

NUTRITION AND HYDRATION

The CDF Response, In Perspective

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INTRODUCTION
This study examines the recently published document, "Responses to Certain Questions of the United States Conference of Catholic Bishops Concerning Artificial Nutrition and Hydration," from the Vatican's Congregation for the Doctrine of the Faith (CDF).¹ We begin with a summary analysis of the document, moves to a consideration of the exceptions to a "general rule" proposed by the CDF, considers two important contextual points made by the CDF, and closes by noting the moral significance of some of the pre-suppositions in the CDF response.

THE QUESTIONS

On Sept. 16, 2007, the CDF issued a response to two questions that had been submitted two years earlier by the bishops of the United States. The U.S. bishops were unsure about the full meaning of a statement made by Pope John Paul II in March 2004 concerning the care of patients in what is medically referred to as persistent vegetative state (PVS). (PVS is often called a post-coma non-responsive state in order to avoid the possible implication that an individual in this condition would no longer be regarded as a human person.) In 2005, the bishops posed two ques-

tions to the CDF seeking clarification of the pope's March 2004 allocution. The questions were:

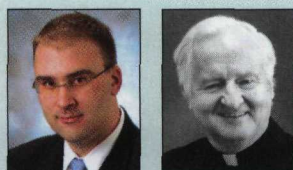
■ Is the administration of food and water (whether by natural or artificial means) to a patient in a vegetative state morally obligatory except when they cannot be assimilated by the patient's body or cannot be administered to the patient without causing significant physical discomfort?

■ When nutrition and hydration are being supplied by artificial means to a patient in persistent vegetative state, may they be discontinued when competent physicians judge with moral certainty that the patient will never recover consciousness?

THE CDF RESPONSE AND THE MEANING OF "IN PRINCIPLE"

The CDF responded to these questions proposed by the U.S. bishops by saying that the administration of food and water, even by artificial means, is *in principle*² an ordinary and proportionate means of preserving life. Artificially administered nutrition and hydration (ANH) should not be withdrawn solely because there is moral certitude that the patient will not recover consciousness. The response of the CDF repeats the position articulated in the pope's 2004 allocution and affirms a general rule: the use of ANH for PVS patients constitutes ordinary or proportionate care *in principle*. The meaning of "in principle" in the original statement of John Paul II occasioned a great deal of debate. Ensuing discussion and interpretation determined that "in principle" indicated that the general rule noted above was not absolute and allowed for exception. In this recent response to the U.S. bishops questions, the CDF has confirmed this interpretation by citing exceptions to the general rule that it set forth.

The CDF released a commentary to accompany their response to the U.S. bishops.³ As the



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commentary indicates, underlying the CDF determination that ANH does not constitute an excessive burden in principle—that is, in most cases—is the conviction that ANH “generally does not impose a heavy burden either on the patient or on his or her relatives” because it “does not involve excessive expense, it is within the capacity of an average health care system,” and “does not of itself require hospitalization.” Moreover, the commentary asserts that ANH is not “a treatment that cures the patient, but is rather ordinary care aimed at the preservation of life.” Finally, the CDF states that if ANH is withheld from PVS patients “the cause of their death will be neither an illness nor the ‘vegetative state’ itself, but solely starvation and dehydration.”⁴

POSSIBLE EXCEPTIONS TO THE GENERAL RULE THAT ANH FOR PVS PATIENTS CONSTITUTES ORDINARY CARE

After positing the general rule that ANH for PVS patients constitutes ordinary care, the CDF offers four possible exceptions to this interpretation. These exceptions appear in the CDF commentary.⁵ They are:

- Cases occurring in “remote places” or in situations of “extreme poverty,” which might make the administration of ANH impossible. In such cases, no one is held to do the impossible— “*Ad impossibilitatem nemo tenetur.*”
- Cases in which “a patient may be unable to assimilate food and liquids, so that their provision becomes altogether useless.”
- Cases in which ANH “may be excessively burdensome for the patient.” These cases are considered to be “rare.”
- Cases in which ANH “may cause significant physical discomfort, for example resulting from complications in the use of the means employed.”

