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The Catholic Tradition On the Use Of Nutrition and Fluids

Bedrock teaching of theology on the meaning of life and death and not a misplaced debate on 'the casuistry of means' should guide our judgments on the difficult decisions cast up by modern medical technology.

Despite a centuries-long teaching on the topic, three recent cases raise anew the question of the church's position on the obligation to use nutrition and fluid to sustain the life of a patient who is no longer able to eat. In the first case, begun on Sept. 7, 1986, a New York trial judge ordered a feeding gastrostomy performed on Msgr. Thomas O'Brien, the 83-year-old pastor emeritus of St. Malachy's (The Actors' Chapel) in Manhattan, who had suffered such a massive stroke the previous spring that it was impossible for him to swallow, speak or take nourishment. After Monsignor O'Brien had deliberately pulled out a nasogastric feeding tube some 15 times, Rita Kerr, S.F.R, the executive director of the Frances Schervier Home and Hospital, requested that a feeding tube be surgically placed directly into the stomach. At the time it ordered the gastrostomy, the court stated that it was doing so as a temporary measure until an adequate psychiatric assessment could be made of Monsignor O'Brien's actions.

At a hearing on Oct. 28, 1986, four psychiatrists testified that Monsignor O'Brien was competent and was able to make a rational decision affecting his life. The court also heard testimony from a long-time friend of the priest that the Monsignor had found the feeding tube denigrating and would want it removed so that he could have "God and not the doctors decide what would happen to him." After seeing the patient himself, the judge concluded that Monsignor O'Brien understood that the gastrostomy was necessary to sustain his life but "it was clear that he was not happy with the tube and would have preferred to have it out."

Despite that finding, State Supreme Court Justice Edward Greenfield would not order the discontinuance of a life-support mechanism. He insisted that he would issue such an order only with "the clearest and most compelling indications from the person most directly involved." Here, he believed, such evidence was lacking. In his words, "It would appear that as a devout, observant Catholic, Monsignor O'Brien would do nothing affirmative to hasten his [own] death."

Believing that Monsignor O'Brien's plea for removing a life-sustaining feeding tube would so violate the priest's most deeply held theological convictions that he would never knowingly make it. Judge Greenfield ruled that Monsignor O'Brien was incompetent. He so ruled—despite the contrary opinion of the psychiatrists—because of "the theological implications that would follow from a removal of the feeding tube on demand."

Those implications, he believed, transformed Monsignor O'Brien's demand into a wholly illicit request—one strictly forbidden by the priest's religion. Consequently, he interpreted the priest's repeated actions in pulling out the nasogastric tube not as a conscious decision to end life-prolonging treatment, but simply as an attempt to rid himself of an annoying, irritating medical device. The discomfort produced by the tube would be overcome by the surgical implantation of a feeding gastrostomy directly into the stomach. In the court's opinion, once that had been done, Monsignor O'Brien would be content "to leave his fate in the hands of God." (Shortly after the court's ruling, Monsignor O'Brien died with the gastrostomy system in place

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Support for Judge Greenfield's interpretation would be found in the *amicus curiae* brief submitted by the New Jersey Catholic Conference to that state's Supreme Court in the case of Nancy Jobes. The brief, which represents the official view of New Jersey's Roman Catholic bishops, speaks to two cases involving a request to withhold or withdraw life-sustaining nutrition and fluids that were heard in New Jersey courts in the fall of 1986. The first. *In re* Nancy Jobes, involves a request by the family to have a feeding tube removed from a 31-year-old woman who had been in a persistent vegetative condition for some five years. After a lengthy court hearing, a Superior Court judge found that the patient would not want to be maintained in that condition and authorized the discontinuance of the feeding tube. His ruling is presently under review by the New Jersey Supreme Court.

The second case. *In re* Beverly Requena, involves a fully competent 55-year-old woman dying of amyotrophic lateral sclerosis (Lou Gehrig's disease) at St. Claire's Hospital in Denville, N.J. (the same Catholic facility in which Karen Ann Quinlan was a patient some 10 years earlier). Mrs. Requena, who is on a respirator, is completely paralyzed from the neck down, is unable to speak and is barely able to sip liquid nutrients through a straw. She will soon lose her ability to swallow. Mrs. Requena had informed the hospital that when her swallowing capacity was gone she would refuse to accept feeding by a nasogastric tube or any other artificial device. The administration of the hospital, citing its "pro-life" values, refused to allow the hospital or its personnel to participate in the withholding of artificial feeding. It asked Mrs. Requena to leave the hospital. When she refused, St. Claire's brought suit to force her out.

