FEATURE ARTICLE

Artificial Nutrition and Hydration: Advancing the Conversation

By Birgitta N. Sujdak Mackiewicz, Ethics Fellow, OSF Saint Francis Medical Center, Peoria, IL

JUST PRIOR TO BEING HONORED at the Catholic Health Association's 21st Annual Theology and Ethics Colloquium, Fr. Kevin O'Rourke, OP, JCD, STM, presented his observations regarding "The Development of Catholic Teaching on the Use of Assisted Hydration and Nutrition" at an event sponsored by the Center for Health Care Ethics and the Department of Philosophy at Saint Louis University. A response was given by Fr. John Kavanaugh, SJ, a professor of philosophy at Saint Louis University. Following the presentation, the audience had the opportunity to engage the two speakers. Not surprisingly, a lively discussion ensued. Some of that discussion is reflected in the summary below.

Drawing on his own body of work,[1] O'Rourke emphasized what he understands to be the important questions in the debate surrounding the provision of artificial nutrition and hydration (ANH). Three main questions emerged: 1) whether ANH is medical treatment or medical care, and whether that distinction is relevant; 2) by what other measures we might evaluate the appropriateness of ANH for those in a PVS; and 3) what weight the March 2004 papal allocution and further statements carry in light of the tradition of the church's teachings.

Medical treatment or care?

In examining the first issue of whether ANH is medical treatment or care, O'Rourke, a professor of bioethics at Loyola University Chicago's Stritch School of Medicine, acknowledged the varying opinions on the matter and the medical interventions necessary to provide the ANH, i.e., a physician order for the placement of a percutaneous endoscopic gastrostomy (PEG) tube. Recognizing that this debate may never be settled, yet not deterred by the lack of consensus on this issue, O'Rourke noted that the question of whether ANH is medical treatment or medical care is irrelevant, citing Daniel Sulmasy's recent detailed explication of the issue.[2] Rather, he emphasized the relevant question according to Catholic tradition is whether the ANH, regardless of its status as treatment or care, is overly burdensome.

The tradition allows the refusal of both treatment and care that is determined to be overly burdensome in relation to the benefit it provides the patient. Thus even if ANH is determined to be medical care, to justify its use one must determine if the benefits it provides outweigh the accompanying burdens of ANH. Arguing that it is morally possible to determine that a patient diagnosed as being in a persistent vegetative state (PVS) will not recover, O'Rourke situated the evaluation of the benefits of ANH in light of the understanding that PVS is a fatal pathology, that ANH merely prolongs the inevitable death of the patient, and does not offer any hope of reversing the PVS. O'Rourke also emphasized the subjective nature of evaluating the burden of ANH, reminding the audience that this evaluation rightly rests with the patient and family, not the church.

While further considering the benefits and burdens of ANH, O'Rourke emphasized the need to examine how ANH enables the PVS patient to fulfill the purpose of life: friendship with God in this life and the next. O'Rourke questioned whether, in the case of PVS patients, ANH benefits the patient by promoting this goal or places a greater burden on the patient by hindering the patient's ability to continue his or her friendship with God in the next life.

Statements from the church

Turning to recent church statements on ANH, beginning with an examination of the allocution by Pope John Paul II,[3] O'Rourke noted that the allocution speaks of the requirement of providing ANH in principle (which, in French, the language of the allocution, translates to "as a general rule"), allowing for further discussion on the issue. Reflecting on conversations with various church officials, academics, and his personal experiences, O'Rourke observed that while the allocution may have led to further discussion on the issue, it also led to confusion. For exam-

ple, many bishops remain unclear on how to interpret the allocution, leading to a request by the U.S. Conference of Catholic Bishops for further clarification from the Vatican's Congregation of the Doctrine of the Faith. No answer has been received thus far.[4] Additionally, O'Rourke cautioned, statements such as the allocution are recognized as opinion[5] rather than magisterial teaching, and have not been repeated, suggesting that they are thus non-binding. Finally, such statements must be evaluated in light of subsequent allocutions like that of November 2004 regarding pastoral and palliative care. In this document, the pope emphasized "True compassion . . . encourages every reasonable effort for the patient's recovery. At the same time, it helps draw the line when it is clear that no further treatment will serve this purpose."[6]

Feeding by hand

Agreeing with O'Rourke that it was possible to make judgments in the appropriate application of principles, Kavanaugh approached the issue from a different angle. He did not focus on the question of whether one has a moral obligation to provide ANH to patients in a PVS, rather, he argued that if we discern that ANH is inappropriate or not morally required, the burden lies in showing why we are not then required to *attempt* to feed those patients by hand. This hand feeding approach is called "assisted feeding" and involves massaging the throat to initiate the patient's swallow reflex.

