ARTIFICIAL NUTRITION AND HYDRATION AND THE CATHOLIC TRADITION

The Terri Schiavo Case Had Even Members of Congress Debating the Issue

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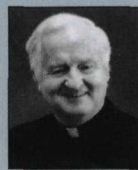
In most instances, the use of artificial nutrition and hydration (ANH) for a patient in a permanent vegetative state (PVS) is an issue of interest only to the patient's family, on one hand, and to theologians and philosophers, on the other. But in early 2005, the case of Theresa Marie "Terri" Schiavo became for several months the top news story in the nation. Before her feeding tube was finally removed and she died, in March of that year, Ms. Schiavo was the subject not only of countless newspaper articles and TV broadcasts but even of special laws passed in her name by a state legislature and the U.S. Congress.

It seems appropriate, then, to begin a discussion of the use of ANH in end-of-life decisions by pointing out two misconceptions that were prevalent in the wake of the Schiavo case.

First, some religious figures maintained that ANH should be applied until death is imminent and inevitable. They often used terminal illness as a synonym for imminent and inevitable death. Catholic teaching has never required that efforts to preserve life must be prolonged until the person's death is imminent and inevitable. If death is imminent and inevitable, then certainly life support may be removed. But it may also be withheld or removed if it does not offer hope of benefit or if it imposes an excessive burden upon the patient, the family, or the community to which the patient belongs.[1]



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Second, Ms. Schiavo was in a PVS, often called a "post-coma non-responsive condition" by Catholic theologians who react negatively to the term "vegetative." The thorough autopsy performed after her death by John R. Thogmartin, MD, the medical examiner of Florida's Pasco and Pinellas counties, found that her cerebral cortex was totally dysfunctional and her brain severely impaired.[2] She was not in a minimally conscious state, nor was there hope that intensive therapy might help her recover cognitive-affective function. The videotape, shown frequently on television programs, that seemed to show her responding to conversation or visually tracking a balloon was deceptive, if not contrived.[3] Clearly, there was moral certitude that she would not recover consciousness no matter what type of therapy might be employed.[4]

In this article, I will:

- Summarize the teaching of the church in regard to the use and forgoing of life support. Forgoing life support connotes both withholding and withdrawing surgical or medical interventions designed to heal or attenuate the effects of a lethal pathology. The act of withholding or withdrawing life support follows the same moral norms.
- Present the different opinions within the Catholic community in regard to the use of ANH.
- Present a theological framework for evaluating the use of ANH and other life-prolonging interventions.
- Consider advance directives as they relate to ANH.

TRADITIONAL CATHOLIC TEACHING

Traditional Catholic teaching in regard to using or forgoing life-sustaining interventions can be briefly summarized.[5]

Human life is a gift from God, and, in response

to that gift, human persons have a responsibility to use the means that will preserve human life.

However, human life is not an absolute good. Theological tradition and explicit church teaching allow one to forgo life-prolonging measures if they do not offer hope of benefit or do impose an excessive burden upon the patient, the patient's family, or the community to which the patient belongs. Thus a person suffering from a lethal pathology need not seek to eliminate, circumvent, or abate the pathology if doing so will cause the patient, the family, or the community to forsake another important human good. This decision is made by the patient, or by a surrogate if the patient is incompetent.

The criteria "hope of benefit" and "excessive burden" have led to the creation of a distinction between "ordinary" and "extraordinary" (sometimes called "proportionate" or "disproportionate") means. Although these terms are often used in the abstract, a proper and accurate use of the terms requires specific knowledge of the individual patient's condition.

Forgoing life-prolonging interventions—that is, allowing a person to die because life support offers no benefit or imposes an excessive burden—is not a form of suicide or euthanasia, both of which are prohibited in Catholic teaching. In the case of suicide or euthanasia, the purpose of the act (*finis operis*) is to end the life of the patient. The purpose of the act of allowing to die is to avoid performing an action that is either futile or overly burdensome. Note that, in these conditions, the conclusion is not that *life* is futile or burdensome, but that the means to prolong it are futile or impose grave burdens.*

Church Teaching on Use or Forgoing of ANH

The teaching of theologians and the magisterium (the pope and bishops) of the church concerning the specific use of ANH is not as unified and definite as that concerning life-sustaining interventions in general.