Judge Reginald Stanton, the same judge who two years earlier had authorized the removal of a feeding tube from a dying, senile 84-year-old Claire Conroy, ruled that Beverly Requena's decision to refuse artificial feeding must be honored by the hospital, notwithstanding its official policy that "food and water are fundamental care that cannot be withheld from patients." In a lengthy explanation of his ruling. Judge Stanton criticized the hospital for its misguided tendency to "find a 'pro-life' vs. 'anti-life' issue where it does not truly exist." In his graphic phrasing: "This poor woman is not anti-life, and her decision is not anti-life. She would dearly like to be well and have a decent life. Unfortunately, a decent life is not hers to have." The issue for the hospital, physicians and patients is not "pro-life vs. anti-life," but respect for the personal worth, dignity and integrity of the individual human being who happens to be a patient. And, as Judge Stanton put it, "The right to make informed, autonomous decisions about one's own treatment is a crucial part of that personal worth, dignity and integrity."

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Against that background, the New Jersey Catholic Conference submitted its *amicus curiae* brief in the Jobes case. The brief is remarkable in several ways. As Paul Armstrong, the attorney who represented the family of Karen Ann Quinlan and now represents the family of Nancy Jobes, observed: "It is hard to reconcile this brief with those submitted by the bishops earlier in the cases of Karen Ann Quinlan and Claire Conroy, and it is hard to reconcile the position advanced in Jobes with the longstanding teaching of the church." The difficulty is that in the earlier cases, the bishops supported the termination of what was thought to be life-sustaining treatment for the irreversibly comatose Karen Quinlan and the removal of a feeding tube from the demented, dying Claire Conroy. Now the bishops are maintaining that "Catholic patients and their families, as well as caregivers, are obliged in all cases to accept, or to continue once begun, artificial medical measures that provide nutrition and hydration." Puzzled as well as troubled with the shift, Mr. Armstrong politely remarked, "I must say this latest statement is not my understanding of the fullest teaching of the Catholic Church."

Mr. Armstrong and the Catholic community are legitimately confused by the New Jersey bishops' recent statement. Examining the brief in more detail, reviewing the church's traditional teaching and pondering the reflections of moral theologians on the issue of withholding nutrition and fluids will help us uncover this confusion.

The bishops begin their statement by noting that they are providing the court with "the moral and philosophical insights of Catholic ethical teaching" on the withholding of nutrition and fluids as it applies to the care of an individual such as Nancy Jobes (a Presbyterian being treated in a nonsectarian nursing home) and as it governs the practice of medicine in Catholic health-care facilities. They frame the issue, not in terms of the dignity of the individual, but as a concern for the right to life and society's duty to protect that right. They then forthrightly make their standard known: "Nutrition and hydration, which are basic to human life, and as such distinguished from medical treatment, should always be provided to the patient." Not to do so would, in their view, "introduce a new attack upon human life."

After admonishing the court not to draw its conclusion from an analysis of the "quality of life" of the patient, not to allow euthanasia and not to lessen the respect for the human life of the person who is seriously ill or dying, the bishops state that they "join the broad stream of ethical

consciousness when we ask the court not to look favorably upon a plea sanctioning starvation as a means of death for a patient who would not otherwise die immediately." The bishops buttress their stand with a November 1985 statement from the Pontifical Academy of Sciences: "If the patient is in a permanent coma, irreversible as far as it is possible to predict, treatment is not required but *care, including feeding, must be provided*" They also cite the Bishops' Committee for Pro-Life Activities, which states that since food and water can "generally be provided without the risks and burdens of more aggressive means of sustaining life, the law should establish a strong presumption in favor of their use."

The bishops conclude by urging the New Jersey Supreme Court to "stop the trend toward a public policy that does not advocate the preservation of life." Lest there be any doubt as to the "pro-life" stand they want protected, the bishops remind the court that "as long as evidence of human life is present, and it is present until death occurs, a living person exists." And that person, so long as he or she exists—regardless of condition, regardless of stated wishes, regardless of suffering and the burden of continued life—must be provided nutrition and fluids. To do otherwise, so the New Jersey bishops hold, would be intentional euthanasia.