It is worth noting that the third and fourth causes for exception are distinguishable from each other. The third exception speaks about “burden for the patient” and does not specify that it means physical burden. Physical burden, such as infection or aspiration, is considered in the fourth exception. Hence, it seems reasonable to conclude that in the third exception, the CDF has in mind the psychic burden that may be involved in the use of ANH, a type of burden that we will discuss later.

CONTEXTUAL CONSIDERATIONS

The CDF response to the U.S. bishops’ questions can further be considered in light of two

contextual points. The first pertains to the Catholic Church’s steady opposition to a creeping acceptance of euthanasia, especially in Europe. The second pertains to the rules for interpretation of the exchange between the U.S. bishops and the CDF as dictated by canon law.

EUTHANASIA AND EUROPE

Some wondered why the CDF devoted such attention to a papal allocution, the least authoritative form of papal communication. The reason for this continuing interest in the allocution is better understood in light of the growing acceptance of euthanasia throughout Europe. The Vatican has strongly advocated against the acceptance of euthanasia as a morally acceptable response to illness, injury or incapacitation. The church continues to forcefully advocate the protection of human dignity and the value of human life “from the womb to the tomb.” Any action that even resembles euthanasia will receive stringent scrutiny by the Holy See. Speaking to the morality of ANH in PVS patients in March 2004 offered yet another opportunity for the Holy See to make known its reasons for protecting the dignity and value of human life, even in such a profoundly debilitated state as PVS.

RULES FOR INTERPRETATION

When interpreting and applying the documents of the Holy See, there are a number of traditional norms, some dating back to the early days of church legislation. Most of these norms were collected in the Rules of Law (*Regulae Iuris*) in the *Libro Sexto* of Pope Boniface VIII in 1300. Many of the rules are repeated in one way or another in the present *Code of Canon Law*. Two canons of the present code are relevant for our study:

- Canon 18: “Laws which establish a penalty or restrict free exercise of rights . . . are subject to strict interpretation.”
- Canon 52: “A singular decree has force only in respect to the matters which it decides and for the persons for whom it was given.”

Hence, the application of the CDF response, because it limits the free exercise of rights, will only apply to a restricted number of cases, specifically to patients with a firm diagnosis of PVS. Some commentators have sought to extend the statement to people with other pathologies, such as advanced Alzheimer’s disease or acute dementia. But the response concerns only patients who are diagnosed as being in a persistent vegetative

state, not to all patients who are unable to assimilate food and water without artificial assistance. If the CDF wanted to extend this teaching, it could use another form of communication, for example, an Apostolic Instruction. Moreover, because the questions were presented by the U.S. bishops, the response applies only to them and the ecclesiastical communion for which they are responsible, not, for example, to the church in Canada or Australia.

PRESUPPOSITIONS OF THE CDF RESPONSE

When applying the CDF response, some of its presuppositions can be called into question, potentially disposing of more exceptions on the part of care givers than are indicated in the CDF response. Following is a consideration of some of these presuppositions as they relate to the tradition of the church on this matter.

The CDF proposes that ANH “does not involve excessive expense.” The majority of the authors of the CDF response come from countries in which universal health coverage is a given. The situation here in the U.S. is obviously different and often poses significant financial hardships for the caregivers of patients in PVS, third-party payers or the civic community. The possibility that the immediate caregivers may not be financially burdened does not mean that the cost of caring for patients in PVS is negligible. The vast majority of patients who receive ANH in the U.S. receive their care in hospitals or long-term care facilities, both of which may very well impose “excessive expense” on one or all of the entities mentioned above.

The CDF proposes that ANH “does not of itself require hospitalization.” Is the obvious corollary of this suggestion that if the administration of ANH were to require hospitalization, such care could constitute an excessive burden imposed upon the caregivers? If so, then many patients, as expressed in an advanced directive, or caregivers might determine this treatment to be excessively burdensome. In those instances in which care is given at home, very few families are able to offer the comprehensive nursing care required of a patient in PVS without the regular assistance of an actual home-care nurse. This, in turn, brings us back to a question of cost and burden.

