WITHDRAWING NUTRITION AND HYDRATION

The Catholic Tradition Offers Guidance for the Treatment of Patients in a Persistent Vegetative State

BY MICHAEL R. PANICOLA, PhD

Dr. Panicola is the ethicist for SSM Health Care, St. Louis. An expansion of this article appears in The Hastings Center Report, *November-December, 2001, vol. 31, no. 6.*

The issue of withdrawing medically assisted nutrition and hydration from patients in a persistent vegetative state (PVS) continues to be a source of conflict for Catholics. This was illustrated recently in the cases involving Hugh Finn and Steven Becker, in which Catholics of presumed goodwill came down on both sides of the fence.[1] On one side were those who argued that withdrawing medically assisted nutrition and hydration from Finn and Becker was morally acceptable in light of a holistic benefit-burden analysis. On the other side were those who argued that withdrawing medically assisted nutrition and hydration from Finn and Becker was equivalent to murder in that both men were essentially starved to death when they could otherwise have lived for several years.

One reason for the conflict among Catholics is that the medical reality of PVS is often misunderstood. PVS is an eyes-open state of unconsciousness with sleep-wake cycles in which the patients are completely unaware of themselves and their surroundings.[2] PVS may be caused by a traumatic brain injury or by a nontraumatic brain injury that results in the loss of all higher brain functions with either complete or partial preservation of brainstem autonomic functions. Recovery of consciousness is highly improbable after twelve months for patients in a PVS caused by a traumatic brain injury and after three months for patients in a PVS caused by a nontraumatic brain injury.[3] The life expectancy of patients in a PVS is greatly reduced, with the average ranging from two to five years. Death is usually brought on by an infection in the lungs or urinary tract, respiratory failure, or sudden death of unknown cause.[4] The length of survival depends in part on how aggressively such medical complications are treated.

Another reason for the conflict among Catholics is that the moral issue of prolonging the lives of patients in a PVS with medically assisted nutrition and hydration has not been resolved by the magisterium and thus is open for discussion in the Catholic community.[5] Yet, even though this issue has not been settled at the hierarchical level and serious disagreement exists among Catholics, three particular principles in traditional Catholic teaching on prolonging life suggest that withdrawing medically assisted nutrition and hydration from patients who have been accurately diagnosed in a PVS is morally justified and is most in keeping with the teaching itself.

HUMAN LIFE IS A BASIC BUT LIMITED GOOD

Traditional Catholic teaching on prolonging life affirms that human life is a basic and precious good that flows forth from God. The love that God has for humanity is shown most enduringly in the life of the human person who has been made in God's image. "Life as a sign of God's love and care is sacred, has meaning because of God's love and not because of personal merit, and should be treated with dignity and respect at every stage."[6] The good of human life is tied, not to functional ability or social utility, but to the very fact that it comes from God.

It is because human life is an utterly free and unmerited gift from God that one has a duty to prolong life. Fulfilling this duty in the course of one's existence may sometimes involve either seeking or receiving medical care. However, Catholic teaching on prolonging life has always held that the duty to maintain life through medical means is limited. It ceases when medical treatment cannot offer one a reasonable hope of benefit in terms of pursuing the spiritual goods of life (love of God and love of neighbor), *or* can only offer one a physical condition in which the pursuit of the spiritual goods of life will be profound-

ly frustrated in the mere effort for survival.[7] This is exactly what Pius XII means when he states:

> But normally one is held to use only ordinary means—according to circumstances of persons, places, times and culture—that is to say, means that do not involve any grave burden for oneself or another. A more strict obligation would be too burdensome for most men and would render the attainment of the higher, more important good too difficult. Life, health, all temporal activities are in fact subordinated to spiritual ends.[8]

Life gives us an opportunity to love God through loving others.

