear that it could lead many to conclude that the only way to die with dignity is through physician-assisted suicide or direct euthanasia. It could discourage people from residing in Catholic-sponsored retirement centers or extended care facilities because of the fear of being subjected to disproportionate medical procedures at the end of life. Tragically, Catholic-sponsored extended care facilities might need to transfer PVS patients whose advance directives indicate that they do not want medically administered artificial nutrition and hydration.

Richard McCormick was prescient 15 years ago when he envisioned the following "fanciful" scenario: "Imagine a 300-bed Catholic hospital with all beds supporting PVS patients maintained for months, even years by gastrostomy tubes. . . . An observer of the scenario would eventually be led to ask: 'Is it true that those who operate this facility actually believe in eternal life?'" (*Corrective Vision*, Sheed & Ward, Kansas City, MO, 1994, p. 232.)

**John Collins Harvey, MD, PhD, Professor of Medicine, Emeritus, Georgetown University Medical Center, Center for Clinical Bioethics, Washington, D.C.**

No Catholic physician would willfully end a patient's life by any act of commission or omission. Catholic physicians would always provide ordinary treatments to patients in

their care and extraordinary treatments when indicated. When providing extraordinary treatments, the physician will always assess their use by the burdens/benefits ratio of the treatment. If the burdens of the treatment are greater than the benefits, the physician may, in good conscience, withdraw the burdensome treatment.

All physicians know that feeding a patient through a nasogastric tube requires careful insertion of such a tube by a trained health care worker to avoid misplacement into the trachea; trauma to the nasopharynx with resultant hemorrhage; undue pressure upon the mucosa of the esophageal gastric junction or the stomach pouch with resultant ulceration and hemorrhage; and possible penetration through the esophageal and or stomach walls causing contamination and subsequent life threatening infection of either the mediastinal and pleural spaces or the peritoneal cavity when fluid is inserted into the tube.

Doctors also know that the fluid inserted into the tube used to hydrate and nourish the patient who cannot swallow requires careful preparation by a trained dietitian to insure the proper balance of nutrients to maintain a balanced metabolism and prevent excessive anabolism or catabolism; correct volume and consistency of the fluid makeup to avoid over hydration and anasarca or under hydration and generalized debilitation; proper sterilization of the fluid to avoid inducing a gastrointestinal infection with resultant diarrhea and its complications; and proper monitoring of administration of the fluid by a trained health care professional who is alert to possible regurgitation of the material into the esophagus with the resultant flooding of the lungs and the development of aspiration pneumonia.

Pius XII, following a centuries-old Catholic moral tradition around ordinary and extraordinary means and their accompanying burdens and benefits, taught how to evaluate burdens of treatment. In his 1957 address to Catholic physicians and anesthesiologists, he said:

Normally one is held to the use only ordinary means—according to the circumstances of persons, places, times, and culture—that is to say, means that do not involve the grave burdens for oneself or another. A more strict obligation would be too burdensome

for most men and would render the attainment of the higher, more important, good too difficult. Life, health, all temporal activities are in fact subordinated to spiritual ends.

Pius XII emphasized the principle of totality (extended to the psychological and spiritual dimensions of the whole person) and the importance of consequences in that burdensome treatment is extraordinary, and that families have a role in making decisions for unconscious patients.

Pope John Paul II wrote in his 1995 encyclical, *The Gospel of Life*, that

Euthanasia must be distinguished from the decision to forego so-called ‘aggressive medical treatment,’ in other words, medical procedures which no longer correspond to the real situation of the patient, either because they are by now disproportionate to any expected results or because they impose an excessive burden on the patient and his family. . . . To forego extraordinary or disproportionate means is not the equivalent of suicide or euthanasia; it rather expresses acceptance of the human condition in the face of death.

Patients in an irreversible persistent coma caused by anoxia for a period of time extending more than six minutes have, among the many produced deficits by this cause, death of the cells of the cerebral cortex. As a result, they have no voluntary motor power and the physiological mode of death for such a patient is dehydration, for they do not have the abilities to bring food and fluid to their mouth, nor, if such is put into the mouth, to chew and move it to the posterior part of the tongue nor to swallow it into the esophagus. Physicians can give care to such a sick person, but curing such an individual is beyond the physician’s ability. Death is inevitable in these patients when the lower part of the brain ceases to function. Thus, the care of such a patient does not call for extraordinary or disproportionate means but only ordinary or proportionate care.

Feeding such a patient by administering nutrition and hydration by nasogastric tube has recently been defined as *ordinary care* by the Congregation for the Doctrine of the Faith. I think that no Catholic physician in the past would ever, in conscience, have discontinued this treatment with

the direct intention of procuring the death of the patient, nor do I think that any Catholic physician in the future, in conscience, will ever discontinue this treatment with the direct intention of procuring the death of the patient. If, however, this treatment becomes burdensome because complications have occurred, the physician must judge its continuation or withdrawal upon the calculated burdens/benefits ratio of the treatment. If the burdens exceed the benefits, the treatment may legitimately be discontinued according to the recent teachings of the CDF.