Reflecting on the example of the death of John Paul II and his refusal of a PEG tube and large doses of antibiotics, Kavanaugh proposed that this might inform our discussions on the question of ANH for patients in PVS or other diseases such as Alzheimer's. He raised two particular concerns: 1) the absence of a phenomenology of feeding, and 2) what we understand to be our goals in life.

Acknowledging that ANH may not be morally obligatory for those in PVS, and taking a self-described metaphysical approach, Kavanaugh questioned why an alternative method of feeding, such as assisted feeding, is not offered. If the intention is to withhold or withdraw treatment or care that is overly burdensome, is there not an obligation to attempt to find a different, less burdensome means of providing nutrition and hydration? Sharing his experiences abroad, Kavanaugh noted that the vast majority of patients in PVS could be fed by hand as their swallowing reflex can be provoked,[7] but currently we lack the human resources to provide this hand feeding. Concerns about the cost of providing assisted feeding may be addressed by reexamining our mission in Catholic health care. Why would we question the provision of resources for assisted feeding, but not hesitate to provide more expensive technological interventions of various kinds? By medicalizing feeding, Kavanaugh argued, we have lost the human meaning associated with feeding: touch, companionship, presence, and accompaniment in their illness.

Initially meant as a short-term means of providing nutritional support, Kavanaugh lamented that we now often choose the PEG tube because it is the easier mechanism of feeding, not the more effective or less risky means. The use of the PEG has led us to forget what it is that we are trying to accomplish with the placement of the PEG. He suggested there is a personal interaction integral to the act and experience of feeding. If the hand feeding fails, however, this does not mean that there is a moral obligation to place a PEG. The moral obligation was to attempt to provide not only physical sustenance via assisted feeding, but also human solidarity. To emphasize how we have depersonalized the purpose of the PEG and the phenomenology of feeding, Kavanaugh recalled a story of a patient with a PEG (though clearly not in PVS) who asked for a beer. He desired the experience (taste and sensation) of enjoying a beer. Rather than handing the beer to the patient, it was poured into his PEG!

Goals of life

Kavanaugh concluded by challenging O'Rourke's notion of friendship with God as the ultimate goal. He argued that there is a more complex goal and capacity we have as human persons. We are challenged, he asserted, to "accept the kind of beings we are . . . beings who are limited and dependent." To ask whether or not our intervention benefits the person is not the issue. Rather, we must ask ourselves if we exhibit care, love, and honor for the person even in his or her "brokenness." Forgoing ANH may be morally justifiable, Kavanaugh argued, but not to attempt to feed by hand represents a "profound betrayal of friendship" of the one we must encounter and to whom we have an obligation both in "full flourishing" and in our "vulnerability." We must recognize the centrality of the human relationship in which we recognize the PVS patient not simply as a human person but as "the living God, word made flesh in his weakest moments."

The complex issues surrounding the question of the provision of nutrition and hydration for those in PVS and the inherent difficulty in making objective statements about the morality of the utilization or withholding of either ANH or assisted feeding was brought into sharp focus by O'Rourke's final comments during the discussion. Reemphasizing the subjectivity of an intervention such as assisted feeding, he remarked that from his perspective the "notion that I'm unconscious and someone is going to massage my throat so I swallow, is to me abhorrent. I don't want treatment of that nature." Perhaps the most human solidarity can provide is the guarantee that the subjectivity required to evaluate the burdens of either of these approaches assures that these questions will continue to be answered on a case by case basis, and always reflecting the dignity of the human person in PVS.

NOTES

1. For a detailed look at O'Rourke's position on ANH, see his recent article, "Artificial Nutrition and Hydration and the Catholic Tradition," *Health Progress,* May-June 2007: 50-54.
2. Daniel Sulmasy, "End-of-Life Care Revisited," *Health Progress,* July-August 2006: 50-56.
3. Pope John Paul II, "Care for Patients in a Permanent Vegetative State," Origins 33, no. 43 (April 8, 2004): section 4, 737-740.
4. Ironically, the question was submitted by the USCCB which, at the time, was headed by Cardinal William Levada. He is now the head of the CDF and must, therefore, answer his own question.
5. O'Rourke references a conversation he had with a member of the Pontifical Council on Life which has issued statements on the issue of PVS. This conversation affirmed that these documents, though signed by John Paul II, were recognized by the council as opinion rather than magisterial teaching.
6. Pope John Paul II, "Statement on Palliative Care: To the Participants in the 19th International Conference of the Pontifical Council on Pastoral Health Care," *National Catholic Bioethics Quarterly* 5, no. 1 (2005): 153-155.
7. Ronald Cranford, "The Persistent Vegetative State: The Medical Reality (Getting the Facts Straight)," *Hastings Center Report* 18, no. 1 (1988): 27-32.