Developing Directive 58

A Look at the History of the Directive On Nutrition and Hydration

BY REV. THOMAS R. KOPFENSTEINER, STD

Fr. Kopfensteiner teaches moral theology at Fordham University, Bronx, NY.

Although many of the developments of the recently revised *Ethical and Religious Directives for Catholic Health Care Services (ERD)** have been documented, a complete history of the 1994 revision has not yet been written. The revision was the responsibility of the National Conference of Catholic Bishops (NCCB)'s Committee on Doctrine, which set up a special commission in 1987 to initiate the task. The special commission proposed the rationale for a thorough revision of the *ERD*, which had been operative since 1971 with minor additions in 1975; the commission provided an outline of the revision; the commission also prepared draft texts of the revised *ERD*. Each of the draft texts reflected the work of the members of the special commission, the Committee on Doctrine, and select centers that were intimately involved in healthcare across the country. Those centers were the Catholic Health Association, the Pope John Center, the Medical Moral Board for the Catholic Health Facilities of the Archdiocese of San Francisco, the Center for Health Care Ethics at St. Louis University Medical Center, and the Kennedy Institute of Ethics. In March 1993 the special commission was dissolved by the chair, leaving it to the full Committee on Doctrine to complete the revision.

This article deals with the development of Directive 58, which concerns the provision of "nutrition and hydration to all patients, including those who require medically assisted nutrition and hydration." The issue of nutrition and hydration was a pressing one when the special commission began its work, especially in light of the case of Nancy Cruzan, who was diagnosed to be in a persistent vegetative state. Tracing the genesis of the directive will show the bishops' desire not to provide a definitive statement with regard to the person in a persistent vegetative state but to present in a balanced way the church's moral tradition concerning the use or withdrawal of life-sustaining procedures.

This article has three parts. Part one deals with the first drafts of the *ERD* when the revision was the responsibility of the special commission. Part two deals with how the Committee on Doctrine dealt with the issues of nutrition and hydration and the persistent vegetative state. Part three details the final changes to the text in light of observations by the Congregation for the Doctrine of the Faith. Presenting the sometimes divergent formulations of the *ERD* will show how the present wording was decided on only after several years of open and frank discussion.

The Genesis of the Directive, 1991-1992

The first draft of the *ERD* was dated May 1991. There were five parts to the *ERD*, each consisting of a narrative introduction and specific directives. "Issues in Caring for the Dying Person" was Part Four. Nowhere in the draft text did the bishops deal explicitly with nutrition and hydration. In the introduction, they wrote only that "especially in the dying process we must evaluate the use of technology at our disposal, conscious that we can use the technology at hand to maintain physical life far beyond its meaningful continuance." They mentioned the persistent vegetative state, however, explicitly in a directive. "Although partial brain death is not a sufficient criterion to claim the patient's organs for transplantation, in certain cases, e.g., a persistent vegetative state, this criterion is a factor in determining proper treatment" (Directive 43). The draft text of July 1991 was substantially the same, although the text now referred to the patient in a persistent vegetative state as a dying patient. This way of speaking

*U.S. Catholic Conference, Washington, DC, 1995.

about the patient was meant to move the discussion away from emotional language that described the patient as severely disabled or as starving.

The draft texts reveal that the bishops initially dealt with the persistent vegetative state more explicitly than with the issue of medically assisted nutrition and hydration. Even then, some bishops expressed serious reservations about the wording of the proposed directive, but suggested no alternative wording. At this time, too, the Committee for Pro-Life Activities was preparing its statement on the issues and, although it was being written in consultation with the Committee on Doctrine, the special commission suspected that the *ERD*, eventually, would build on the committee's work. In addition, the special commission thought the text could be revised after the healthcare centers had been included in the consultation process.

On the issues of nutrition and hydration and the persistent vegetative state, the responses to the draft text varied. Some readers offered no comment on the issues other than to applaud the commission's attempt to deal with them; others agreed that the issues needed to be addressed but found the draft text inadequate. Others questioned the accuracy of using partial brain death in reference to the treatment of the persistent vegetative state. Others thought that the provision of nutrition and hydration to a patient in a persistent vegetative state should be addressed in a single directive. Still others merely wanted further explanation of the relative value of purely physical life.