The pursuit of the spiritual goods of life is intimately connected with human life in that physical existence affords one the opportunity to love God through loving others.[9] One is able to love God in the context of human life through loving others as oneself. Yet human life is not itself an absolute good. The good of life is a limited good precisely because it is the basis for pursuing the higher, more important spiritual goods of life (love of God and love of neighbor).

Applying this understanding of human life to patients in a PVS suggests that the duty to prolong their lives has ceased. Because these patients have reached a point where their ability to pursue the spiritual goods of life has been *totally eclipsed*, the best treatment is no treatment. They are beyond the reach of medical treatment (including medically assisted nutrition and hydration) and should be provided only supportive nursing care so that they may be allowed to die in relative peace, without having their physical lives prolonged by unreasonable medical means.

To be clear, though, the decision to allow patients in a PVS to die does not imply that their lives are less valuable than others. In truth, "every human being, regardless of age or condition, is of incalculable worth."[10] Rather, the decision is based on the fact that physiological existence no longer offers these patients any hope at all of pursuing those goods for which human life is the fundamental condition.

This understanding of human life as a limited good subordinated to the spiritual goods of life has not been embraced by everyone. Some authors argue that certain goods cannot be weighed one against the other; such goods are "incommensurable" because they are necessary for integral human fulfillment.[11] Aesthetic experience, human life, knowledge, play, practical reasonableness, religion, and sociability are all examples of incommensurable goods.[12] These goods should be recognized and respected in the context of human life. However, it is not always possible to promote all of these goods in a particular situation; thus a reasonable selection of one or another good to be more fully realized is morally acceptable. Still, no reasonable grounds suffice for sacrificing one good for another. It is never right under any circumstance whatsoever to attack one of these goods. Incommensurable goods must all be accepted as moral realities and appreciated in every situation.

This concept of goods is problematic for two reasons. First, it fails to recognize that goods must often be weighed one against the other. Because of the limits of temporal existence, a choice of one good automatically rules out a choice of others. By choosing to spend the morning playing a round of golf, for example, one closes the door on other possible options, at least while engaged in the activity of golfing. During the round of golf, one is unable to pursue such other goods of life as furthering one's knowledge of the arts or strengthening one's faith commitment through attending a liturgy. Though not attacking these other goods, one is making a value choice for one good over the others. This is a weighing of goods and suggests that goods are not incommensurable in reality.

Second, this concept of goods tends toward vitalism. If the good of human life cannot be weighed against other goods, then life has to be prolonged insofar as doing so is a physical possibility. One can never attack the good of life by subordinating it to other goods. Does this, however, seem prudent? Are there *no* limits to life? Do we exist simply so that our vital physiological functions can be maintained? Or do we exist so that we can experience life, engage loved ones, interact with others, participate in society, pursue personal interests, at least at a

minimal level? It would be devastating to accept human life as an incommensurable good that cannot be compared to other goods in reaching medical-moral decisions. Doing so would negate the rights of patients to make autonomous decisions on limiting medical care; would lead to overtreatment, whereby some lives would be prolonged far beyond what is reasonable; and would impose a major burden on families to meet the demands and absorb the costs associated with caring for patients whose lives are prolonged unnecessarily. Human life is indeed always a good, as some of the supporters of the incommensurable goods theory point out, but it is a good that need not and should not be made absolute.

> Human life is a good that need not and should not be made absolute.

Treatment Must Offer a Reasonable Hope of Benefit

Traditional Catholic teaching on prolonging life asserts that for a medical means to be considered morally obligatory it must offer one a reasonable hope of benefit. Yet how does one determine whether a medical means is beneficial? In assessing the potential benefit of medical treatment, one must consider several criteria. As the Congregation for the Doctrine of the Faith notes in its "Declaration on Euthanasia," one can determine whether a medical means is proportionate or beneficial by "studying the type of treatment to be used, its degree of complexity or risk, its cost and the possibilities of using it, and comparing these elements with the result that can be expected, taking into account the state of the sick person and his or her physical and moral resources."[13] All of these criteria coalesce in determining whether a particular medical means offers one a reasonable hope of benefit.

