

The CDF Statement on Artificial Nutrition and Hydration: What Should We Make of It?

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During the past few weeks, there has been much conversation within the Catholic health care community and among theologians and ethicists, both within and outside of Catholic health care, about the meaning of the most recent statement from the Vatican's Congregation for the Doctrine of the Faith (CDF) on artificial nutrition and hydration. The statement (or "Responses" to two specific questions posed by U.S. bishops) and an accompanying "Commentary," intended to clarify the meaning of the March 2004 allocution of John Paul II,¹ has actually generated a range of interpretations and a number of questions. In this short essay, I wish to try to sort out a) what seems to be clear in the statement and commentary, b) what seems less clear, and c) what is puzzling.

What Seems Clear In the CDF Statement and Commentary

One of the most important points in the March 2004 papal allocution, and again in the CDF statement, is that the person who is in a permanent vegetative state (PVS) retains full human dignity and must be treated accordingly. In light of this, the CDF statement says it is not morally permissible to remove artificial nutrition and hydration *solely* because that person will not likely regain consciousness. Permanent loss of consciousness does not result in a life that is any less valuable or any less worth preserving.

Equally clear in the commentary is that it is not morally permissible to withdraw a feeding tube for the explicit purpose of ending the PVS patient's life. This would constitute euthanasia.

The moral obligation to provide nutrition and hydration to persons in PVS seems to be a *prima facie* obligation ("in principle"), that is, it ought to be done barring extraordinary circumstances. Or, put differently, the burden of proof is on those who wish to withdraw. One such circumstance is if and when artificial nutrition and hydration become

medically futile, that is, they can no longer be assimilated by the person's body. Another is if they cause "significant physical discomfort." While the meaning of this phrase is not explained in the Responses, the commentary states that "the possibility is not absolutely excluded that . . . artificial nourishment and hydration may be excessively burdensome for the patient or may cause significant physical discomfort, for example resulting from complications in the use of the means employed." One would have to assume that such complications refer to chronic infections at the site of the tube, recurring aspiration pneumonia, diarrhea, and the like. Because the person in PVS is believed to be incapable of experiencing anything, one would have to assume that a judgment is being made that persons who are conscious would find these complications to be a "significant physical discomfort" and so the person in PVS would as well if he or she could experience them. The commentary refers to these occasions as "rare cases." One would also have to surmise that if the patient had co-morbidities (e.g., terminal cancer or end-stage heart disease), those co-morbidities would impact an assessment of the burdens and benefits of tube feeding. A final exception, noted in the commentary, but not in the Responses themselves, is if and when artificial nutrition and hydration cannot be provided because they are not available ("very remote places") or cannot be afforded ("situations of extreme poverty").

There is at least one other consideration that seems to be clear. Like John Paul II's allocution, the CDF statement and commentary are explicitly directed to persons in a permanent vegetative state, not to other types of patients. Hence, what is said in these documents should be limited to PVS patients. A key factor in interpreting Vatican documents is that they should be interpreted narrowly, not broadly. But why only PVS patients? From the perspective of the CDF (and John Paul II), these individuals are not dying and do not have a terminal pathology. In the words of the commentary, they "are not facing an imminent death." Instead,

as some say, they are seriously disabled. Given this limited application, the CDF statement should have very little impact on Catholic health care. Where it will likely have some impact is on long-term care facilities and, there, it will only affect some PVS patients (i.e., those for whom the exceptions do not apply).

What Is Less Clear from the CDF Statement and Commentary

A question that has arisen and which is not addressed in the CDF statement and commentary (nor was it addressed in John Paul II's allocution) is whether a PVS patient's advance directive can be honored if it explicitly states that the person would not want to be kept alive through artificial nutrition and hydration if in a PVS. It is quite possible that the individual, while still well, considers a lifetime on a feeding tube and/or in an unconscious state to be psychologically abhorrent and excessively burdensome. The judgment is from the future patient's perspective. It is not a judgment that the person has no value nor does it involve a judgment by someone else that the individual's life has no value. Nor is the removal of artificial nutrition and hydration viewed as a means to end one's life. It is simply an expression by the individual that a life maintained through a feeding tube without being able to experience the joys of eating and drinking by mouth is psychologically repugnant and constitutes an excessive burden. Others will likely come to a different conclusion and will argue that such advance directives, in the case of PVS, cannot be honored in a Catholic facility and the patient will need to be transferred. It seems reasonable that these situations will need to be judged on a case-by-case basis.

What is Puzzling about the CDF Statement and Commentary

The CDF statement and commentary (like the papal allocution of March 2004) raises a number of puzzling questions. These questions are likely to fuel theological debate for some time and, perhaps, even raise concerns among a variety of groups.