In light of these concerns, the February 1992 draft text stated in the introduction that "life-sustaining technology, including respirators, antibiotics, artificial feeding and hydration, must be judged in light of the Christian meaning of life, suffering and death." By drawing a parallel between a respirator and artificial feeding and hydration, it was thought that the argument about the persistent vegetative state could proceed from the universally held opinion that a lucid and conscious person could legitimately remove a respirator to the more doubtful position that a person who would never regain consciousness could have nutrition and hydration withdrawn or withheld. This reasoning was supported further in a directive which stated, "although life is sacred, it is not an absolute good; hence life need not be maintained by the use of all available technology. . . . The condition of the person, especially those who are dying, e.g. persons in the final stages of Alzheimer's, cancer or renal failure, or in the state commonly called a persistent vegetative state must be considered in decisions to discontinue or forego life sustaining treatment" (Directive 50). The subsequent text of July 1992 specified "those persons who were dying" as those "who have no reasonable hope of recovery" and made explicit that "rational reflection on the meaning of human life in all its dimensions is indispensable for formulating a moral judgement of the use of technology to maintain life." None of the texts, then, could support the argument that nutrition and hydration should be provided simply because it kept the person alive. The use of any technology is to take into account all dimensions of human living. The physical good of life cannot be exaggerated but must be balanced with the other goods humans pursue.

A New Direction, 1993-1994

The next revision of the *ERD* occurred in early 1993. At this point, the drafts more consciously reflected the concerns and interests of the members of the Committee on Doctrine. At the suggestion of one member, for instance, the *ERD* were expanded to include a separate section on spiritual and pastoral care to underscore the distinctiveness of Catholic healthcare. Consequently, "Issues in Care for the Dying" became Part Five. More substantially, the draft of February 1993 addressed the issue of persistent vegetative state from a new perspective. The narrative read:

> Some state episcopal conferences and individual bishops have addressed the difficult issue concerning artificial hydration and nutrition. They are guided by the Church's teaching which, in forbidding euthanasia, states: "By euthanasia is understood an action or an omission which of itself or by intention causes death, in order that all suffering may in this way be eliminated." While they agree that hydration and nutrition is not morally obligatory either when it brings no comfort to a person who is imminently dying or when it cannot be assimilated by a person's body, they present varying viewpoints concerning whether it is morally permissible to withdraw artificial hydration and nutrition from a person, for instance, in a persistent vegetative state. In evaluating the use of technology, then, physicians and patients are to be guided by these instructions and by the prudence that many ordinaries already have voiced.

Similar language was found in the draft texts of May 1993 and July 1993 with explicit reference to statements of the pro-life committee, several Texas bishops, the Oregon and Washington bishops, and the Pennsylvania bishops. There was no specific directive dealing with the persistent vegetative state in any of these texts. The only mention of nutrition and hydration occurred in a

directive which read "the free, informed and ethically justified decisions of the person concerning the use or withdrawal of life-sustaining treatment, including medically provided nutrition and hydration, should be respected." Whether one is ethically justified to withdraw or withhold nutrition and hydration from a person in a persistent vegetative state was the question with which the Committee on Doctrine—like the special commission before it—now began to struggle.

The bishops specified their approach to the issue of nutrition and hydration in the draft text of September 1993. The text was prepared for the meeting of the Committee on Doctrine in October in Weston, MA. Most significantly, Directive 61 simply read "the free, informed and ethically justifiable decisions of the sick person concerning the use or withdrawal of life-sustaining procedures should be respected." In other words, unlike the earlier draft texts, medically provided nutrition and hydration was no longer characterized explicitly as treatment.

This, of course, opened the way to characterize medically provided nutrition and hydration as care. Speaking of nutrition and hydration as care precludes them from being removed from a person in a persistent vegetative state, except in rare instances. One member suggested that the narrative be changed to read that "hydration and nutrition, even when provided artificially, are integral to health care. But, artificial hydration and nutrition are not morally obligatory when they bring no comfort to a person who is imminently dying or when they cannot be assimilated by a person's body. In the case of a permanently comatose person who is not imminently dying, the presumption is in favor of artificial hydration and nutrition. When the burdens seem disproportionate, explicit guidance should be sought from the local bishop."

The committee's draft text of November 1993, however, was more cautious. The bishops added to the narrative that "when it comes to provision for the dying, the Church recognizes legitimate distinction between normal care owed to the person, and medical procedures that either address the person's illness or the delivery of nutrition and hydration to the person. The former is always morally obligatory. The latter involves complex moral decisions that must be guided by the Church's moral traditions." The draft text of November 1993 also included a new and more nuanced directive, but without explicitly addressing the persistent vegetative state. "Ordinary care requires the administration of hydration and nutrition to patients, even by artificial means, as long as this is of sufficient benefit to the patient to outweigh the burdens involved for the patient and those who care for the patient" (Directive 67).

