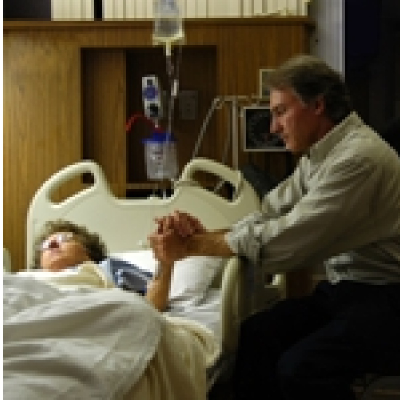
November 17, 2009



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Since the 1980s, there have been a number of high profile cases involving persons receiving medically assisted nutrition and hydration (MANH), e.g., Claire Conroy, Paul Brophy, Nancy Cruzan, Hugh Finn, and Terri Schiavo. The provision of nutrition and hydration through the use of various medical interventions, sometimes referred to as "tube feeding," is one of the most complex and controversial issues in contemporary bioethics.

Legal and moral debate has frequently arisen about tube feeding for a person in a persistent/permanent vegetative state (PVS). While these patients sustain certain brain functions such as wake/sleep cycles and automatic nervous system functions, all detectible activity of the neocortex has ceased, with virtually no expected prospects for recovery.

Nutrition and hydration can be provided by a variety of medical means, wrongly designated as "artificial," e.g., a nasogastric (NG) tube inserted through the nose and into the stomach, usually employed for short-term use. Some of these medical means of tube feeding necessitate surgery, e.g., a percutaneous endogastric tube (PEG tube) passes through an incision in the abdominal wall and into the stomach, or a jejunostomy tube (J tube) which passes through the abdomen into a portion of the small intestine. In every case, feeding tubes and incisions need consistent monitoring.

As with any other medical intervention, an informed decision about the use of MANH must take into account various factors, e.g., the patient's diagnosis, prognosis, current condition, and complicating factors such as co-morbid conditions. In the use of MANH, others issues are also relevant, e.g., what type of MANH is best suited for this person and for how long, what are its

benefits and burdens, what are its side effects? In other words, there is no singular or simple answer to the question of tube feeding.

In the past several decades, over 40 courts in the U.S. have addressed MANH, and there is a virtual universal legal consensus that MANH is a medical treatment that can be withheld or withdrawn following a careful decision-making process. Less unanimity exists in the medical and moral fields. Some clinicians and ethicists believe, e.g., that MANH is more like basic care and must be considered by different standards, while others believe that considerations regarding the use of MANH are the same as any other type of medical intervention.

At the same time, all clinicians agree that withholding or withdrawing MANH is appropriate when 1) it is medically futile (it does not provide effective nutritional support or prevent dehydration), 2) the patient would experience no real benefit, 3) the burdens for the patient outweigh the benefits, and 4) the patient is dying.

Given this complex history, it is not surprising that within the Catholic tradition a number of theologians, ethicists, and groups of bishops have come to different conclusions regarding the use of MANH. The pivotal question has been whether or not MANH is a medical intervention or basic and ordinary health care. Other questions further complicate this issue, e.g., can PVS be diagnosed with certitude, and how does one determine the quality of life of patients in PVS?

The International Congress on “Life-Sustaining Treatments and the Vegetative State: Scientific Progress and Ethical Dilemmas” was held in Rome in March 2004. John Paul II delivered an allocution to this Congress and encouraged scientists and researchers to find better ways to diagnose PVS more accurately. The Pope referred to studies that have shown up to 43% of patients mis-diagnosed, and to cases of recovery after a period of time with continued rehabilitative efforts. John Paul II acknowledged that recovery is more difficult the longer the condition of the vegetative state remains.

The papal allocution “reaffirms with vigor” the intrinsic worth and the personal dignity of every person, including those in the PVS, and insists on their right to basic health care, particularly nutrition and hydration, hygiene, a comfortable environment, and the prevention of complications due to bed confinement. In other words, PVS patients retain their moral claim to basic health care.

The allocution underscores that the administration of water and food – even when given by medical means – is a natural way of conserving life. In other words, the administration of food and water, even when medically delivered by feeding tubes, is not merely a medical act, but a natural means of preserving life. What is central to the Pope's allocution is the dignity of the person receiving care. The use of MANH should be presumed "in principle," and clear medical reasons must be given in each particular case to demonstrate why MANH is not morally obligatory.

The allocution does not require the use of MANH in every case as the moral obligation is conditioned by the medical efficacy of the means used to achieve its proper goal to nourish the patient and alleviate suffering. When it is medically demonstrable that these goals are not being achieved, the moral obligation to use MANH ceases.

