

# REMOVING LIFE SUPPORT: MOTIVATIONS, OBLIGATIONS

## *An Opinion on NCCB Committee for Pro-Life Activities' Statement on Artificial Hydration and Nutrition*

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In April 1992 the Committee for Pro-Life Activities of the National Conference of Catholic Bishops (NCCB) issued a resource paper titled "Nutrition and Hydration: Moral and Pastoral Reflections."<sup>1</sup> Because this paper considers an important ethical question in regard to healthcare for severely impaired persons, and because the answer to this question is disputed within the Catholic community,<sup>2</sup> a thorough analysis is in order. Considerations include the authority of the document, the document's main principles, the application of these principles, and some recent actions by state Catholic conferences that have a bearing on the document's contents. The purpose of this article is to help the Catholic community reach a consensus about this ques-

tion, which clergy, healthcare providers, and laypersons have discussed for more than a decade.

### THE DOCUMENT'S AUTHORITY

In determining the authority of a document issued by the bishops, one must look at the Second Vatican Council's statements about such teachings and then at the document itself, including internal evidence of the intentions of the bishops' committee and the character and source of the document. The **Box** describes in detail our analysis of these matters. At best, the document and its conclusions may be viewed as a pastoral statement, offering some tentative reasoning and conclusions to be considered in cases that concern the use of medically assisted nutrition and

**Summary** In April 1992 the Committee for Pro-Life Activities of the National Conference of Catholic Bishops issued a resource paper titled "Nutrition and Hydration: Moral and Pastoral Reflections." At best, this document and its conclusions may be viewed as a pastoral statement, offering some tentative reasoning and conclusions to be considered in cases that concern the use of medically assisted nutrition and hydration.

When discussing the question, Is the withholding or withdrawing of medically assisted hydration and nutrition always direct killing? the document applies two principles—"no reasonable hope of benefit" and "involving excessive burdens." The document's crucial part is its admission that artificial hydration and nutrition may be removed without the intention of causing death, and that "this kind of decision should not be equated with a decision to kill or with suicide." The committee assigns decision-making responsibility to patients, families, and healthcare professionals, but continues its dis-

cussion for 20 pages and offers cautious conclusions concerning removal of such therapy.

Two assumptions seem to underlie the document's overly cautious conclusions, the first being that mere vegetative function mandates continued life support. The first assumption overemphasizes the value of physiological functioning insofar as the purpose of human life is concerned. It also is contrary to the goal of medicine, which envisions restoration of cognitive-affective function as an element of successful therapy.

The second assumption is that withdrawal of artificial hydration and nutrition from persons in PVS may lead to euthanasia. But mandating the continuation of nonbeneficial therapy simply because it prolongs physiological function seems to lead people to favor euthanasia rather than reject it. The issue might be more easily resolved if medically assisted hydration and nutrition were considered explicitly to be the same form of therapy as a respirator.



hydration. We should seriously consider the advice given by the bishops' committee, but we have no moral obligation to accept in detail the contents of "Nutrition and Hydration: Moral and Pastoral Reflections."

## THE SIGNIFICANT PRINCIPLES

The first part of this document considering the proper medical care for persons in persistent vegetative state (PVS) gives eight moral principles of Catholic theology. Only two of them are signifi-

## THE DOCUMENT'S AUTHORITY

The Second Vatican Council states clearly that bishops are authentic teachers in the Church, and when they speak as teachers, their statements are to be accepted by Catholics. According to the council: "The Bishops are heralds of the faith, who draw new disciples to Christ; they are authentic teachers, that is, teachers endowed with the authority of Christ, who preach the faith to people. The faith which is destined to inform their thinking and direct their conduct."<sup>\*</sup>

The council describes two forms of teaching offered by bishops and the Holy Father: infallible teaching and authentic teaching. Infallible teaching is to be accepted by divine faith, "definitively and absolutely." Authentic teaching, which concerns matters pertaining to faith and morals, is to be accepted by the people to whom it is directed with trust and confidence because authentic teachers speak in the name of Christ.