That standard is more than puzzling; it is wholly contrary to the centuries-long tradition of the church on the duty to preserve life. Beginning with the teachings of Domingo Soto in the 16th century—that religious superiors could only require their subjects to use medicine that could be taken without too much difficulty—through the Vatican's 1980 "Declaration on Euthanasia," there have been clear limits set on what one is obliged to undergo to preserve life. The most famous formula for that limitation was the distinction first proposed in 1595 by Domingo Banez between "extraordinary" and "ordinary" means, by which was meant measures proportionate to one's condition or state in life. Thus, if something were very costly or burdensome or if it did not offer substantial benefit to the patient, there was no moral obligation to use it. This standard applied even to life-saving measures.

That the doctrine has continued unchanged to the present day is seen in the Vatican's recent "Declaration on Euthanasia," which states: "It is permitted, with the patient's consent, to interrupt those means where the results fall short of expectation." Withdrawing treatment, in the Vatican's words, "is not the equivalent of suicide; on the contrary, it should be considered as an acceptance of the human condition, or a wish to avoid the application of a medical procedure disproportionate to the results that can be expected, or a desire not to impose excessive expenses on the family or community." That such treatments include even nourishment and fluid is seen in the recent policy on

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"The Rights of the Terminally Ill" issued by the Pro-Life Committee of the U. S. Catholic Conference: "Laws dealing with medical treatment may have to take account of exceptional circumstances where even means of providing nourishment may be too ineffective or burdensome to be obligatory."

That statement, not the prefatory comments cited by the New Jersey Catholic Conference—that "nutrition and fluids can *generally* be provided without the risks and burdens of more aggressive means of sustaining life"—is the operative standard held and taught by the church. It recognizes that there are certain circumstances in which the patient's condition is so debilitated that any treatment would be futile or, if not futile, would prove so burdensome as to be nonobligatory. In those limited situations, the withholding of nutrition and hydration is designed not to hasten the death by starvation or dehydration, but to spare the patient the prolongation of life when the patient can derive no benefit from such prolongation.

The clearest statement of that teaching is found in the *Relationes Theologicae* by the 16th-century Dominican moralist Francisco DeVitoria. In a commentary on the obligation to use food to preserve life, DeVitoria asks: "Would a sick person who does not eat because of some disgust for food be guilty of a sin equivalent to suicide?" His reply: "If the patient is so depressed or has lost his appetite so that it is only with the greatest effort that he can eat food, this right away ought to be reckoned as creating a kind of impossibility, and the patient is excused, at least from mortal sin, especially if there is little or no hope of life."

DeVitoria provides an everyday example of the type of "delicate treatment" that would be beyond what one is obliged to employ to preserve life: "Chickens and partridges, even if ordered by the doctor, need not be chosen over eggs and other common items, even if the individual knew for certain that he could live another 20 years by eating such special foods." If this was true of hens and partridges in DeVitoria's time, how much the more so today for total parenteral nutrition, feeding gastrostomies, nasogastric tubes and other artificial means of providing alimentation?

That DeVitoria's views were neither unique nor subsequently abandoned is best seen in a 1950 *Theological Studies* essay on "The Duty of Using Artificial Means of Preserving Life" by the widely respected Jesuit moralist

Gerald Kelly. Kelly was concerned with the same questions now confronting the courts in O'Brien, Requena and Jobes: Is there a moral obligation to continue intravenous feeding of an irreversibly comatose, terminally ill patient?

After a thorough survey of the prior teachings on the subject, Kelly finds that the authors hold that "no remedy is obligatory unless it offers a reasonable hope of checking or curing a disease (Nemo ad inutile tenetur)" From this Kelly concludes that no one is obliged to use any means—natural or artificial—if it does not offer a reasonable hope of success in overcoming that person's condition.

Practical application of principles is the mark of a moralist, and Kelly provides us with two cases—cases nearly identical to questions raised in the cases of Requena, O'Brien and Jobes. In his first example, a terminally ill cancer patient's painful death is being prolonged by intravenous feeding. With such therapy, the patient could survive for several more weeks. The physician stops the intravenous feeding, and the patient dies soon thereafter. As is true in the present disputes, the commentators were divided over whether the intravenous feedings constituted an "ordinary" or "extraordinary" means of preserving life. Kelly concedes that one could consider the treatment as "ordinary." But one must still determine if the patient is obliged to undergo it. Kelly's answer is straightforward and clear: Since the prolonging of life is relatively useless, the patient may refuse the treatment. Further, he argues, if the patient is so racked with pain that he is unable to speak for himself, "the relatives and physicians may reasonably presume that he does not wish the intravenous feeding" and licitly discontinue it.