**Daniel O'Brien, PhD, Vice President, Ethics, and  
John Paul Slosar, PhD, Director, Ethics, Ascension  
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As we read it, the CDF *Responsum* concerning obligations to persons in a persistent vegetative state simply reiterates the two central points of John Paul II's March 2004 allocution. Understood in light of our interpretation of that teaching,\* the *Responsum* affirms and clarifies that Directive 58 applies to persons in a PVS. As the accompanying *Commentary* makes clear, the new statement does *not* preclude a judgment of extraordinary or disproportionate means when the artificially delivered nutrition and hydration (ADNH) entails disproportionate burdens or complications in a specific case, when it can no longer be assimilated by the body, or the patient is immanently dying. Like the papal allocution, the *Responsum* and *Commentary* do, according to our understanding, preclude unilateral decisions by health care professionals to withdraw nutrition and hydration from persons in a PVS based solely on a determination of "no hope of recovery," in those rare cases in which the patient does not have either a surrogate who can speak on his or her behalf or an advance directive.

The question of whether or not Catholic health care organizations may still follow advance directives regarding ADNH for PVS patients without any physical complications will likely be the issue around which there will be competing interpretations and the need for further reflection. However, consider the case of an adult devout

Jehovah's Witness patient who rejects all blood products, even at risk to her own life. Even though in the Catholic tradition blood products would generally, that is, "in principle," as the allocution and *Responsum* say, be considered ordinary means, they are rendered disproportionate means for the Jehovah's Witness patient for reasons of religious belief and conscience. Following this reasoning, we believe that Catholic facilities could still follow advance directives in the present context of concern. Doing so would not necessarily be considered contrary to Catholic teaching and the ERDs, because both specifically recognize the moral right of patients to forgo life-sustaining treatments that *in the patient's judgment* do not offer a reasonable hope of benefit or entail excessive burdens.

Regardless, it is important for patients and staff to realize that this teaching applies only to ADNH for persons in a permanent vegetative state, the issue which the *Responsum* explicitly addresses, i.e., the "manifest mind and intention" of its authors.\* In other words, and more precisely, this *Responsum* should *not* be extrapolated to apply in the context of other medical conditions, e.g., end-stage dementia or cancer, or to other treatment modalities, e.g., antibiotics or ventilators. To do this would be to misconstrue the manifest intention of the CDF and the teaching itself.

**Michael Panicola, PhD, Corporate Vice President,  
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The recent statement of the Congregation for the Doctrine of the Faith (CDF) regarding the use of nutrition and hydration for patients in a vegetative state has caused quite a stir within the Catholic health ministry.

Following the papal allocution of 2004, the CDF asserts that "the administration of food and water even by artificial means is, in principle, an ordinary and proportionate means of preserving life." It is, therefore, obligatory insofar as it achieves its purpose, "which is the hydration and nourishment of the patient" and it may *not* be discontinued solely because the patient will never regain consciousness.

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\* See, D. O'Brien, J.P. Slosar, A. Tersigni, "Utilitarian Pessimism, Human Dignity and the Vegetative State," *The National Catholic Bioethics Quarterly* 4, 3 (2004): 497-512.

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\* Regarding how to interpret church teaching with regard to the "manifest intention" of authors, see *Lumen gentium*, no 25, Vatican Council II: The Conciliar and Post Conciliar Documents, edited by Austin Flannery, O.P. (New York: Costello Publishing Company, 1992), 379.

However, in its accompanying commentary, the CDF indicates exceptions to this general rule may apply, namely: 1) where, “due to emerging complications, a patient may be unable to assimilate food and liquids, so that their provision becomes *altogether useless*”; or 2) where, “*in some rare cases*, artificial nourishment and hydration may be excessively burdensome for the patient or may cause significant physical discomfort” (emphasis added).

Given that the CDF’s statement applies *only* to patients in a vegetative state, which is a relatively rare condition, the net effect on patient care within Catholic settings will be minimal. However, situations will arise on occasion as to whether artificial nutrition and hydration should be continued for patients suffering from this condition. In some, perhaps many, of these situations, I believe the CDF’s statement will pose problems for Catholic facilities. The reason I say this is because patients in a vegetative state rarely meet the exceptional criteria that the CDF outlines for discontinuing artificial nutrition and hydration. Though such patients suffer from a severe brain injury, unlike other patient populations, they do not often fail to assimilate the artificial nourishment and hydration. Thus, exception one is out.