The council states specifically: "The faithful for their part, are obliged to submit to their bishops' decision, made in the name of Christ, in matters of faith and morals and to adhere to it with a ready and respectful allegiance of mind, that is with a submission of will and intellect."<sup>\*</sup> The same document of the council offers signs by which Catholics may judge that the teaching of a bishop, and especially the teaching of the Holy Father, is to be considered authentic: "By the character of the document in question, by the frequency with which a certain doctrine is pro-

posed, by the manner in which the doctrine is formulated."<sup>\*</sup>

The bishops, speaking alone or in a group, seldom speak infallibly and often do not offer authentic teaching. Rather, they offer encouragement, guidelines, or admonitions to the people whom they serve. These statements, called "pastoral teachings," are to be taken seriously, but they do not have the force of infallible or authentic teaching.<sup>†</sup>

What type of teaching is communicated in the statement of the Bishops' Committee for Pro-Life Activities? From internal evidence, it is clear that the bishops who issued this document, a resource paper, did not intend to communicate infallible teaching, nor did they intend to communicate authentic teaching. They state: "We are fully aware that such guidance [concerning the use of hydration and nutrition] is not necessarily final."<sup>‡</sup> Moreover, in their conclusion the bishops' committee calls for continued public discussion of this issue on the part of Catholics and others concerned about the dignity of the human person, indicating that their argumentation and conclusions are tentative.

Another sign that the document under study is only pastoral teaching is "the character of the document in question." Usually only documents issued by the Holy Father for the entire Church or by a bishop for the diocese he serves would have the "character" to mandate assent through an act of faith or through respectful submission of will and intellect. Occasionally a national conference

of bishops will have the authority to issue a statement containing authentic teaching, but only if the Holy See grants the right to issue such a statement in advance.<sup>§</sup> For this reason, statements approved by vote of a national conference of bishops are usually called pastoral statements, as opposed to infallible or authentic teaching.

In addition, the source of the document under consideration is not the National Conference of Catholic Bishops (NCCB) speaking as a whole, nor is it the NCCB's administrative board. Rather, it is only one committee of the conference. This document and its conclusions, then, may be viewed as a pastoral statement, offering some tentative reasoning and conclusions to be considered in cases that concern the use of medically assisted nutrition and hydration. We should seriously consider the advice given by the bishops' committee, but we have no moral obligation to accept in detail the document's contents.

Except for the portions of the document that contain papal teaching, the statements and practical guidelines are only as forceful as the reasoning put forth in their support. As Bp. James McHugh, a prominent member of the Pro-Life Committee, stated, the document "stands on its consistency with Catholic teaching and the reasonableness and persuasiveness of its arguments."<sup>¶</sup> However, some of the document's practical guidelines are stated more forcefully than the authority of the document would warrant.<sup>\*\*</sup>

\* "Constitution on Church," n. 25, in Austin Flannery, ed., *Documents of Vatican II*, Scholarly Resources, Wilmington, DE, 1975.

† Congregation for the Doctrine of the Faith, "Instruction on the Ecclesial Vocation of the Theologian," *Origins*, July 5, 1990.

‡ Committee for Pro-Life Activities, "Nutrition and Hydration: Moral and Pastoral Reflections," *Origins*, April 9, 1992, p. 706.

§ *Code of Canon Law*, c. 455. Also see A. Dulles, "Bishops' Conference Documents: What Doctrinal Authority?" *Origins*, January 14, 1985, p. 528; Congregation for the Doctrine of the Faith, "Bishops Conferences and their Doctrinal Commissions," *Origins*, June 6, 1991, p. 71.

¶ Catholic News Service, "Bishops' Paper Gets an Argument," *Davenport Messenger*, April 16, 1992, p. 6.

\*\* Committee, p. 709, para. 6.



cant for our analysis.

The first moral principle concerns the motivation for removing life support. The document states that Catholic teaching prohibits the removal of life support if the direct intention is to kill the patient. This principle, presented in the language of the "Declaration on Euthanasia" issued by the Vatican in 1980,<sup>3</sup> is contained in the following statement:

All crimes against life, including "euthanasia or willful suicide," must be opposed. Euthanasia is "an action or an omission which of itself or by intention causes death, in order that all suffering may in this way be eliminated." Its terms of reference are to be found "in the intention of the will and in the methods used." Thus defined, euthanasia is an attack on life which no one has a right to make or request, and which no government or other human authority can legitimately recommend or permit. Although individual guilt may be reduced or absent because of suffering or emotional factors that cloud the conscience, this does not change the objective wrongfulness of the act.<sup>4</sup>

As the committee's document states later, this definition of euthanasia implies that passive euthanasia—that is, removing life support with the intention of killing the patient—is also prohibited, even if the remote intention that "clouds the conscience" of the agent is to remove all suffering.

The second significant principle concerns the moral obligation to prolong life and the cessation of this obligation. The committee's document declares:

Everyone has the duty to care for his or her own life and health and to seek necessary medical care from others, but this does not mean that all possible remedies must be used in all circumstances. One is not obliged to use either "extraordinary" means or "disproportionate" means of preserving life—that is, means which are

## Disagreement

results from interpretation of "useless or futile therapy."

understood as offering no reasonable hope of benefit or as involving excessive burdens.<sup>5</sup>

The document uses the term "no reasonable hope of benefit" and "involving excessive burdens" to signify the two criteria for judging medical means to be extraordinary or disproportionate. These are two specifically distinct criteria for removing life support.