Some people wish to classify ANH as "comfort" or "natural" care; that is, they do not consider it a life-sustaining intervention.[6] Proponents of this view would classify ANH with basic nursing, like bathing patients and changing their linen. They maintain that ANH should always be utilized for dying people who cannot eat or swallow and that, even though it does prolong life, it should not be evaluated as a life-prolonging intervention. Pope John Paul II seemed to affirm this opinion when he stated, in his allocution of March 20, 2004, that ANH is not a medical act but, rather, a natural means of preserving life.[7]

Let us concede for the moment that ANH is not a medical act but a natural means to preserve life. (Most people in the fields of medicine and clinical bioethics would not make this concession, because utilizing ANH involves nursing expertise and, often, anesthesia and surgery.) Even natural care must be evaluated ethically, in terms of hope of benefit and excessive burden.[8] For example, good nursing care requires that a bedridden patient be turned frequently so that he or she will not develop decubitus ulcers; but if turning

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should involve great pain or possibly even broken bones, it should *not* be performed because it might then impose an excessive burden.

If ANH is considered a form of life-sustaining intervention, the opinion of Catholic theologians is not unified. There is disagreement in relation to the hope of benefit and to the burden associated with its use.

Hope of Benefit Some theologians—let us call them the "Alpha Group"*—maintain that the prolongation of life of people who cannot eat or drink and who have no potential for cognitive-affective function (people, for example, in a PVS or suffering from advanced Alzheimer's disease), is a "great benefit" because it prolongs human life and helps them avoid a painful death. (The most authoritative study of patients in the PVS condition maintains that they do not experience pain.)[9]

Some Alpha Group adherents maintain that the papal allocution confirmed this opinion by stating that "use of ANH should be considered in principle ordinary and proportionate and as such morally obligatory."[10] However, it seems certain that "in principle" does not mean absolute and for all cases.[11] Thus a final decision concerning

*Thus people with disabilities are not per se the topic of this article. See the *Not Dead Yet* website (www.notdeadyet.org), for example.

*The main proponents of this opinion are Germain Grisez, PhD; William May, PhD; and Joseph Boyle, PhD, although many others joined them in the article in which they originally stated their opinions: "Feeding and Hydrating Permanently Unconscious and Other Vulnerable Persons," *Issues in Law & Medicine*, vol. 3, no. 2, Winter 1987, pp. 203-217.

whether the use of ANH is appropriate will still require complete knowledge of the patient's condition and resources.[12] *Moreover, the allocution's* statements have not been repeated by the teaching authority of the church, which a sign that this teaching is not authoritative.[13] Finally, in a later statement on palliative care for the dying, Pope John Paul II seemed to affirm the traditional teaching. He stated:

> True compassion encourages every reasonable effort for the patient's recovery. At the same time, it helps to draw the line when it is clear that no further treatment will serve the purpose. Indeed, the object of the decision of whether to withdraw the treatment has nothing to do with the value of the patient's life, but rather whether such medical intervention is beneficial for the patient. The possible decision not to start or to halt a treatment will be deemed ethically correct if the treatment is ineffective or obviously disproportionate to the aims of sustaining life or recovering health.[14]

Other theologians—we will call them the "Beta Group"*—maintain that human life in a condition bereft of cognitive-affective function is not a great benefit, for either the patient, the family, or the community. They base their opinion on the premise that a person in this condition is no longer able to strive for the spiritual purpose of life. They support their position by quoting the famous statement of Pope Pius XII, made when he was discussing the use of mechanical ventilation: "Life, health, all temporal activities are in fact subordinated to spiritual ends,"[15] and by citing supportive statements from professional societies and surveys.[16]

In Regard to Excessive Burden Alpha Group theologians maintain that ANH is not an excessive burden because it is not expensive and can be administered by family members or nonprofessional aides.[17] Moreover, they avow that sustaining human life in a noncognitive condition shows solidarity (charity) with the patient.[18]

Beta Group theologians point out that, even though the formula and intravenous feeding tubes used in administering ANH are not themselves expensive, implanting the tubes often requires anesthesia and surgery and that, moreover, PVS patients are often cared for in private or state facilities, which are very expensive.[19] Also, they maintain that solidarity (charity) is better demonstrated through prayers for the dead than it is by prolonging life that does not benefit the patient.[20]

A Theological Framework for ANH

We are born with a natural desire to strive for many of the goods of human life— for example, life, reproduction, society, and truth.[21] To prolong life, we strive for health of mind and body. Throughout history, various professions have been founded and developed in order to promote this quest. Especially in the past 100 years, the professions of medicine and public health have helped people to lead healthier and longer lives. The success of medicine disposes medical professionals and the public at large to think of a long life as the goal of human existence.