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The draft text of November 1993 was the first text sent to the entire NCCB; it was also sent to the healthcare centers that served the special commission. The text was also sent to the Congregation for the Doctrine of the Faith, though the congregation's observations were not reviewed until October 1994. The committee received over 1,100 suggested changes; about 150 for Part Five. On the one hand, some respondents questioned the meaning of "normal" and "ordinary" care, fearing that the traditional language of ordinary and extraordinary means of medical treatment was obscured. On the other hand, some thought that it was "embarrassing" to draw attention to the lack of consensus among the bishops on the issues, fearing that the text would lead to geographical morality. They encouraged the committee not to give equal weight to all the statements made by state Catholic conferences or individual bishops and suggested that the committee delete references to the various statements and make explicit reference only to the statement of the Committee for Pro-Life Activities.

The draft text of June 1994 was the result of the consultation. Two points can be made about the text. First, the narrative omitted any mention of the distinction between treatment and care. Consequently, the revised directive read "nutrition and hydration should be provided to patients, even by artificial means, as long as this is of sufficient benefit to the patient to outweigh the burdens involved" (Directive 59). Second, the committee did not raise any one episcopal statement on nutrition and hydration above another. The narrative section continued to reference the varying viewpoints of the bishops' statements on the issue of the persistent vegetative

state. Yet the text now read: "In evaluating this use of technology, *until more authoritative teaching is put forth*, physicians and patients can be guided by these local instructions and by the prudent judgement that many bishops have already voiced, giving due respect to the authority of the local bishop." In the draft texts of July 1994 and November 1994, the text in italics was changed to "in the present state of the question."

The Final Revisions, October-November 1994

The observations of the Congregation for the Doctrine of Faith were addressed by the committee at a meeting in October 1994 in Gulf Shores, AL. The congregation suggested that while it was helpful to note the various statements on the issue of nutrition and hydration, it would be appropriate to highlight the resource paper of the Committee for Pro-Life Activities; they argued that both doctrine and pro-life were committees of the conference. Their suggested rewording of the narrative is in italics.

> Some state Catholic conferences and individual bishops have addressed the moral issues concerning *medically assisted* hydration and nutrition. *The National Conference of Catholic Bishops' Committee for Pro-Life Activities also addressed this question in a major report in April 1992 entitled "Nutrition and Hydration: Moral and Pastoral Reflections." The bishops* are guided by the Church's teaching forbidding euthanasia which is ". . . an action or omission which of itself or by intention causes death, in order that all suffering may in this way be eliminated." These statements agree that hydration and nutrition are not morally obligatory either when they bring no comfort to a person who is imminently dying or when they cannot be assimilated by a person's body. *The NCCB Pro-Life Committee report, in addition, offers physicians and patients guidance concerning* varying positions on whether it is morally permissible to withdraw medically assisted hydration and nutrition from a person, for instance, who is in a persistent *comatose* state.

Some bishops, however, were hesitant to draw such explicit attention to the pro-life committee's report in the text of the *ERD*. While both groups were committees of the conference, the report of the pro-life committee was a document approved only by the 50-bishop Administrative Committee, not the full conference. Since the *ERD* were to be approved by the full conference, the bishops feared that they would be giving more authority to the report than it merited. Others countered that the pro-life committee's report had more authority than the statements of individual bishops or groups of bishops because the report had been submitted for review to the congregation.

A final draft text dated November 9, 1994, incorporated four changes. First, the narrative explicitly mentioned the Committee on Pro-Life Activities. Second, no mention was made that bishops' statements presented varying viewpoints on whether it was permissible to withdraw medically assisted nutrition and hydration from a person in a persistent vegetative state. Third, the bishops added that the pro-life committee's report "points out the necessary distinctions between questions already resolved by the magisterium and those requiring further reflection, as, for example, the morality of withdrawing medically assisted hydration and nutrition from a person who is in the condition which is recognized by physicians as the 'persistent vegetative state' (PVS)." Finally, only the report from the pro-life committee was referenced in the accompanying note.

At the November 1994 meeting of the bishops' conference, there were two developments. Some bishops wanted to amend the text to read "that nutrition and hydration are not morally obligatory *when they are ineffective in preserving life* or when they bring no comfort to a person who is imminently dying or when they cannot be assimilated by a person's body." Others wanted the text to read "that nutrition and hydration are not obligatory either when the means of providing the feeding and hydration cause a grave burden to a person who is imminently dying or when feeding and hydration cannot be assimilated by a person's body." Because these amendments would effectively preclude any debate when the issue was whether or not to provide medically assisted nutrition and hydration to the person in a persistent vegetative state, they were not accepted. The second change was in the wording of the directive. It was amended to read that "there should be a presumption in favor of providing nutrition and hydration to all patients, including patients who require medically assisted nutrition and hydration, as long as this is of sufficient benefit to outweigh the burdens involved to the patient" (Directive 58).