If either criterion is verified in a particular case, then life support may be removed. In the past the same committee and many others writing on the topic referred to the first criterion for removing life support as "useless or futile therapy."<sup>6</sup> Therapy is useless or futile if it does not achieve the goal for which it is used.<sup>7</sup> Useless or futile therapy is often referred to as ineffective therapy, but the meaning is the same. As discussed later, the goal of medical therapy is not restoration of one organ, but rather of the person's integrated well-being. In this document the committee uses the phrase "offers no reasonable hope of benefit" or "of limited usefulness" to signify that the means are useless or futile.

Pointing out that the committee acknowledges two distinct criteria for removing life support, and that it substitutes another term for "ineffective therapy," may seem a bit pedantic. But this clarification is necessary because the disagreement in regard to the use of medically assisted hydration and nutrition results from interpretation of the term "useless or futile therapy" (as discussed later).

### APPLICATION OF THE SIGNIFICANT PRINCIPLES

When considering the question, *Is the withholding or withdrawing of medically assisted hydration and nutrition always direct killing?* the document applies two principles—"no reasonable hope of benefit" and "involving excessive burdens"—and offers the following conclusions:

We should not assume that all or most decisions to withhold or withdraw life support are attempts to cause death. Sometimes other causes may be at work, for example, the patient is imminently dying, whether a feeding tube is placed or not,

from an already existing terminal condition. *At other times*, although the shortening of the patient's life is one foreseeable result of an omission, the real purpose of the omission was to relieve the patient of a particular procedure that was of limited usefulness to the patient or unreasonably burdensome to the patient and the patient's family or care giver. *This kind of decision should not be equated with a decision to kill or with suicide.*<sup>8</sup> (Emphasis added)

The latter part of this statement is an application of the principle of double effect, a principle used frequently in the Catholic tradition, especially in regard to removing life support from dying patients and relieving their pain.<sup>9</sup> Although one can foresee the death of the person in PVS from whom ineffective or burdensome life support is removed, the intention of the person removing life support is either to stop doing something that is useless (that has no reasonable hope of benefit) or to do something good (to remove a burden).

The family of Nancy Beth Cruzan, for example, did not intend her death; indeed, if her medical condition had been different, they would have done everything to restore her health and to keep her alive. But after Cruzan spent several years in a comatose condition, it became obvious to the people who loved her that medically assisted hydration and nutrition was useless or futile insofar as the goals of medical therapy and the purpose of life were concerned.<sup>10</sup>

Clearly, the admission that medically assisted hydration and nutrition may be removed without the intention of causing death, and that "this kind of decision should *not* be equated with a decision to kill or with suicide," is the crucial part of the document. This statement admits that artificial hydration and nutrition may be declared extraordinary or disproportionate for persons in PVS when it is judged that such therapy offers no reasonable hope of benefit (is useless or futile) or imposes an excessive burden.

The conviction of the committee members that decisions concerning the use or removal of life support are the responsibility of patients, families, and healthcare professionals is expressed by the committee in response to the question: "Who should make decisions about medically assisted hydration and nutrition?" The committee maintains:

Ideally, then, the patient will act with the advice of loved ones, of health care personnel who have expert knowledge of medical

aspects of the case, and of pastoral counselors who can help explain the moral issues and spiritual values involved. . . . When a patient is not competent to make his or her own decisions, a proxy decision maker who shares the patient's moral convictions, such as a family member or guardian, may be designated to represent the patient's interests and interpret his or her wishes.<sup>11</sup>

However, even though the document assigns decision-making responsibility to patients, families, and healthcare professionals and admits that medically assisted hydration and nutrition may be removed in certain circumstances without intending the patient's death, it continues for another 20 pages and then concludes with the statement:

We hold for a presumption in favor of providing medically assisted nutrition and hydration to patients who need it, which presumption would yield in cases *where such procedures have no medically reasonable hope of sustaining life* or pose excessive risks or burdens.<sup>12</sup> (Emphasis added)

Why the need for extended discussion after having stated the essential principles for ethical decision making in regard to the removal of medically assisted hydration and nutrition? Why offer such a cautious conclusion? Why the emphasis on the value of sustaining life for people in PVS? Two assumptions seem to underlie the document's application of principles and hence its major conclusions.