One such puzzlement is a seeming shift from a 500-year-old theological tradition in the determination of what constitutes ordinary and extraordinary means and, hence, what is and is not morally obligatory. In the theological tradition, no intervention, no matter how simple or basic or

readily available, was said to be ordinary or extraordinary apart from an assessment of the burdens and benefits of the intervention on a particular patient.² The same intervention could be ordinary for one patient (and, hence, morally obligatory) and extraordinary for another (morally optional) depending on the condition of each patient. Yet, in the CDF documents, artificial nutrition and hydration are said to be "an ordinary and proportionate means of preserving life . . . [and] therefore obligatory," apart from any patient-centered considerations. The only way this could be said *not* to be a change from the traditional approach is if this statement were to mean "in the abstract, feeding tubes are an ordinary means of preserving life and are therefore morally obligatory," but one must always make specific determinations in relationship to the particular patient. Even this, however, would seem to be a somewhat different approach from past formulations because typically assessments of benefits and burdens are to be made by the patient (or at least from the perspective of the patient, to the degree possible) and these judgments are not made in the abstract.³

Another puzzlement is how benefits and burdens are understood.⁴ Benefits in the theological tradition have seemed to be understood broadly.⁵ Interventions could result in a variety of benefits to the individual considered, at least implicitly, holistically. But the notion of benefits in the CDF documents seems to be reduced to maintaining physiological existence. Feeding tubes benefit the body, but do they benefit the person considered as a whole—emotionally, psychologically, socially, spiritually? In addition, the criterion for judging the benefit of feeding tubes is whether they achieve their purpose (finality), i.e., preserve life. Does this criterion apply only to feeding tubes or does it also apply to other interventions as well? One can think of any number of interventions in a medical context that achieve their purpose, but are really of no benefit to the person considered as a whole in certain situations (e.g., ventilators, dialysis, pressers, etc.). Would it be morally obligatory to continue these interventions simply because they attain their finality?

Also, in the theological tradition, an assessment of burdens could include burdens to the family and the community as well as to the individual.⁶ But the CDF documents exclude burdens to the family and community as a legitimate consideration in the moral assessment. Granted, the assessment

of such burdens is generally done by the patient. It is somewhat different, and potentially more dangerous, if family or community members determine that various interventions in the care of a patient are excessively burdensome to themselves. But it is not difficult to imagine situations where the burdens of care become excessive for a particular family, financially and otherwise. How would this differ from the burdens upon a family in the care of a cancer patient or one with Alzheimer's disease where these burdens can be part of a moral assessment?

There are any number of other puzzlements that deserve attention, but space does not permit their discussion here. However, I at least wish to note them:

- Referring to artificial nutrition and hydration as a “natural” means of preserving life when it consists in a man-made concoction of nutrients delivered through a tube
- Entirely dissociating the cause of death from the withdrawal of a feeding tube from one of the effects of the brain injury, namely, an inability to reach and grasp, to masticate, and to swallow
- Not referring to the 500-year-old theological tradition on ordinary and extraordinary means and, instead, only referring to select church documents going back to 1980
- Citing only that portion of the *Declaration on Euthanasia* that refers to “imminent death,” when, in the text, that is only one instance where treatment might be considered extraordinary and not morally obligatory
- Insisting that artificial nutrition and hydration are not a medical treatment because they are not intended to cure the inability to swallow when, in fact, there are many interventions in medicine that may not be intended to cure, but rather compensate for some malfunction or inability (e.g., ventilators at times, insulin injections, dialysis)
- Seeming to foster a certain vitalism as well as the technological imperative

There are also questions about the accuracy of the medical assumptions in the CDF statement and commentary and whether what is proposed conflicts with the standard practice of medicine. Other puzzlements are more of a legal nature. As noted above, how should Catholic health care facilities deal with advance directives and the legal requirements associated with them? How should they deal with the statement that artificial nutrition and hydration are not medical treatment when that is how they are understood in

medicine, and how they have been defined by some courts, including the U.S. Supreme Court, and some legislatures?

These are all issues for theological/ethical discussion and debate. In the meantime, Catholic health care facilities will hopefully take a measured response to the CDF statement, that is, they will take very seriously the fundamental concerns of the CDF—honoring the dignity of the person in PVS and not withdrawing artificial nutrition and hydration in order to end the person's life—while not going to the extreme of believing that feeding tubes must be continued in every single person in PVS without exception. Every intervention on a patient, whether it is a form of basic care or medical treatment, must be evaluated in relationship to each individual patient and his or her condition (and here the CDF statement can provide some boundaries and some guidance). Such evaluations are at the core of the Catholic theological tradition regarding the duty to preserve life and the limits to that duty. These evaluations and judgments are a vital expression of the wisdom of the Catholic tradition that results in avoiding two extremes—hastening death and prolonging life beyond what is reasonable. They are judgments grounded in part in some of the most basic beliefs of our religious tradition—that we are finite, that there is a time to die, and that we are ultimately called to eternal communion with the giver of life.

NOTES

1. John Paul II, “Care for Patients in a ‘Permanent’ Vegetative State,” *Origins* 33 (April 8, 2004): 737, 739-40.
2. See Daniel A. Cronin, “The Moral Law in Regard to the Ordinary and Extraordinary Means of Conserving Life,” in Rev. Russell Smith, ed., *Conserving Human Life*, Braintree, Mass.: Pope John XXIII Medical-Moral Research and Educational Center, 1989, pp. 3-145, especially pp. 90-92.
3. For further discussion of this issue, see Ronald Hamel and Michael Panicola, “Must We Preserve Life?” *America* (April 19-26, 2004): 6-13.
4. *Ibid.*
5. Cronin, pp. 85-98.
6. See, for example, Sacred Congregation for the Doctrine of the Faith, “Declaration on Euthanasia,” *Origins* 10 (August 14, 1980):154-56, Part IV.