

Q & A Regarding the Revision of Directive #58 in the
Ethical and Religious Directives for Catholic Health Care Services

November 23, 2009

Why did the bishops revise Directive #58 now?

The United States Conference of Catholic Bishops had extensively rewritten the *Ethical and Religious Directives for Catholic Health Care Services* (ERDs) in 1994 and last revised the document in 2001. At that time, the Holy See had not spoken regarding the morality of providing medically assisted nutrition and hydration (MANH) to patients in a persistent vegetative state (PVS). The Introduction to Part Five of the ERDs at that time explained that there was a “necessary distinction between questions already resolved by the magisterium and those requiring further reflection, as for example, the morality of withdrawing MANH from a person who is in the condition that is recognized by physicians as the ‘persistent vegetative state.’” However, in March 2004 Pope John Paul II addressed this issue and in August 2007 the Congregation for the Doctrine of the Faith issued a clarifying document on the issue. Therefore the Introduction to Part Five and Directive #58 have been revised in light of these statements.

Does Directive #58 now require that all patients who cannot take food and fluids by mouth receive MANH?

No, it does not. What the revised Directive does say is that patients who both can be fed and hydrated and who would benefit from being provided with food and water, even by artificial means, should, as a general rule, be fed and hydrated. In other words, there is a general moral obligation to provide patients with nutrition and hydration.

This general obligation applies as well to patients who are in a chronic condition and who could continue to live if they are provided with nutrition and hydration. This part of the Directive focuses particularly on patients in a persistent vegetative state and embodies the teaching of Pope John Paul II contained in his 2004 address as well as the statement made by the Congregation for the Doctrine of the Faith in September 2007.

However, the Directive also notes that there are exceptions to this general obligation:

- With regard to **dying patients**, nutrition and hydration may be deemed to be excessively burdensome to the patient or may provide little or no benefit in which case they become morally optional.

- With regard to **patients in a chronic condition**, for example, a patient in a persistent vegetative state, the obligation could also become morally optional if providing nutrition and hydration cannot be expected to prolong life or become excessively burdensome or cause significant physical discomfort (e.g., medical complications resulting from the use of medically administered nutrition and hydration).

So while the Directive emphasizes the general moral obligation to provide nutrition and hydration, even when administered medically, it also recognizes that this obligation is not absolute and that the use of these measures must be assessed with regard to their benefits and burdens to the patient.

Must all patients in a persistent vegetative state (PVS) receive MANH?

The revised Directive #58 makes two assertions in this regard: (1) that in principle there is an obligation to provide food and water to patients, and that this includes MANH for those who cannot take food and water orally and (2) that MANH becomes “morally optional” when (a) they can no longer prolong life or (b) when they become “excessively burdensome for the patient.” This judgment is a clinical judgment between the patient (or surrogate) and the physician. Among the clinical elements that need to be assessed are: the indications and contraindications of tube feeding for this particular patient and understanding potential medical complications that might occur. In the actual circumstances facing a given patient, MANH might not be appropriate. However, Pope John Paul II in his 2004 address and the Congregation for the Doctrine of the Faith in their 2007 doctrinal statement both insist that the belief that a patient is never likely to regain consciousness is not in itself a sufficient reason for withdrawing MANH.

Will Directive #58 significantly increase the number of people receiving MANH?

Although at this point in time, the answer to this question is rather speculative, it is not likely that Directive #58 will significantly increase the number of people on MANH. The Directive merely puts into the ERDs a teaching that has been in effect for several years. There is no indication of a significant increase in MANH for PVS patients in either 2004 or 2007.

Will a Catholic hospital initiate MANH against the patient’s wishes?

No hospital or physician, including a Catholic hospital or physician, may ever initiate a non-emergency invasive procedure, such as inserting percutaneous endoscopic gastrostomy (PEG)

tube, without the permission of the patient or his or her surrogate. This could be considered an affront to human dignity and, in addition, could give rise to legal proceedings.

Does the new Directive #58 mean that Catholic health care facilities will not honor a patient's advance directive?

No, it does not. In the vast majority of cases, patients' advance directives will be honored. As previously noted, MANH at the end of life may be medically inappropriate. There may be the occasional situation, such as some patients in a persistent vegetative state, when what the patient is requesting through his or her advance directive is not consistent with the moral teaching of the Church. In these few cases, the Catholic health care facility would not be able to comply.

But this is nothing new. Directives #28 already notes that "the free and informed health care decision of the person or the person's surrogate is to be followed so long as it does not contradict Catholic principles." And Directive #59 echoes this: "The free and informed judgment made by a competent adult patient concerning the use or withdrawal of life-sustaining procedures should always be respected and normally complied with, unless it is contrary to Catholic moral teaching." In those rare instances when the Catholic health care organization is not able to comply with an advance directive, it is not permitted to impose MANH upon the patient contrary to the patient's wishes as they are expressed in the advance directive or by the patient's surrogate. This could give rise to legal proceedings. Instead, other options would need to be explored.

Does Directive #58 place Catholic health care facilities in conflict with Federal and/or state laws?

Directive #58 does not appear in and of itself to conflict with any federal or state law. Whether the *application* of Directive #58 will conflict with a given state law depends on the circumstances of each individual case.

Does the revision of Directive #58 change the standard of care, often described as ordinary and extraordinary means, as traditionally used by Catholics?

Part of the long moral tradition of the Catholic Church regarding end of life issues has been the moral distinction between "ordinary" and "extraordinary" means. As shown in Directives #56 and #57, this distinction involves an assessment of the burdens and benefits of a treatment. Those means of preserving life are proportionate or "ordinary" and therefore obligatory when "in the judgment of the patient [they] offer a reasonable hope of benefit and

do not entail an excessive burden or impose excessive expense on the family or the community” (Directive #56). Those means of preserving life are disproportionate or “extraordinary” and therefore not morally obligatory when “in the judgment of the patient [they] do not offer a reasonable hope of benefit or entail an excessive burden or impose excessive expense on the family or the community” (Directive #57). The language of Directive #58 continues to allow for this burden/benefit assessment with regard to MANH.

Please note: This document reflects the views of CHA ethics staff and is not intended to be an official interpretation of Directive #58.

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