The first assumption is that mere vegetative function mandates continued life support. In other words, the document assumes that if life is maintained only in a permanently unconscious condition, the therapy that sustains such limited function is useful or effective. Hence it is ordinary therapy.

The second assumption is that removing medically assisted hydration and nutrition from persons in PVS will lead to euthanasia. Both these assumptions require further analysis.

#### **FIRST ASSUMPTION: VEGETATIVE FUNCTION MANDATES CONTINUED LIFE SUPPORT**

The document extensively discusses the assumption that life support offers "reasonable hope of benefit" if it prolongs human life merely in the vegetative state. This assumption underlies the conclusion that the presumption to provide medically assisted nutrition and hydration does not yield unless it is concluded there is "no medically



reasonable hope of sustaining life."

To put the thesis of the bishops' committee positively, if "a medically reasonable hope of sustaining life" is present, even merely at the physiological level of function, then artificial hydration and nutrition must be continued. This assumption colors the rest of the document and leads the committee to preclude any explicit consideration of whether artificial hydration and nutrition offers "reasonable hope of benefit" (is useful) for persons in PVS. Indeed, the whole emphasis of the rest of the document is on the burden imposed by artificial hydration and nutrition. It does not explicitly consider the question, Would artificial hydration and nutrition be useless or futile therapy for persons who have been diagnosed as being in PVS? Rather, it is assumed that such therapy would be effective if mere physiological function could be maintained.

The committee seems to base this first assumption on reasoning developed seven years ago by a group of theologians who affirmed that feeding and hydrating patients in PVS "by means of tubes is not useless in a strict sense because it does bring to these patients a great benefit, namely, the preservation of their lives and the prevention of death through malnutrition and dehydration."<sup>13</sup> These theologians maintained we have a moral obligation to prolong physiological function even if it is medically certain that cognitive-affective function cannot be restored. The theologians were probably influenced in turn by St. Thomas Aquinas, who wrote that prolonging life is one of the four goods which people should pursue by reason of their humanity.<sup>14</sup> In the time of St. Thomas, however, medical science was not far enough advanced to prolong mere physiological function without prolonging cognitive-affective functions. But because of St. Thomas's distinction between "human acts" (acts of cognitive-affective function) and "acts of man" (acts of physiological function),<sup>15</sup> he would have approved the withdrawal of life support if the therapy could sustain only acts of man.

Three arguments may be put forward to question the committee's assumption that the ability to prolong only physiological function mandates continuing artificial hydration and nutrition.

**Overemphasis on the Value of Physiological Function** The assumption is inconsistent with Catholic theological tradition because it overemphasizes the value of mere physiological function insofar as the purpose of human life is concerned. To see this point more clearly, let us consider the terms "proportionate and disproportionate means," which the "Declaration on Euthanasia" recommends as substitutes for the terms "ordinary and extraordinary

means." A means can be judged proportionate or disproportionate only in relation to a goal. Is the goal of medical therapy merely prolonging human life, or is it prolonging human life in a manner that enables one to strive for eternal life? To strive for eternal life, we need some degree of cognitive-affective function.

Papal statements confirm the need to refer the moral evaluation of means to prolong life to our quest for eternal life. Pope Pius XII stated: "Life, health, all temporal activities are in fact subordinated to spiritual ends."<sup>16</sup> The "Declaration on Euthanasia" states: "Everyone has the duty to lead his or her life in accord with God's plan. That life is entrusted to the individual as a good that must bear fruit here on earth, but that finds perfection only in eternal life."<sup>17</sup> Because persons in PVS cannot perform human acts (i.e., acts emanating from the intellect and will) as a result of a dysfunctional cerebral cortex, they cannot perform acts that enable them "to bear fruit here on earth," that is, to strive for the spiritual goal of life.<sup>18</sup>

If the document's statements about the benefits of prolonging life for people in PVS were theologically certain, we would have a moral obligation to prolong the life of anencephalic infants and pre-viable fetuses "as long as possible." At present, anencephalic infants and pre-viable fetuses, even if born alive, do not receive aggressive medical care because nothing can be done to foster their humanity. They receive "comfort care," but no effort is made to keep them alive in face of serious irreversible and untreatable conditions. When newborns or people in PVS are no longer able to strive for the spiritual purpose of life, they are still persons, but they are persons who will no longer benefit from our efforts to keep them alive.