Christians (and adherents of other faiths as well) are convinced that although we all seek health, longevity is *not* the goal of human life. Rather, the manner in which we strive for, and utilize, the goods of *this* life is related to attaining *eternal* life. As Thomas Aquinas stated: "Everyone has it instilled by nature to love their own life and whatever is directed thereto and to do so in due measure, that is, to love these things not as placing their end therein, but as things to be used for the sake of the last end."[22] Christ told us about our last end when he spoke about the Kingdom of God and about how people must live in order to be worthy of that Kingdom. It is clear from his life and preaching that the Kingdom is not of this world. It may be "near" but it is "not yet."[23] The Kingdom, for Christians as individuals and as a community, is beyond human life.

Hence while we strive for the goods of human life and seek to prolong our lives with the help of medicine, we know from experience and faith that death is inevitable, a fact of human life. Avoiding death at all costs has never been a tenet of Catholic faith. Is death a penalty, a mitigated evil, or can it be reckoned as the fulfillment of human life? Cardinal Joseph Bernardin offers us an example of how death can be a fulfillment. "It's very simple," he writes. "If you have fear and anxiety and you talk to a friend, then these fears and anxieties are minimized and could even disappear. If you see them as an enemy, then you go into a state of denial and try to get as far away as possible from them. People of faith who believe that death is the transition from this life to eternal life, should see death as a friend."[24]

To coordinate the benefits of medicine with striving for eternal life, let us turn to Thomas Aquinas. In the *Summa Theologica* and in other writings,

*Among these writers are the late Fr. Richard McCormick, SJ, STD; Fr. John Paris, SJ, PhD; James Shannon, PhD; James Walters, PhD; Fr. John F. Tuohey, PhD; Fr. Kevin O'Rourke, OP, JCD; Fr. Benedict Ashley, OP, PhD; and Fr. Albert Moraczewski, OP, PhD

Thomas presented the goal of human life as happiness, which is found in charity, that is, in friendship with God.[25] He maintained that we strive for this goal through "human acts" (*actus humanus*), that is, acts of intellect and will.[26] He distinguished these acts from "acts of the person" (*actus hominis*), that is, acts of the autonomic nervous system, vegetative and mere physiological acts that of themselves do not enable us to strive for happiness.[27] Medicine has developed to the extent that it can keep people alive in a condition in which they will be able to perform *only* physiological acts, with no capacity for ever again performing human acts. Is there a moral obligation to use life-sustaining interventions to keep people in this condition alive?

Some Alpha Group writers maintain that there is an obligation to keep people in the PVS condition alive because they are not suffering from a fatal or lethal pathology. However, a more complete evaluation of their condition reveals that a fatal pathology—the inability to eat and drink—is indeed present but is being abated by ANH. Is it beneficial for the patient to continue this form of life support? Does life in this condition outweigh the burdens that are imposed upon the patient, the family, or the community?

These theologians also maintain that using the Thomistic distinction between human acts and acts of the person leads to dualism. My colleague Fr. Benedict Ashley, OP, has adequately spoken to this allegation. "The human body is human precisely because it is a body made for and used by intelligence," he writes. "Why should it be dualism to unify the human body by subordinating the goods of the body to the good of the immaterial and contemplative intelligence?"[28]

Moreover, the form of the human organism is the rational soul.[29] But the soul needs proportionate matter—the functioning human body (specifically, the human brain)—in order for the organism to strive for its purpose in life.[30] It is not dualism to maintain that when the body (brain) and soul are no longer proportionate to one another, it no longer benefits the human entity to preserve its existence.