The CDF proposes that the purpose of ANH “is not, nor is it meant to be, a treatment that cures the patient, but is rather

ordinary care aimed at the preservation of life.” The CDF’s suggestion that ANH is not meant to be a treatment that cures a patient is not congruent with human experience in the hospital and long-term care setting. When families, in consultation with a clinical care team, initiate ANH for a loved one, it is usually done so with the intent and hope for substantive recovery. Moreover, persons are increasingly designating in advanced directives or by oral communication their clear desire to not receive ANH if there is no hope of cognitive recovery. These wishes reflect an attitude recognized in moral theology as *psychic aversion* (*horror mentis*). This attitude arises because people feel that such care does not truly benefit a patient in a permanently comatose condition and that it will often place a burden upon the loved ones giving care. As mentioned above, it is not unreasonable to interpret the CDF response as recognizing the possibility of this attitude.

The CDF proposes that if ANH is removed, the cause of death “will be neither an illness nor the ‘vegetative state’ itself, but solely starvation and dehydration.” Here, the CDF offers an interpretation of what kind of act constitutes euthanasia. This interpretation is at odds with the traditional teaching of moral theology. When life support is removed because it does not offer hope of benefit or imposes an excessive burden, the cause of death is the pathology which is no longer abated or circumvented. This is at the heart of the distinction between the licit removal of life support and passive euthanasia. This distinction has been explained by several Catholic moral theologians of the past, and its misconception, as expressed in this document, would call into question the removal of any form of life support under any conditions.

The CDF proposes that if care is “prolonged over time,” it may constitute an excessive burden. The CDF response does admit that caring for a PVS patient over time may be a notable burden. This is similar to the recognition of family burden offered by Pope John Paul II in his original allocution on care of PVS patients. The bishops of the United States issued some “talking points”—in the form of a Q&A—when they released the response they had received from the CDF, and they suggest that the main burden for the care givers will be financial. They also suggest that Catholic health care facilities and the Catholic community should offer assistance and provide “concrete examples of the

Church's commitment to human life."⁶ Once again, given the psychic aversion to continuing care for comatose people who will never recover consciousness, it is questionable whether the Catholic community will respond to this challenge.

CONCLUSION

The "talking points" of the U.S. bishops also state that Directive 58 of the *Ethical and Religious Directives for Catholic Health Care Services*, which speaks of a "presumption in favor of providing nutrition and hydration to all patients, including patients who require medically assisted nutrition and hydration," remains applicable.⁷ It is important to remember that this same directive also allows forgoing ANH if the burden outweighs the benefit. Finally, it is worth noting, in closing, that the other pertinent directives remain applicable. Hence, people may still make provision in advance for the type of care they wish to receive as death approaches (Directives 25 and 28), and it may happen that patients and families make different decisions in regard to hope of benefit and excessive burden when seeking to counteract fatal pathologies (Directives 25, 28, 56 and 57). ■

NOTES

1. Congregation for the Doctrine of the Faith, "Responses to Certain Questions of the United States Conference of Catholic Bishops Concerning Artificial Nutrition and Hydration," September 16, 2007, www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20070801_risposte-usa_en.html.
2. In the French translation of the March 2004 papal allocution, the phrase "general rule" was used.
3. Congregation for the Doctrine of the Faith, "Commentary," September 16, 2007, www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20070801_notacommento_en.html.
4. Congregation for the Doctrine of the Faith, "Responses to Certain Questions of the United States Conference of Catholic Bishops Concerning Artificial Nutrition and Hydration," September 16, 2007.
5. For all quotations here, see the Congregation for the Doctrine of the Faith "Commentary."
6. Emphasis added. A link to the Q&A from the U.S. Conference of Catholic Bishops Committee on Doctrine and Committee on Pro-Life Activities, as well as other relevant documents and information, can be found at www.usccb.org/comm/archives/2007/07-143.shtml.
7. U.S. Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, Washington, DC, 2001.

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