The language of the directive reflects a way of reasoning known as "tutiorism." Tutiorism holds that, in cases of doubt, one acts responsibly when the safer course is followed. When the fundamental good of life is at issue, as in the care for the dying, one proceeds in a tutioristic manner. Tutiorism, however, should not be understood simplistically. Tutiorism should not degenerate into rigorism. In a medical context, tutiorism refers only to the need to be certain of the diag-

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"Synergy" is a buzzword we hear often these days.

the Web site an even more useful tool for busy people. Imagine logging on to the CHA site and receiving not merely a personalized greeting but links to suggested resources which are based on your job responsibilities, your site history, and your stated interests and are particularly appropriate for your needs.

One of the many buzzwords that gets bandied about in the Internet world is "synergy," usually meaning the commingling of certain commercial interests to achieve mutually desired goals. You've probably seen Web sites that purport to offer a complete guide to something, say restaurants in your metropolitan area. It would be a rare site, indeed, that would actually present all the possible dining establishments objectively. The synergy in this example involves the Web site creator and the companies who pay to be part of the proffered list. The site pretends to be an objective guide but actually serves as a way to present covert advertising. That's synergy working against you, not with you.

Just as it has been doing with healthcare throughout its history, CHA seeks to model what this power of the Internet should be used for. That approach to the resources of this world is not really anything new for Catholic healthcare; nor is it any change in course for CHA to serve as a gathering point for the ministry. □

CHA's Web site can be found at www.chausa.org. David Warren welcomes your feedback at 314-253-3464; e-mail: dwarren@chausa.org.

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al out for developers in 2000. Most encouraging is the cooperation, enthusiasm, and willingness to invest resources of both the city of Alton and Saint Anthony's in their partnership.

It's clear from Saint Anthony's experience that a successful partnership of city and hospital depends on a number of important factors:

- Key stakeholders must be willing to make a real commitment. The goals of the partnership must be high priorities of all parties, and all must be willing to commit not only money, but also people's time and energy.
- The process needs a champion, someone who will continuously keep the vision in focus and maintain momentum, and who will be engaged in the process long enough to be a real driving force.
- You must have a plan that clearly maps out both the physical objective and the strategy to achieve it.
- Responsibility must be clearly defined.
- The process must progress independent of political changes. Institutionalize the plan and commitment so that the process is outside the political arena. Establishing the redevelopment corporation helped provide this separation in Hunterstown's case.
- Take advantage of your assets. In the case of Hunterstown, the potential for views of the Mississippi River and access to the waterfront add to the expectation that the neighborhood can become desirable. Development will capitalize on the advantages of this location.
- Stick to it. Effecting real change in a neighborhood is a long-term process, and success requires patience and the flexibility to adjust to the marketplace. □

For more information contact Warren Hauff, 314-725-2927; e-mail: warren.hauff@christnerinc.com.

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nosis and prognosis of the patient's condition.

Undoubtedly, physicians act responsibly by initiating treatments with the hope of stabilizing or improving the condition of the patient, especially in an emergency situation. The diagnosis of the persistent vegetative state only occurs over time. In other words, as the condition of the patient becomes clearer, the initial presumption that obliged the physician to treat the patient may wane; the presumption to treat the patient must eventually cede to the truth of the patient's diagnosis and prognosis.

When a patient is diagnosed to be in a persistent vegetative state one weighs the maintenance of life against a condition in which the patient will never know who he or she is; will never know familiar surroundings; will never recognize loved ones. In such a situation, one can legitimately judge medically assisted nutrition and hydration as a disproportionate means of preserving life; the burdens imposed outweigh the benefits gained. The decision to remove nutrition and hydration from such a patient does not signal callous abandonment; it is not done "with the intention of causing death." Rather, removing nutrition and hydration reflects the recognition that "the duty to preserve life is not absolute"; it is done with the intention of removing an excessive burden that no longer needs to be endured.

In the end, the bishops did not resolve the morality of withdrawing medically assisted hydration and nutrition from a person who is in a persistent vegetative state. Instead, they reiterated the traditional categories that help guide prudential healthcare decisions. Like all medical procedures, nutrition and hydration must be evaluated in terms of the benefits and burdens to the patient. Weighing the benefits and burdens will depend on an accurate diagnosis of the patient's condition which, as in the case of the persistent vegetative state, occurs only over time. Once a person is diagnosed to be in a persistent vegetative state, however, the *ERD* do not preclude the removal of nutrition and hydration from the patient. □