Although it is clear that a medical treatment must be beneficial to be considered morally obligatory, it is less clear what constitutes a "benefit." In the medical context, a treatment is considered beneficial if it restores one's health, relieves one's pain, improves one's physical mobility, returns one to consciousness, enables one to communicate with others, and so on. Catholic teaching on prolonging life recognizes all of these improvements in one's condition as benefits; but it specifies that, to be *truly* beneficial, treatment must improve one's condition to the point that one is able to pursue the spiritual goods of life, at least at a minimal level, without experiencing significant burdens.[14] Bishop William H. Bullock, DD, EDS, of the Diocese of Madison, WI, describes this well:

> 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.[15]

This more holistic understanding of benefit, expressed in Catholic teaching on prolonging life and summarized eloquently by Bishop Bullock, is profoundly connected to the Catholic view of the human person as a physical, psychological, social, and spiritual being whose ultimate goal in life is to love God through loving others as oneself.

Applying this understanding of benefit to patients in a PVS suggests that medical treatment is not morally obligatory because it provides no reasonable hope of benefit to such patients. Although medically assisted nutrition and hydration provide the sustenance necessary to prolong the lives of patients in a PVS, it is not considered a *beneficial* medical treatment in the Catholic moral tradition because it does not restore such patients to a relative state of health. No matter how long medically assisted nutrition and hydration prolongs the lives of patients in a PVS, it will never improve their overall medical condition to the point where they can again pursue the spiritual goods of life. The tragic reality is that these patients are no longer capable of receiving any meaningful benefit from medicine's efforts to keep them alive.

Not everyone has embraced this understanding of benefit. Some authors contend that the mere fact that human life can be prolonged is itself a benefit sufficient to justify continued medical

treatment. William E. May, in an article he wrote with several colleagues, argues that feeding and hydrating patients in a PVS "by means of tubes is *not* useless in the strict sense because it does bring to these patients a great benefit, namely, the preservation of their lives and the prevention of their death through malnutrition and dehydration."[16] May and his coauthors do not say as much, but it is clear that his concept of benefit presupposes that human life is a good that cannot be weighed against other goods. The criticisms concerning the incommensurable goods theory relate to the argument of May, et al., as well.

Still, the question remains: Why is the mere prolongation of life itself a "great benefit"? How do patients who cannot experience life, engage loved ones, interact with others, participate in society, pursue personal interests, at least at a minimal level, benefit from having their lives prolonged? These are questions that May and his coauthors are unable to answer because they fail to recognize that "what is truly beneficial to us as human persons is a broad human judgment" encompassing more than life's physiological dimension.[17] Traditional Catholic teaching on prolonging life has never accepted so narrow a concept of benefit as the one proposed by May and his colleagues. To do so would be an idolization of human life and an abandonment of the fundamental Christian conviction that human life is not the final end of the person. The late Rev. Richard A. McCormick, SJ, STD, once sketched a "fanciful scenario" speaking to this point: "Imagine a 300-bed Catholic hospital with all beds supporting PVS 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 eternal life?'"[18]

Some authors, attempting to circumvent the argument that the mere prolongation of life is not a meaningful benefit, maintain that medically assisted nutrition and hydration is a basic element of care, rather than medical treatment, and as such should always be provided to a patient. Robert Barry argues that medically assisted nutrition and hydration is not on the same moral plane as medical treatment because, whereas medical treatment aims at curing a clinically diagnosable condition, medically assisted nutrition and hydration meets "the basic needs of organisms to function and grow, and they are not remedies of diseases in and of themselves."[19] But this argument is seriously flawed because it misrepresents the nature of the therapy. No significant moral difference exists between medically assisted nutrition and hydration and other medical interventions such as mechanical ventilation, which most experts agree is a medical treatment. Both are administered and supervised by medical professionals, and both are geared toward restoring a vital physiological function. As Albert Moraczewski remarks:

> The situation is similar to a patient who cannot breathe unaided because some part of the respiratory system is not functioning properly. Oxygen, water, and food are all necessary elements for maintaining life. If because of some current pathology, the person requires that these be supplied by technological means, then it would seem that the same moral principles can be applied to determine the respective moral obligations to initiate or continue life conserving procedures. By technological means we are circumventing an obstacle that prevents food and water (or oxygen) from entering the body in the normal manner. Hence when we cease by-passing the obstacle, the person dies from a combination of his pathology and the lack of nutrition and hydration (or oxygen).[20]

Even if it were determined that medically assisted nutrition and hydration is a basic form of care, decisions to initiate or continue it would still hinge on the moral norms articulated in traditional Catholic teaching on prolonging life.[21] Even the great 16th- and 17th-century moral theologians held that the taking of food could be considered extraordinary or morally optional, given one's condition and circumstances. These theologians were talking about food in its natural state. How much more would their comments apply to the use of medically assisted nutrition and hydration supplied either through creating a surgical opening in the gastrointestinal tract or through an intravenous line?

Treatment Must Not Impose An Excessive Burden

Traditional Catholic teaching on prolonging life holds that for a medical means to be considered morally obligatory it must, first, offer a reasonable hope of benefit, and, second, impose neither an excessive burden on the patient nor an excessive expense on the patient's family or community.[22] Given the fact that medically assisted nutrition and hydration provides no reasonable hope of benefit to patients in a PVS, and thus is not medically required, it might seem that a discussion of burdens is unnecessary. This may be true on some level. Nevertheless,

burden factors are given considerable weight in Catholic teaching on prolonging life; it is therefore important to see how they come into play in cases involving patients in a PVS.

The excessive-burden principle is frequently set aside in discussions concerning the prolongation of life for patients in a PVS. Most commentators assume that such patients cannot experience pain and suffering because of the profound devastation to their brains.[23] This conclusion is apparently accurate in the light of positron-emission tomography studies that show, in the cortical and subcortical areas of the cerebral hemispheres of PVS patients, severely depressed energy metabolism levels comparable to that found in "brain-healthy" patients under general anesthesia.[24] Still, just as a falling tree makes a noise even if no one hears it, burdens remain even for patients who do not, in the proper sense, experience them. Patients in a PVS are susceptible to a host of problems that qualify as burdens—feeding-tube site infections, incontinence and other bowel and bladder disorders, bedsores, and deformities caused by muscle deterioration and contracture, among others.

Patients in a PVS are susceptible to problems that qualify as "burdens."

What is more, the element of burden can be particularly real for the families of patients in a PVS. Providing medical care to such patients can be costly, especially if their lives are prolonged for many years, and take a heavy toll physically, emotionally, and spiritually on family caregivers. Anyone familiar with the stories of Karen Ann Quinlan and Nancy Cruzan can attest to this point. But the broader burdens that accumulate for such families are, for various reasons, either overlooked or denied by those who insist that withdrawing medically assisted nutrition and hydration from PVS patients is morally wrong; these writers seem to think such burdens are unimportant.[25] This is not the traditional viewpoint, however. In Catholic teaching on prolonging life, burdens have always been understood broadly, to include not just those borne by the patient but also those borne by the family and the community at large. This broader notion of burden has its roots in a theological anthropology that views the person as a social being with deep familial and communal ties. Burdens that affect others are, in this view, morally relevant considerations in decisions about prolonging life.

Ideally, a patient should be able to evaluate the benefits and burdens of treatment, especially those likely to affect others. But this is not always possible. When patients are no longer able to make decisions for themselves, because their ability to do so is diminished or absent, someone else must make them; whoever assumes the role of surrogate should base such decisions primarily on the patients' best interests, even when the consequences strongly affect others, family and/or community, for example. However, these other people should not be excluded from the assessment altogether. We should, while being mindful of our commitments to the most vulnerable among us, consider the burdens that families and communities endure in caring for PVS patients, all the while guarding against "utilitarian perspectives so deeply sunk into the consciousness of the contemporary world."[26] This is a harrowing choice, to be sure, but one that we must nevertheless undertake as social beings confronted by medicine's virtually unlimited power to prolong life.