The CDF does also allow for burdens to be a tilting factor in whether or not to continue artificial nutrition and hydration. But, it’s physical burdens to the patient caused by the means, not burdens understood in the traditional sense, which could include familial, communal, and social burdens as well. Most of the evidence to date suggests that patients in a vegetative state do not experience physical burdens in the proper sense. How can this exceptional circumstance ever be met then? In reality, it most often cannot, and the CDF states as much by including in its commentary the phrase “in some rare cases” prior to allowing for the burden exception. Thus, exception two is out as well.

The problem for Catholic facilities is that most people do not want to receive artificial nutrition and hydration if they are permanently unconsciousness, and many who complete advance directives specify this in writing and/or tell their surrogate. They hold this view not because they think the artificial means will fail to provide nourishment and hydration or be too burdensome but because they see no benefit to using such a means if their overall condition cannot be improved. This is precisely what the CDF has eliminated

by restricting the notion of benefit to prolonging life and by declaring that nutrition and hydration cannot be discontinued solely because the patient will never regain consciousness.

So what are Catholic facilities to do in such situations? The question is hard to answer if you honestly account for what the CDF’s statement says and allows. You could argue that in the United States the *Ethical and Religious Directives for Catholic Health Care Services* (ERDs) are operative and until changed, it’s practice as usual. Well that may be, but statements such as the CDF’s are meant to illuminate the ERDs, and if this most recent statement is embraced as just such an illumination, it will severely limit the ability of Catholic facilities to discontinue artificial nutrition and hydration from patients in a vegetative state, despite what the patient may have wanted. Unfortunately, I think that for patients who have stated in writing or through a surrogate that they would not want to be kept alive by artificial means if permanently unconscious, or for families who desire as such, Catholic facilities will have to transfer the patient. Otherwise, Catholic facilities will just have to make pastoral exceptions that depart from the theoretical teaching.

**Mark Repenshek, PhD, Healthcare Ethicist,  
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In a 1996 article in *Theological Studies*, Kevin Wildes addresses the relative norm of excessive expense in the Catholic moral tradition. In that piece, Wildes argues “moralists have always taken into account the element of expense.”<sup>1</sup> The norm of excessive expense is to take into account the person’s economic status and may therefore vary widely. Traditional moral theology, it is argued, recognizes differing economic realities that are part of the human condition and therefore places the determination of excessive expense within the prudential judgment of the patient.<sup>2</sup> It seems the recent *Commentary* on the *Responsum* from the Congregation for the Doctrine of the Faith (CDF) constrains this important nuance.

The *Commentary* states that the administration of food and water is morally obligatory *in principle*, which with regard to the matter of excessive expense suggests, that *in principle* “does not exclude the possibility that, in very remote places or in situations of extreme poverty, the artificial provision of food and

water may be physically impossible.” This statement seems at first blush to significantly constrain the tradition’s recognized relative norm concerning the definition of excessive expense. However, I would suggest this statement may be more morally problematic than merely a constraint of what was heretofore a matter solely of prudential judgment of the patient.

In 2005, *Health Affairs* published “Illness and Injury as Contributors to Bankruptcy.” In that piece, David Himmelstein and co-authors used four criteria to measure “Major Medical Bankruptcy.” One criterion used to determine major medical bankruptcy was a debtor who reported uncovered medical bills exceeding \$1,000 in the past year.<sup>3</sup> The median income in the year prior to bankruptcy filing was \$24,500 for an average family of 1.32 debtors and 1.33 dependents.<sup>4</sup> This median income for the average family size reported in the study represents over 200 percent of the 2007 Health and Human Services federal poverty guidelines.<sup>5</sup> Given charge estimates for procedures to enable enteral feeding varying from \$1,700 to \$2,000,<sup>6</sup> and the possibility that such costs may lead to major medical bankruptcy as Himmelstein’s work suggests, it seems disingenuous to suggest that only in “very remote places or in situations of extreme poverty” might the artificial provision of food and water be of excessive expense.

The strength of the Catholic moral position on the matter of excessive expense and disproportionate burden is that it recognizes the economic inequalities that exist as part of the human condition. Furthermore, it recognizes that such economic inequality may be socially constructed and thoroughly unjust when examined in light of Catholic social teaching. It is the nuance of the tradition that allows the patient herself to determine what may constitute excessive expense. In other words, it may very well be that two persons, who of equal income, judge a particular medical intervention as disproportionate based on two very different, and appropriate, understandings of excessive. It is this insight of the Catholic moral tradition that creates the sufficient condition for a determination of disproportionate burden. Specific to the *Commentary* on the *Responsum*, the CDF’s use of *in principle* may create a moral impossibility for patients without the financial means to afford the medical interventions proposed by health care providers when such patients fall outside the criteria of geographic remoteness or “situations of extreme poverty.”