In the second case, Kelly goes even further. When asked if oxygen and intravenous feeding must be used to extend the life of a patient in a terminal coma, he replies: "I see no reason why even the most delicate professional standard should call for their use. In fact, it seems to me that, apart from very special circumstances, the artificial means not only need not but should not be used, once the coma is reasonably diagnosed as terminal. Their use creates expense and nervous strain without conferring any real benefit."

A 1958 doctoral dissertation at the Gregorian University

in Rome, "The Moral Law in Regard to the Ordinary and Extraordinary Means of Preserving Life," by Daniel A. Cronin (the present Bishop of Fall River, Mass.), provides the most authoritative historical study of this topic. After a review of over 50 moral theologians, from Aquinas to those writing in the early 1950's, Cronin concludes that the church's teaching is consistent in its view: "Even natural means, such as taking of food and drink, can become optional if taking them requires great effort or if the hope of beneficial results (*spes salutis*) is not present." For the patient whose condition is incurable, Cronin writes, "even ordinary means, according to the *general norm*, have become extraordinary [morally dispensable] for the patient and [so] the wishes of the patient, expressed or reasonably interpreted, must be obeyed."

Cronin's retrospective analysis of the tradition firmly establishes that the moralists have always held that no means—including food or water—can be said to be absolutely obligatory regardless of the patient's status. How then did the idea that food and water must always be provided the patient gain currency? Perhaps it arose from the hesitancy expressed by Kelly to advise physicians that it is morally permissible to discontinue intravenous feeding lest such action be misinterpreted as a form of Catholic euthanasia.

That reluctance was intensified in Charles McFadden's widely circulated *Medical Ethics*, which was published in 1967. McFadden wrote that while the long-term use of artificial feedings could constitute a grave and nonobligatory burden, as a matter of practical medical advice he would never propose the removal of intravenous feeding once it had been instituted. The danger is that of scandal, guilt on the part of the family and misuse by insensitive or unscrupulous physicians. Those not familiar with the nuanced distinctions, he argued, might believe that the patient had been deliberately killed to alleviate his suffering. Others then might all too readily terminate nourishment for anyone whose life was considered "useless." Opposition to the application of the traditional doctrine to medical practice soon led to the notion that what was theoretically correct was not only rash, it was wrong. From there it was an easy step to the position that it was wrong because it violated fundamental principles such as: "One must always use 'ordinary' means to preserve life."

The feeding issue fairly much dropped from the literature until the Karen Ann Quinlan case once again brought it to public attention. Then Paul Ramsey, whose essay "On (Only) Caring for the Dying" has yet to be surpassed for insight and beauty in describing the Christian's responsibility toward the dying, adopted and updated Kelly's formulation. Ramsey's version reads: "Never abandon care." For the dying, Ramsey maintains that care is not recourse to pretended remedies; it is comfort and company. For those, such as Nancy Jobes, who are now beyond both, there is no objection to withholding or withdrawing nourishment. The application of the theory occurred when Ramsey equated the respirator and the intravenous treatment as equally aimless means of prolonging Karen Ann Quinlan's dying.

Ramsey's perspective was subsequently endorsed by Richard A. McCormick, S.J., when, during a June 1982 hearing at the President's Commission on Ethical Problems in Medicine, the question was asked whether there was any moral difference between removing a respirator, antibiotics or artificial feeding from Karen Ann Quinlan. The reply from the Catholic tradition was clearly, "No." If, for example, she were to contract pneumonia, there would be no need to use antibiotics because she would stand to gain nothing from such an intervention. A similar argument could likewise be made with regard to the continued use of feeding through the nasogastric tube. We were aware, as were McFadden and Kelly, of the danger of misinterpretation and misuse of the principle, and we were aware that there are forces in our society that would welcome the highly publicized withdrawal of nutrition from Quinlan as an invitation to active euthanasia. Hence we cautioned that it might be imprudent to withdraw the treatment in *her particular* well-publicized case.

'To persist in indiscriminately using such gestures can convey stupidity and cruelty, not compassion and love.'

Until such highly emotionally charged cases as Quinlan's, there was little ambiguity or hesitancy about ending artificial feeding for dying patients. For example, in his widely noted and frequently anthologized 1976 annual discourse to the Massachusetts Medical Society, "On Caring for the Patient With Cancer," Dr. J. Englebert Dunphy admonished physicians: "There is no need to prolong a useless and tragic life [of a patient racked with cancer] by force feeding or giving antibiotics . . . to drag it out for a few more agonizing days or weeks." In his sharply stated summary: "That is the science without the humanity of medicine."