Are burdens ever decisive in PVS cases? The truth is, probably not. Still, burdens are objectively discernible, morally significant factors that merge with other factors, thus reinforcing the argument that life-prolonging measures, including medically assisted nutrition and hydration, are not obligatory for persons in a PVS.

Respecting Life's Limits

It is understandable that Catholics are concerned about how patients are treated as they approach the mystery of death, especially in a time when euthanasia and physician-assisted suicide are gaining popular support. However, this concern is misplaced when it comes to decisions to withdraw medically assisted nutrition and hydration from patients who have been accurately diagnosed as being in a PVS.

Such concern is misplaced because these decisions are morally justified according to traditional Catholic teaching on prolonging life and indeed seem most consonant with the basic principles of the teaching itself. Decisions to withdraw nutrition and hydration in such cases will, without question,

be emotionally difficult for both family members and the medical professionals involved. Nevertheless, moral issues should not be reduced to emotional responses.[27] One may *feel* that one is killing the patient by withdrawing medically assisted nutrition and hydration, but the ultimate cause of death is the underlying pathology that made the nutrition and hydration necessary in the first place.

In cases of PVS, a decision to withdraw medically assisted nutrition and hydration is not the moral equivalent of murder but an acceptance of the limits of life, a faith-filled affirmation "that the person has come to the end of his or her pilgrimage and should not be impeded from taking the final step."[28] As Catholics, we are often quick to witness to the value of life, but we should be equally quick to witness to the limits of life. A recognition of life's limits would be as clear a statement as any that we believe and trust in God who has been most fully revealed in the life, death, and resurrection of Jesus Christ. □