## NOTES

1. Kevin W. Wildes, “Ordinary and Extraordinary Means and the Quality of Life,” *Theological Studies* 57 (1996): 500-512; 504.
2. Daniel A. Cronin, “Moral Law in Regard to the Ordinary and Extraordinary Means of Conserving Life,” in *Conserving Human Life*, ed. Russell E. Smith (Braintree, MA: Pope John Center, 1989) 1-145, 108.
3. David U. Himmelstein, Elizabeth Warren, Deborah Thorne, and Steffie Woolhandler, “Illness and Injury as Contributors to Bankruptcy,” *Health Affairs* [Web exclusive] (2005): W5-63 - W5-73.
4. Himmelstein, W5-66.
5. *Federal Register*, Vol. 72 (January 24, 2007): 3147-3148.
6. The charge estimates are for percutaneous endoscopic gastrostomy tube (PEG tube) and local to the author’s point-of-reference and may therefore vary depending upon ministry. Of note is that these charges are only for the procedure to place and do not include the ongoing solution, maintenance, and supportive services after the tube has been placed.

### **Fr. Myles Sheehan, SJ, MD, Senior Associate Dean, Medicine/Geriatrics, Loyola University Health System, Maywood, Ill.**

I have three reactions to the recent statement of the Congregation of the Faith on Feeding and Hydration in Persistent Vegetative State. First, appreciation for the clarification. Second, in that same spirit of appreciation, I feel gratified that the document is clearly speaking about care of persons in a persistent vegetative state who are already receiving medically assisted feeding and hydration. It says nothing about the placement of feeding tubes or their use in other conditions. This should counter the media’s unfortunate misrepresentation about the use of feeding tubes and irresponsible suggestion that the church is teaching that every disorder requires the placement of a gastrostomy tube. Neither John Paul II’s statement nor this clarification addresses issues outside of persistent vegetative state. Third, as a Jesuit physician who cares for older persons, I will continue my current practice of recognizing that there is a presumption in favor of medically assisted feeding and hydration, but that presumption can be called into question by a variety of concerns, especially the concern about whether or not the treatment will work.

I do not usually place gastrostomy tubes in persons with advanced dementia who have eating disorders, and it is very rare that I place gastrostomy tubes in any individual with a clearly fatal pathology, like cancer. Why? Because I believe these persons are dying and, with some specific exceptions,

it is my clinical experience that medically assisted feeding and hydration is not effective in cases of this type for prolonging life or treating the underlying pathology. I am vigorous in maintaining oral feeding and hydration, sometimes feeding patients by hand myself. I believe that I am in conformity with the spirit and letter of church teaching. In those persons who are doing well with a feeding tube but cannot swallow, I do not stop the feeding, any more than I stop providing oral feeding and hydration to persons who can swallow. This is nothing new, and was my practice, and I believe the accepted practice of most Catholic health care facilities, with rare exceptions, prior to John Paul II's March 2004 statement or the CDF's recent clarification.

**Msgr. Stephen Worsley, MD, Vice President, Mission and Ethics, St. Joseph Hospital, Nashua, N.H.**

*The invitation to write about the implications of the CDF statement on nutrition and hydration for PVS patients led me to reflect on how I (and we) respond to such events. When read in context of the other pieces published here I trust this will make sense and may prove helpful to the reader.*

As a young physician, I was regularly humbled by the limitations of my knowledge. There was so much to learn. Yet nothing left me with a greater feeling of helplessness than the death of a child. We were trained to cure our patients. A child's death was the ultimate failure. With help, I eventually discovered a different reality. Sometimes a family's greatest need for a physician as healer comes after the death of their child. Helping parents realize that their child had received the best of everything—because he or she had been loved—was probably the most important thing I ever did as a physician.

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Time and again, I encounter people whose love for a dying family member is palpable. They want to do what is best, but are confused. They fear that they will run afoul of the church's teaching unless they "do everything."

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It seemed so clear when their priest explained all that end-of-life stuff in his homily. But now the same priest is in my office. *His* mother is dying. "Is it OK to not . . . ?" Together, we walk through her last months.

The winter after her funeral, he asks if I will give a talk in his parish. "This stuff is not as easy to explain as it used to be." I suggest a topic for the bulletin announcement, "Bioethics—You May Know More than You Realize." After coffee and donuts, I start the discussion with two questions:

*Who made you?*

*Why did God make you?*

They are good questions. Most of the folks recognize them from the first chapter of the old catechism. We talk about their answers for a while. Then we talk about the teachings of Pius XII, John Paul II and Benedict XVI. Finally, we discuss the importance of love and prayer in decision making. I hand out a short bibliography so folks can look up papal teachings and the *ERDs* on the Internet. The pastor smiles, his confidence renewed.

Driving home, I realize what he has taught me: The world needs ethicists as healers. Now.