A more nuanced view of human function and the moral obligation to continue life support than that offered in the document of the Pro-Life Committee is found in a recent statement of Bp. William H. Bullock in Des Moines:

God has given life to carry out human activities that make us better persons, serve the community and lead to eternal life with Him. Therefore, the benefit of care or treatment to prolong life of a dying person, or of a person for whom these human activities have become very difficult or even no longer possible, diminishes in proportion to what remains possible for them.<sup>19</sup>

**Contrary to the Goal of Medicine** Second, the committee's assumption is contrary to the statements of



medical societies that have considered the ethical issue of removing life support from persons in PVS.<sup>20</sup> Their statements are based on the goal of medicine, which envisions restoration of cognitive-affective function as an element of successful therapy. In this regard, Edmund Pellegrino and David Thomasma maintain: "The aim of medicine is to address not only the

bodily assault that disease or an injury inflicts, but also the psychological, social, even spiritual dimensions of this assault. To heal is to make whole or sound, to help a person reconvene the powers of self and return, as far as possible, to his conception of a normal life."<sup>21</sup>

Leon Kass adds: "Healing is thus the central core of medicine: to heal the whole person is the doctor's primary business. . . . The wholeness means a certain well-working of the enlivened body and its unimpaired powers to sense, think, feel, desire, move and maintain self."<sup>22</sup>

A medical decision that a person is in PVS is not made quickly. Indeed, a person may be in a vegetative state for months before the diagnosis is made. But once it has been made by competent physicians (usually neurologists or neurosurgeons), certain conclusions concerning effective and ineffective therapy may be drawn with moral certainty.<sup>23</sup>

Professional medical groups have declared that artificial hydration and nutrition should be judged in the same way as any other medical or surgical therapy. Medical societies agree that the therapy of comatose patients must envision the return of some degree of cognitive-affective function. If it does not, "in keeping with the qualitative notion of futility any treatment that merely preserves permanent unconsciousness or that fails to end total dependence on intensive medical care should be regarded as non-beneficial and therefore futile."<sup>24</sup>

**Should Life Be Prolonged?** Third, the document's assumption is also contrary to the "common estimation of the faithful." When we have queried people on whether they want life continued after a medically certain diagnosis of PVS, universally they have answered no. Moral judgments are not made as a result of surveys and polls, but the atti-

# The committee overemphasizes the value of mere physiological function.

tudes and responses of people seeking to work out their salvation "in fear and trembling" help us understand what is realistic. In this regard, Rev. Richard McCormick, SJ, observes: "Imagine a 300-bed Catholic hospital with all beds supporting P.V.S. patients maintained for months, even years by gastrostomy tubes. . . . An observer of the scenario would eventually be led to ask: 'Is it true

that those who operate this facility actually believe in life after death?'"<sup>25</sup>

People who followed the Nancy Beth Cruzan case, and those still following the Christine Busalacchi case, realize that a minimal human function of persons in PVS may be sustained indefinitely by artificial hydration and nutrition. But as the Supreme Court of Illinois stated, "this fact is irrelevant."<sup>26</sup> The important ethical and judicial question concerns benefit to the patient. Thus the significant issue is not, Can life be prolonged? but rather, Should life be prolonged?

Hence, the main area of disagreement between the bishops on the committee and some theologians (referred to in question six of the document) is not over the analysis of the *burden* resulting from the use of artificial hydration and nutrition for patients in PVS, as the document maintains. Rather, the theologians (and many bishops) who disagree with this document's conclusions do so because they maintain that artificial hydration and nutrition is useless or futile therapy for persons in PVS. The document refers to such argumentation as "unconvincing," but it never considers the argumentation sufficiently. Rather, the committee devotes most of its attention to the issue of burden and never addresses the issue of uselessness and futility.

Because the definition of useful and useless therapy is so central to the dispute within the Catholic community concerning the use of artificial hydration and nutrition for persons in PVS, the document's protracted discussion concerning the issue of burden for patients in PVS need not be analyzed at this time. However, the document's assertion that persons in PVS do not have a "terminal illness" or are "not dying" must be considered. Clearly, terms such as "terminal illness" and "not dying" may be understood in dif-



ferent ways, but all will agree that persons in PVS will die unless they are given food and water by some form of medically assisted therapy. Is it possible to heal the dysfunctional cerebral cortex by treating the symptoms such as the inability to eat, chew, and swallow? Does it benefit the patient to treat these symptoms without curing the underlying pathology? To repeat: The ethical issue is not

whether a person in PVS is dying, but whether therapy should be used to prevent his or her death.

#### **SECOND ASSUMPTION: THE DANGER OF PROMOTING EUTHANASIA**

The second assumption underlying the lengthy document and its cautious conclusion may be phrased in this manner: If hydration and nutrition is withdrawn from patients in PVS, this will lead to the practice of active euthanasia on other debilitated patients. This assumption is discernible frequently in the latter part of the document.