NOTES

1. See Russell Smith and Michael Valente, *Medical Dilemmas and Moral Decision Making,* Diocese of Richmond, Richmond, VA, 2001.
2. Multi-Society Task Force on PVS, "Medical Aspects of the Persistent Vegetative State," *New England Journal of Medicine,* May 6, 1994, pp. 1,499-1,508, and June 2, 1994, pp. 1,572-1,579.
3. Charles Weijer, "Cardiopulmonary Resuscitation for Patients in a Persistent Vegetative State: Futile or Acceptable?" *Canadian Medical Association Journal,* February 24, 1998, pp. 491-493; Multi-Society Task Force on PVS.
4. Robin S. Howard and David H. Miller, "The Persistent Vegetative State," *British Medical Journal,* February 11, 1995, pp. 341-342.
5. United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services,* Revised, July 2001, Washington, DC, p. 30.
6. Dennis Brodeur, "Feeding Policy Protects Patients," *Health Progress,* June 1985, p. 39.
7. James J. Walter, "The Meaning and Validity of Quality of Life Judgments in Contemporary Roman Catholic Medical Ethics," in *Quality of Life: The New Medical Dilemma,* James J. Walter and Thomas A. Shannon, eds., Paulist Press, New York City, 1990, pp. 78-88.
8. Pius XII, "The Prolongation of Life," in *Critical Choices and Critical Care,* Kevin W. Wildes, ed., Kluwer Academic Press, The Netherlands, 1995, p. 192.
9. Richard A. McCormick, "To Save or Let Die: The Dilemma of Modern Medicine," *JAMA,* July 8, 1974, pp. 172-176.
10. McCormick, p. 176.
11. See, for example, Germain Grisez, *Contraception and the Natural Law,* Bruce, Milwaukee, 1964; Germain Grisez, *The Way of the Lord Jesus,* Franciscan Herald Press, Chicago, 1983; and John Finnis, *Fundamentals of Ethics,* Georgetown University Press, Washington, DC, 1983, and *Natural Law and Natural Rights,* Clarendon Press, Oxford, England, 1984.
12. This list of "incommensurable" goods is found in Finnis, Fundamentals of Ethics, p. 51, and *Natural Law and Natural Rights,* pp. 85-90.
13. Congregation for the Doctrine of the Faith, "Declaration on Euthanasia," in Walter and Shannon, eds., *Quality of Life,* p. 263.
14. Walter, "The Meaning and Validity of Quality of Life Judgments," in *Quality of Life,* pp. 85-86.
15. William H. Bullock, "Assessing Burdens and Benefits of Medical Care," *Origins,* January 30, 1992, pp. 554.
16. William E. May, et al., "Feeding and Hydrating the Permanently Unconscious and Other Vulnerable Persons," in *Quality of Life,* p. 200.
17. Richard A. McCormick, *Corrective Vision,* Sheed & Ward, Kansas City, MO, 1994, p. 232.
18. McCormick, *Corrective Visions,* p. 232.
19. Robert Barry, "The Ethics of Providing Life-Sustaining Nutrition and Fluids to Incompetent Patients," *Journal of Family and Culture,* Summer 1985, p. 25.
20. Albert S. Moraczewski, "The Moral Option Not to Conserve Life under Certain Circumstances," in *Conserving Human Life,* Russell E. Smith, ed., Pope John XXIII Center, Braintree, MA, p. 257. Most Catholic theologians agree that medically assisted nutrition and hydration is a medical treatment subject to the same moral standards as other treatments. See, for example, Brodeur, "Feeding Policy Protects Patients' Rights, Decisions," p. 43; Richard A. McCormick, *The Critical Calling: Reflections on Moral Dilemmas Since Vatican II,* Georgetown University Press, Washington, DC, 1989, pp. 380-381; and Kevin D. O'Rourke and Jean deBlois, "Removing Life Support: Motivations, Obligations," *Health Progress,* July-August 1992, pp. 20-27, 38.
21. This argument is made by several theologians, including Benedict M. Ashley, "Ethical Obligations," in *Scarce Medical Resources and Justice,* Pope John XXIII Center, Braintree, MA, 1987, pp. 159-165; Kevin D. O'Rourke, "On the Care of 'Vegetative' Patients: A Response to William E. May's 'Tube Feeding and the Vegetative State': Part One," *Ethics and Medics,* April 1999, pp. 3-4; Kevin D. O'Rourke, "On the Care of 'Vegetative' Patients: A Response to William E. May's 'Tube Feeding and the Vegetative State': Part Two," *Ethics and Medics,* May 1999, pp. 3-4; and Patricia A. Talone, *Feeding the Dying: Religion and End-of-Life Decisions,* Peter Lang, New York City, 1996, p. 21.
22. National Conference of Catholic Bishops, pp. 22-23.
23. See, for example, New Jersey Catholic Conference, "Providing Food and Fluids to Severely Brain Damaged Patients," *Origins,* January 22, 1987, pp. 582-584.
24. Multi-Society Task Force on PVS, pp. 1,576-1,577.
25. See, for example, Orville Griese, "Feeding the Hopeless and the Helpless," in *Conserving Human Life,* pp. 147-232, and William E. May, "Tube Feeding and the 'Vegetative State,'" *Ethics and Medics,* January 1999, pp. 3-4.
26. McCormick, "To Save or Let Die," pp. 175-176.
27. Moraczewski, p. 64. For a discussion of ways of dealing with the emotional responses to such decisions of patients, family members, and medical personnel, see Gail Povar, "Withdrawing and Withholding Therapy: Putting Ethics into Practice," *Journal of Clinical Ethics,* Spring 1990, pp. 50-56.
28. Texas Catholic Bishops and the Texas Conference of Catholic Health Facilities, "On Withdrawing Artificial Nutrition and Hydration," *Origins,* June 7, 1990, pp. 54.

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Reprinted from *Health Progress*, November-December 2001