The Advance Directive and ANH

There are two forms of advance directive, the living will and the durable power of attorney (DPA). The latter is a better method of receiving or avoiding medical care as one approaches death. However, not even the DPA avoids all problems. It requires that the attorney-in-fact be aware of the wishes of the person for whom he or she speaks and be firm in relaying these wishes accurately to the medical team. As Bill Colby, the lawyer for Nancy Beth Cruzan, observed: "If you want your document to work, you'd better do more than fill it out. . . . For the document to be effective, we have to prepare our agents to be our advocates. And we need to talk, not only to the person to whom we have given decision making power, but with everyone we think might be in the room when decisions are made."[31]

Most states permit conscious patients to refuse ANH; unconscious patients can have arranged to refuse it through an advance directive.* Advance directives are acceptable for implementation in Catholic hospitals if they are in accord with the teaching of the church.[32] The church has set parameters for these documents, seeking to avoid two extremes: "On the one hand, an insistence on useless or burdensome technology . . . and, on the other hand, the withdrawal of technology with the intention of causing death."[33] In determining hope of benefit and degree of burden, the patient (or the patient's proxy) is given freedom of decision making.[34]

As a result of the March 2004 papal allocution, several people and some state Catholic conferences have sought to limit the options insofar as ANH is concerned. For example, the Kansas Catholic Conference has maintained that an advance directive should state "that if I am unable to eat and drink on my own, food and fluids must be provided for me in an assisted manner."[35] This is a form of ecclesiastical positivism. Statements of this nature are not contained in the episcopal letters concerning end-of-life care issued by the Catholic conferences in Illinois, Wisconsin, and Kentucky.[36] A person who thinks that providing ANH or any other form of medical care would constitute an excessive burden for the family, if he or she were to become permanently unconscious, can renounce such care in an advance directive.[37]

Teaching Is Consistent

The teaching of the Catholic Church in regard to preserving human life has been consistent for the past 500 years. The principal criteria for utilizing or forgoing life support are hope of benefit and degree of burden. These criteria apply to the use of ANH, as they do to all medical and surgical procedures currently in use or to be developed in the future.

*Choice in Dying, Box 377, Newark, NJ 07101-9792, offers DPA forms tailored for each of the states.