And in an essay entitled "A Quiet Death, With Dignity" (AM. 3/12/77), Cornelia Holbert wrote about her mother, an 86-year-old victim of multiple strokes whose newly contracted pneumonia was being treated by intravenous fluids and antibiotics. At her own request, her mother was disconnected from those (simple, ordinary and customary) treatments. She was kept comfortable by a fingertip

dipped in ice water and smoothed over her tongue. During this time, her beloved rosary was placed in her hand. In Holbert's moving words, "Love flowed now, not merely love of compassion but the love of adoration for the glory of a soul stripped down to its pure white essence."

Holbert's essay evoked no charges of euthanasia; it conjured up no horrors of death by starvation and dehydration; it provoked no episcopal warnings of denigration of "life." Rather, it was received in simple story form as an exposition of the fervent Catholic prayer for the sick: "For a speedy recovery or a happy death."

This understanding of life, death and the role of medicine continues to predominate in the thinking and writing of Catholic theologians. With the exception of Robert Barry, O.P, whose position parallels that of the New Jersey Conference's brief, we know of no theologian who maintains that nutrition and fluids must always be provided to all patients, including the terminally ill. For Barry, that obligation persists even for those who are brain dead because, in his view, "They are only in the final stages of dying, but not yet dead."

John Connery, S.J., testified against the removal of a feeding gastrostomy from 49-year-old Paul Brophy, an irreversibly comatose Massachusetts man, urging that we not fall into a "quality of life" standard. Nonetheless, Connery wrote of the demented, terminally ill Claire Conroy: "From a moral perspective we would judge that long-term use of a nasogastric tube might be very burdensome for a patient, and therefore morally optional." He continued; "If this was called for (and it seems to be the case), it would be morally permissible for Ms. Conroy (or her proxy following her wishes) to have the treatment withdrawn."

Two of Connery's theological colleagues at Chicago's Loyola University, David Thomasma and James Walter, have recently written in support of termination of life support. Thomasma, writing in Critical Care Clinics, argues that "certain circumstances make administration of food and water futile." In those situations, Thomasma believes, "To persist in indiscriminately using such gestures can convey stupidity and cruelty, not compassion and love." After reviewing the various positions offered in the Brophy case, Walter concluded, "I side with those who see no moral distinction between the refusal or withdrawal of nutrients and the refusal/withdrawal of various medical technologies." Similar positions have been taken by us (Paris [with Andrew C. Varga], "Care of the Hopelessly Ill," **AM**. 9/22/84; McCormick, "Caring or Starving? The Case of Claire Conroy," **AM**. 4/6/85) and by most of the Catholic moralists who have written on this topic, including Andrew C. Varga, S.J., Dennis Brodeur, Albert Moraczewski, O.P., Gary Atkinson, Edward Bayer, James Bresnahan, S.J., David Thomasma, James Walters and Kevin O'Rourke, O.R.

In "The A.M.A. Statement on Tube Feeding: An Ethical Analysis" (**AM**. 11/22/86), O'Rourke discussed the A.M.A.'s statement declaring that artificially or technologically supplied respiration, nutrition and hydration may be withheld from terminally ill and irreversibly comatose patients. His article succinctly summarized the major controversies surrounding this issue. This was a clear and careful reiteration of the ethical assumptions upon which medicine and the efforts to treat people have been based—"to prolong living in order to pursue the purpose of life." Had it been available to the New Jersey bishops prior to the issuance of their brief in Jobes, they might well have avoided the "life at any cost" stance that marks the present document. Further, they might have reflected more fully on the fact that the burden a person would experience in striving to obtain the purpose of life—not the burden associated with the means to prolong it—is and traditionally has been the focus of Catholic moral concern.

It is this bedrock teaching of theology on the meaning of life and death—neither of which in the Christian framework ought to be made absolute—and not a misplaced debate on "the casuistry of means" that should guide our judgments on the difficult and sometimes trying decisions cast up by modern medical technology. To do otherwise—or to count mere vegetative existence as a patient-benefit—is to let slip one's grasp on the heart of Catholic tradition in this matter. It is that tradition, developed over centuries of living out the Gospel message on the meaning of life and death—and not some immediate political "pro-life" agenda—that ought to be the source of our advice and guidance to courts.