Do we need to be concerned about euthanasia? Given the popularity of many books and movements and the increase of specific acts of physician-assisted suicide and outright murder of debilitated persons, the answer can only be yes. But efforts to combat the movement toward euthanasia should not be tied to the removal of life support from persons in PVS.

**Fear of Nonbeneficial Therapy** The tendency to accept euthanasia as a moral option is aligned with the fear many people have of being kept alive by *mechanical devices long after such therapy is beneficial*. Artificial hydration and nutrition for persons in PVS is a form of nonbeneficial therapy. Mandating the continuation of therapy for people who will never benefit from it simply because it prolongs their physiological function seems to lead people to favor euthanasia rather than to reject it.

A few years ago, when speaking at the Center for Clinical Ethics at the University of Chicago about the use of artificial hydration and nutrition, Cardinal Joseph Bernardin, archbishop of Chicago, declared: "If we do not resolve this critical issue in a way that resonates with the common sense of

## **The Church's efforts should be directed toward root causes of euthanasia.**

people of good will, then we may contribute to the sense of desperation that will lead people to consider euthanasia as an alternate solution to the problem."<sup>27</sup>

#### **Artificial Hydration and Nutrition as a Medical Device**

To combat euthanasia, it seems the Church's efforts should be directed toward the root causes of euthanasia in our society, namely, a tendency to judge people by their

"productivity" and an outrageous emphasis on individualism or autonomy.<sup>28</sup> One method of disassociating the removal of life support of people in PVS from the trend toward euthanasia would be to follow the lead of medical societies and state explicitly that artificial hydration and nutrition is a medical device similar to a respirator.

No one seems to claim that removing respirators when they are declared nonbeneficial or overly burdensome by patients, families, and medical professionals could lead to euthanasia or exploitation of the weak and debilitated, even though the patient's death may be foreseen. Ever since 1957, when Pope Pius XII spoke on this matter, the Catholic community has accepted withdrawal of a respirator that is ineffective or imposes a grave burden on the patient or family, even if its continued use would prolong life. Would the issue be more easily resolved if medically assisted hydration and nutrition were considered explicitly to be the same form of therapy as a respirator?

#### **ACTIVITY OF STATE LEGISLATURES**

During the past few years, more than 40 states have passed legislation allowing removal of life support from patients unable to make healthcare decisions for themselves if certain conditions are fulfilled.<sup>29</sup> In some states, removal of life support requires one to have executed a legal document such as a living will or durable power of attorney before becoming incapacitated. In more than 20 states, laws and court decisions allow a guardian, family member, or friend to remove life support from an incapacitated person, even if he or she had not executed a legal document. Two significant considerations surround the enactment of such legislation.

**First Consideration: A Medical Means** In most states



artificial hydration and nutrition is considered to be a medical means of sustaining life that is no different from other means of sustaining life. Although a few states require a specific statement enabling the surrogate to remove artificial hydration and nutrition, once the statement is made, no special aura surrounds artificial hydration and nutrition. According to these laws, it is neither unethical nor illegal to remove artificial hydration and nutrition if the surrogate, in collaboration with medical professionals, judges it to be useless or burdensome therapy. The assumption of such legislation seems to be that artificial hydration and nutrition is ipso facto useless therapy for people in PVS.

**Second Consideration: Reactions of State Catholic Conferences** The various Catholic conferences in these states did not oppose and, in some cases, actively supported the legislation.<sup>30</sup> The various Catholic conferences did not judge prolongation of physiological function, when cognitive-affective function could not be restored, to be a "great benefit," even though the Pro-Life Committee maintains the contrary. Moreover, individual bishops and groups of bishops have stated that artificial hydration and nutrition is ineffective therapy for PVS patients and may ethically be removed if the patient has no hope of recovering cognitive-affective function.<sup>31</sup> It seems the actions of some Catholic conferences throughout the United States render anachronistic the document of the Pro-Life Committee.