While MANH is considered ordinary care even when medically administered, its use is bound by the church's traditional discernment of ordinary/proportionate and extraordinary/disproportionate means (see Declaration on Euthanasia, 1980, and the ERDs, Directives 56-57). The allocution underscores these key points: 1) the inviolable dignity of all human persons regardless of their state of development or decline, 2) the right of every person to receive ordinary health care to preserve life and alleviate suffering, 3) judgments regarding the use of MANH must be based on the actual medical condition of the patient, and 4) if MANH is determined to be disproportionate and medically futile, it can be withheld. In all cases, however, the patient remains the subject of care, comfort and love. In 2007, the Congregation for the Doctrine of the Faith (CDF) reaffirmed these teachings of John Paul II.

In the U.S., guiding principles for Catholic health care facilities and services are contained in the Ethical and Religious Directives for Catholic Health Care Services (ERDs). These guidelines have been issued for many years by the United States Conference of Catholic Bishops (USCCB). From time to time, the ERDs are revised in light of official Church teaching, or perhaps to include new or updated directives that address medical and moral concerns not addressed in earlier publications.

The ERDs in their current format (the 5th edition) were approved and published by the USCCB in 1995 and have been revised twice since then. The latest revision concerns Directive 58, and was approved by the Bishops on November 17, 2009 in order to incorporate the teaching of John Paul II in 2004, and its affirmation/clarification by the CDF in 2007.

In a News Release on November 18th, the Catholic Health Association (CHA) wrote that “the revised Directive does not offer new teaching but rather reflects existing Church teaching which Catholic health care facilities have already incorporated into their practice.”

The revised Directive 58 makes these points:

1. In principle there is a general moral obligation to provide patients with food and water, including medically administered nutrition and hydration for those who are unable to take food orally, even if assisted.
2. This moral obligation extends to patients in a persistent vegetative state because of their innate human dignity.
3. This moral obligation ceases or becomes “morally optional” when MANH becomes excessively burdensome, or no longer accomplishes its objective, that is, medically administered food and water are no longer being assimilated by the patient.
4. It is necessary to distinguish between patients in a chronic state, e.g., PVS, and patients who are dying.

Accordingly, the revised Introduction to Part Five of the ERDs, which contains Directive 58, states, “While medically assisted nutrition and hydration are not morally obligatory in certain cases, these forms of basic care should in principle be provided to all patients who need them, including patients diagnosed as being in a ‘persistent vegetative state,’ because even the most severely debilitated and helpless patient retains the full dignity of a human person and must receive ordinary and proportionate care.”

Since November 17th, there has been a number of false and misleading information about the revision of Directive 58. Joe Carlson, e.g., writing in modernhealthcare.com on November 17th, indicates that Catholic hospitals must now insert and maintain nutrition and hydration tubes, and all PVS patients must be given MANH except those close to inevitable death from underlying conditions. As we have seen, this assertion is incorrect. The Church’s teaching is not that every PVS patient, or a patient in another type of chronic condition, must be maintained on feeding tubes until diagnosed as dying.

By use of the phrase “in principle” in the allocution, the CDF response, and the ERDs, the Church acknowledges that the use of MANH may become medically futile. The CDF gave clear examples: MANH is not available, e.g., in a remote place or in situations of poverty; emerging complications where a patient is no longer assimilating the nourishment; significant physical discomfort.

"Compassion and Choices” (C&C) is a leading force behind the legalization of assisted suicide. It also misrepresents the revision of Directive 58 by stating that Catholic Health Care institutions will no longer honor Advance Directives and PVS patients will be force-fed against their will (see compassionandchoices.org/blog). These assertions are absurd. The C&C website wrongly claims that by “removing all flexibility to respect the wishes of a patient or family, the revised directive creates an obligation to provide patients medically assisted nutrition and hydration in all circumstances… The new guidelines allow no consideration of the burden to the patient…” Directives 24-25 of the ERDs support Advance Directives, e.g., a Durable Power of Attorney for Health Care (DPAHC). Contrary to what C&C assert, a person can indicate in one’s advance directive that MANH is not desired because of the psychological dread of tube feeding. Psychological dread is one of the accepted and traditional moral categories that can constitute extraordinary or disproportionate means (see “A History of Extraordinary Means,” Ethics and Medics, September and November, 2006). Reasonable persons might regard tube feeding excessively burdensome because it causes them great dread (vehemens horror).

Directive 24 cautions that a Catholic health institution “will not honor an advance directive that is contrary to Catholic teaching.” In light of the revised Directive 58, an example would include an Advance Directive that states that a person does not want MANH if diagnosed in a PVS because such a patient has lost all human dignity and is dying.

PVS patients have an intrinsic dignity that demands equality of health care. Consequently, a diagnosis of unconsciousness or of PVS can never in itself be the basis for withholding or withdrawing health care that would be rendered to others.