NOTES

1. Congregation for Doctrine of the Faith, *Declaration on Euthanasia,* May 5, 1980 (www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19800505_euthanasia_en.html); U.S. Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services,* Washington, DC, 2001, Directives 56 and 57.
2. A. L. Caplan, J. J. McCartney, and D. A. Sisti, eds., *The Case of Terri Schiavo: Ethics at the End of Life,* Prometheus Books, Amherst, NY, 2006, pp. 290-314.
3. M. Schiavo and M. Hirsh, *Terri: the Truth,* Dutton, New York City, 2006, p. 175.
4. J. Wolfson, "Summary of Guardian ad Litem Recommendations" in Caplan, McCartney, and Sisti, pp. 99-100; and R. Cranford, "Facts, Lies, and Videotapes: The Permanent Vegetative State and the Sad Case of Terri Schiavo," *Journal of Law, Medicine, and Ethics,* vol. 33, no. 2, Summer 2005, pp. 363-371.
5. There are several sources for Catholic teaching in regard to life support. In addition to the *Declaration on Euthanasia, see also the Ethical and Religious Directives,* Part Five, and B. Ashley, J. deBlois, and K. O'Rourke, *Health Care Ethics: A Catholic Theological Analysis,* 5th ed., Georgetown University Press, Washington, DC, 2006, Chapter 7.
6. R. Doerflinger, "Pope John Paul II on Nutrition and Hydration for the Seriously Ill and Disabled," in E. J. Furton, ed., *Live the Truth: The Moral Legacy of John Paul II in Catholic Health Care: Proceedings of the Twentieth Workshop for Bishops,* National Catholic Bioethics Center, Philadelphia, 2006, pp. 233-353.
7. Pope John Paul II, "Care for Patients in a Permanent Vegetative State," *Origins,* vol. 33, no. 43, April 8, 2004, section 4, pp. 737-740.
8. See Ashley, deBlois, and O'Rourke, Chapter 7; and Doerflinger, p. 242.
9. Multi-Society Task Force on PVS, "Medical Aspects of the Persistent Vegetative State," *New England Journal of Medicine,* vol. 330, nos. 21 and 22, May 26, 1994, and June 2, 1994, pp. 1,499-1,508; 1,572-1,579.
10. Pope John Paul II.
11. Canadian Catholic Bioethics Institute, "Reflections on Artificial Hydration and Nutrition," *National Catholic Bioethics Quarterly,* vol. 4, no. 4, Winter 2004, pp. 773-784. The French version of the papal allocution uses the term *regle general* (general rule) for "in principle."
12. See Ashley, deBlois, and O'Rourke, Chapters 6-7.
13. "Instruction on the Ecclesial Vocation of the Theologian," *Origins,* vol. 20, no. 8, July 5, 1990, pp.117-126; see also K. O'Rourke, "Reflections on the Papal Allocution Concerning Care for Persistent Vegetative State Patients," *Christian Bioethics,* vol. 12, no. 1, April 2006, p. 94.
14. 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,* vol. 5, no. 1, Spring 2005, pp. 153-155.
15. Pope Pius XII, "Address to an International Congress of Anesthesiologists," *The Pope Speaks,* vol. 4, no. 4, 1958, pp. 395-396.
16. B. Jennett, *The Vegetative State: Medical Facts, Ethical and Legal Dilemmas,* Cambridge University Press, Cambridge, England, 2002, Chapter 6 ("Attitudes to the Permanent Vegetative State"); American Academy of Neurology, "Position Statement on the Management and Care of the Persistent Vegetative State Patient," *Neurology,* vol. 39, January 1989, pp. 125-126; American Medical Association, Council on Ethical and Judicial Affairs, "Decisions Near the End of Life," *JAMA,* vol. 267, no. 16, April 22, 1992, pp. 2,229-2,233.
17. W. May, "Caring for Persons in a Persistent Vegetative State," unpublished paper, delivered to Continuing Education Seminar for Priests, April 20, 2005, p. 3.
18. G. Grisez, "Difficult Moral Questions: May a Husband End All Care of His Permanently Unconscious Wife?" *Linacre Quarterly,* vol. 63, no. 2, May 1996, p. 44.
19. D. Sulmasy, "End-of-Life Care Revisited," *Health Progress,* July-August 2006, p. 50.
20. K. O'Rourke, P. Norris, "Care of PVS Patients: Catholic Opinion in the United States," *Linacre Quarterly,* vol. 68, no. 3, Summer 2001, p. 204.
21. T. Aquinas, *Summa Theologica,* I-II: 94: 2.
22. Aquinas, II-II: 126: 1.
23. J. Dunn, *Jesus Remembered,* Eerdmans, Grand Rapids, MI, 2003, p. 435.
24. J. Bernardin, *The Gift of Peace: Personal Reflections,* Loyola University Press, Chicago, 1997, pp. 127-128.
25. Aquinas, II-II: 23: 1. See also *Catechism of the Catholic Church,* Libreroa Editrice Vaticana, Vatican City, 2000, section 1, p. 356.
26. Aquinas, I-II, 1: 1.
27. Aquinas.
28. B. Ashley, "What Is the End of the Human Person?" in L. Gormally, ed., *Moral Truth and Moral Tradition: Essays in Honor of Peter Geach and Elizabeth Anscombe,* Four Courts Press, Dublin, Ireland, 1994, p. 73.
29. Aquinas, I, 76: 1.
30. Aquinas, I, 90: 4: ad 1.
31. William H. Colby, *Unplugged: Retaining Our Right to Die in America,* Amacom, New York City, 2006, p. 145.
32. U.S. Conference of Catholic Bishops, Directive 24.
33. U.S. Conference of Catholic Bishops, Introduction to Part Five.
34. U.S. Conference of Catholic Bishops, Directive 26; Kevin Wildes, "Ordinary and Extraordinary Means and the Quality of Life," *Theological Studies,* vol. 57, no. 3, September 1996, p. 510.
35. Kansas Catholic Conference, "Catholic Declaration on Life & Natural Death," Merriam, KS, January 20, 2006 (go to http://kansas.nasccd.org and click on "Statements."
36. Illinois Catholic Health Association, "Facing the End of Life" (go to www.il-cha.org/ and click on "Resources"); Wisconsin Catholic Conference, "Now and at the Hour of Our Death" (go to www.wisconsin. nasccd.org/ and click on "Resources"); Kentucky Catholic Conference, "Kentucky's Advance Health Care Directives: A Catholic Perspective" (go to www.ccky.org/ and click on "Publications").
37. Sulmasy, p. 56.