## DISCUSSION REQUIRED

We hope that the foregoing considerations will help the Catholic community develop a consensus about use and withdrawal of medically assisted hydration and nutrition for PVS patients. As indicated in the Pro-Life Committee's statement, removal of this form of life support is justified under certain conditions. But discussion is needed concerning the benefit of continuing life support when cognitive-affective function cannot be restored. Moreover, greater clarity is needed in regard to the difference between removal of non-beneficial life support and euthanasia. □

## NOTES

1. Committee for Pro-Life Activities, "Nutrition and Hydration: Moral and Pastoral Reflections," *Origins*, April 9, 1992, p. 705. Nutrition and hydration may be conveyed in different ways, but the patient's medical condition, not the method by which it is conveyed, is the essential element for ethical analysis.
2. See Bp. John Leibrich, Springfield, MO, *Origins*, January 11, 1990, p. 525ff.; Bp. William H. Bullock,

- Des Moines, *Origins*, January 30, 1992, p. 553; Pennsylvania Bishops, *Origins*, January 30, 1992, p. 543ff.; Texas Bishops, *Origins*, June 7, 1990, p. 53ff.
3. Congregation for the Doctrine of the Faith, "Declaration on Euthanasia," *Origins*, August 14, 1980, p. 154.
  4. Committee, p. 706.
  5. Committee, "Moral Principles," para. 4.
  6. National Conference of Catholic Bishops, "The Rights of the Terminally Ill," *Origins*, September 4, 1986, p. 222; William May et al., "Feeding and Hydrating the Permanently Unconscious and Other Vulnerable Persons," *Issues in Law and Medicine*, vol. 3, no. 3, 1987, p. 203ff.
  7. Lawrence Schneiderman, Nancy S. Jecker, and Albert R. Jonsen, "Medical Futility: Its Meaning and Ethical Implications," *Annals of Internal Medicine*, June 15, 1990, p. 949ff.
  8. Committee, p. 707. This document avoids an erroneous assumption contained in a recent statement of the Pennsylvania Bishops (*Origins*, January 30, 1992, pp. 541-553)—namely, that life support may be removed only when death is imminent and unavoidable no matter what means of life support are used. This mistaken assumption is contrary to Catholic theological writing and papal statements of the past 500 years. (See John Connery, "Prolonging Life: The Duty and Its Limits," *Catholic Mind*, October 1980, p. 45ff.)
  9. John Connery, "Catholic Ethics: Has the Rule for Rule Making Changed?" *Theological Studies*, vol. 42, 1981, pp. 232-250.
  10. Dennis Brodeur, "The Ethics of Cruzan," *Health Progress*, October 1990, p. 42ff.
  11. Committee, p. 711.
  12. Committee, p. 712.
  13. May, p. 209. Describing the death of people in PVS as being caused by malnutrition and dehydration is the same as describing the removal of a respirator as smothering a person. Medically assisted hydration and nutrition treats a major symptom of a dysfunctional cerebral cortex; it does not treat the cause of the dysfunction.
  14. Thomas Aquinas, *Summa Theologica* II-II, q. 94, a. 2.
  15. Aquinas, q. 1, a. 1.
  16. Pope Pius XII, "The Prolongation of Life" (November 24, 1957), *The Pope Speaks*, vol. 4, no. 4, 1958, p. 395.
  17. Congregation for the Doctrine of the Faith, p. 154.
  18. The committee's document, in footnote 40, states that "some Catholic moralists, using the concept of 'virtual intention,' note that a person may give spiritual significance to his or her later suffering during incompetency, by deciding in advance to join these sufferings with those of Christ for the redemption of others." This is an erroneous understanding of virtual intention. A virtual intention may substitute for an actual intention if a person is conscious but distracted, but it is significant in the life of a person only when it prompts a human act. By definition, a person in PVS cannot perform human acts. Virtual intentions cannot make "acts of man" into "human acts." Even if I am aware and conscious (actual intention) of what I am doing, I cannot make the circulation of my blood into a virtual act. For more on actual and virtual intention, see B. Merklebach, *Summa Theologica Moralis*, vol. I, no. 55.
  19. "Assessing Burdens and Benefits of Medical Care,"

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## A WARNING TO CHANGE

Reich places responsibility to address structural problems with both the public and private sectors. He suggested such initiatives as performance standards for schools, consolidation of school districts to achieve parity in quality, and higher teacher pay. Business can form partnerships with schools, providing apprenticeships for particular jobs. In his opinion programs that focus on preschool education and health to develop "the capacity to learn" are especially important.

Healthcare organizations are particularly risk averse and resistant to change. Reich advised healthcare leaders, who are "educators in their institutions and communities," to be agents for change. Leaders can demonstrate with real-life answers and anecdotes the benefits of innovation and encourage their organizations to reward people who experiment, even when they fail, he said.

Another factor inhibiting change is the prospective payment system. The Medicare and Medicaid programs, which often do not pay for valuable services, are based on the high-volume paradigm and offer little incentive for innovation and change. Reich urged leaders to educate policymakers and political leaders about how public policies are harming children and families and the quality of healthcare.

Reich left the audience with a warning in the form of the parable of the frog that is put in boiling water and immediately leaps out. But if it is put in lukewarm water and the heat is gradually turned up, the frog is unable to move by the time the water reaches the boiling point. "My fear is that with regard to long-term structural problems, the heat is being turned up too gradually," he said.

"The riot in Los Angeles has focused public attention for a while on economic problems," he noted, "but we may not be able to take the leap when we have to take the leap. We may not be able to change when we have to change." —Judy Cassidy

REMOVING  
LIFE SUPPORT

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*Origins*, January 30, 1992, p. 554.

20. American Academy of Neurology, *Neurology*, January 1989, p. 125; Committee on Ethics, American Nurses Association, *Guidelines on Withholding and Withdrawing Food and Fluid*, Kansas City, MO, 1987; "Position Of American Dietetic Association: Issues in Feeding the Terminally Ill Adult," *Journal of American Dietetics*, 1987; "Current Opinions," Council on Ethical and Judicial Affairs of the AMA, 1989, no. 220.
21. Edmund Pellegrino and David Thomasma, *For the Patient's Good: The Restoration of Beneficence in Health Care*, Oxford University Press, New York City, 1988, pp. 80-83.
22. Leon Kass, "Neither for Love Nor Money: Why Doctors Must Not Kill," *Public Interest*, Winter 1989, p. 25.
23. When referring to the "reliability of prognosis for many such patients" (persons in PVS), the committee's document makes a blatant error. In footnote 39 it quotes an article on a study of patients in vegetative state, as though the statistics concerning recovery of consciousness were valid for patients in persistent vegetative state (Harry S. Levin et al., "Vegetative States after Closed-Head Injury: A Traumatic Coma Data Bank Report," *Archives of Neurology*, June 1991, pp. 580-585). Levin confirms that "the statistics quoted in our article do not refer to patients in persistent vegetative state" (phone conversation, April 2, 1992).
24. Schneiderman, p. 952.
25. Richard McCormick, "Moral Considerations III Considered," *America*, March 14, 1992, p. 214.
26. *Re Estate of Sidney Greenspan v. Andrew Gelman*, Docket N.67903 (July 19, 1990), pp. 708-711.
27. Peter Steinfels, "Prelate Raises Questions on the Dying," *New York Times*, April 23, 1987.
28. Richard M. Gula, "Euthanasia: A Catholic Perspective," *Health Progress*, December 1987, p. 28ff.
29. "Termination of Life Support Legislation," Society for the Right to Die, New York City, 1991.
30. Jay Copp, "Illinois Bishops Back Life-sustaining Treatment Bills," *New World*, June 21, 1991, p. 1.
31. See footnote 2 above; others taking this position include the bishops in Providence, RI, and in Minneapolis.

PROs'  
EFFECTIVENESS

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societies to suspend or revoke physician licenses without undue exposure to litigation

Steps like these might put the U.S. healthcare system on the road to higher-quality care at lower cost. □

## NOTES

1. Utilization and Quality Control Peer Review Organization Program, report to Congress, fiscal year 1988, p. 1 and attachment H, p. 49.
2. New York PRO Scope of Work, Island Peer Review Organization, Lake Success, NY, pp. 7-11.
3. New York PRO Scope of Work.
4. Department of Health and Human Services, Contract No. 500-90-0026, "Physician Consultant," attachment J-3 Statement of Work, Baltimore, September 1990, p. 2.
5. *Results of Peer Review Organization Review for the Third Scope of Work*, based on reports submitted through April 30, 1991, reflecting reviews completed through March 31, 1991.
6. Utilization and Quality Control Peer Review Organization Program.
7. *Results of Peer Review Organization Review for the Third Scope of Work*.
8. Utilization and Quality Control Peer Review Organization Program.
9. Utilization and Quality Control Peer Review Organization Program.
10. *Barron's Guide to Medical Schools*, Barron's Educational Services, Hap-pauge, NY, 1991, p. 50; Saul Wischnitzer, *Barron's Guide to Medical and Dental Schools*, Barron's Educational Services, Hap-pauge, NY, 1991.
11. Committee to Design a Strategy for Quality Review and Assurance in Medicare, Division of Health Care Services, Institute of Medicine, *Medicare: A Strategy for Quality Assurance*, vol. 1, National Academy Press, Washington, DC, 1990, p. 188.
12. Neil Baker, presentation to the Michigan State Medical Society Liaison Committee with the Michigan PRO, 1991.
13. John T. Kelly and James E. Swartwout, "Practice Parameters: A Foundation for Quality Advancement," *AAPPO Journal*, February-March 1991, pp. 33-38.