ARTIFICIAL NUTRITION AND HYDRATION AND THE PATIENT IN PERSISTENT VEGETATIVE STATE: ROMAN CATHOLIC MAGISTERIAL TEACHING ON THE RIGHT TO REFUSE MEDICAL TREATMENT VERSUS THE OBLIGATION TO PROVIDE ORDINARY CARE

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I. INTRODUCTION

The issue of withholding or withdrawing artificial nutrition and hydration ("ANH") from a patient in a persistent vegetative state ("PVS") has over the last four decades evolved into a significant subject which places Catholic teaching on medical ethics in conflict with the consensus legal understanding and the accepted view of professional medical ethicists. After reviewing the consensus legal and medical view, this Article will trace the evolution of the teaching of the Roman Catholic Magisterium on the question

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of providing ANH to patients diagnosed as a PVS. The deviation from the consensus view of legal authorities and professional medical ethicists will be examined, along with the evolution of official Catholic teaching on this issue. A review will be provided of the range of opinion among contemporary theologians on whether there has been a significant change in the official Church teaching over time, or whether there has been simply a clarification in an area that had remained ambiguous with regard to obligation of care and treatment of non-terminal patients. Finally, an effort will be made to determine the current teaching of the Magisterium on provision of ANH to PVS patients and other non-terminal patients, and a judgment whether the terms of the teaching are in conformity with traditional Church teaching on care and treatment of patients.

The teaching of the Roman Catholic Church on the provision of care and treatment of patients is rooted in Scriptural teaching on charity and the recognition of the human dignity of every person. The developments in natural law theory in the sixteenth century, which are briefly discussed in this Article, supported a view shared by medical practitioners and courts that recognizes a patient's right to refuse unwanted burdensome treatment.[2] With the development in the middle of the twentieth century of medical technology that was able to sustain life, which would otherwise be ended by natural causes, legal doctrine and medical ethics drew on the doctrine of the necessity of informed consent before treatment could be rendered to a patient.[3] The doctrine of informed consent recognized not only the right of the individual to assent or refuse such treatment; but that when a terminal patient becomes mentally incompetent or unconscious, family members of patients could assert the right to have treatment withdrawn on the grounds that it merely prolongs the dying process.[4] Early cases of treatment dealt with withdrawal

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[2] DAVID F. KELLEY ET AL., CONTEMPORARY CATHOLIC HEALTH CARE ETHICS 126–27 (Georgetown University Press, 2d ed. 2013) ("The ethical distinction between mandatory and optional treatment has been provided by the Catholic tradition in its centuries-old distinction between ordinary and extraordinary means of preserving life, terms often used even in secular conversation and policies. The distinction goes back at least to the sixteenth century, was included in the important work of Alphonse Liguori in the eighteenth century, and was emphasized and made popular by the teaching of Pope Pius XII in the 1950's . . . . The more restrictive approach looked only to the burdens of treatment itself. A treatment was said to be extraordinary if it was painful, caused great hardship, or was expensive.").

[3] KEVIN D. O'ROURKE & PHILIP J. BOYLE, MEDICAL ETHICS: SOURCES OF CATHOLIC TEACHINGS 212–13 (Georgetown University Press, 4th ed. 2011) ("[T]he doctor, as a private person, cannot take any measure or try any intervention without the consent of the patient.").

[4] *Id.* at 265 ("In general [the doctor] can take action only if the patient explicitly or implicitly, directly or indirectly, gives him permission. The technique of resuscitation which concerns us here does not contain anything immoral in itself. Therefore the patient, if they were capable of making a personal decision, could lawfully use it and, consequently, give the doctor permission to use it. On the other hand, since these forms of treatment go beyond the ordinary means to which one is bound, it cannot be held that there is an obligation to use them nor, consequently, that one is bound to give the doctor permission to use them. . . . The rights and duties of the family depend in general upon the presumed will of the unconscious patient if he is of age and 'sui juris.' Where the proper and independent duty of the family is concerned, they are usually bound only to the use of ordinary means. Consequently, if it appears that the attempt at resuscitation constitutes in reality a burden for the family that one cannot in all conscience impose it upon them, they can lawfully insist that the doctor should discontinue these attempts, and the doctor can lawfully comply.").

of mechanical support such as ventilators.[5] Roman Catholic teaching, medical ethics, and legal rulings were generally in agreement on the appropriateness of withdrawal of such "extraordinary" treatment.[6] Requests to discontinue provision of artificial nutrition and hydration in the case of terminally ill patients, which was also viewed as medical treatment that could be refused, were initially viewed as supported by Catholic teaching, and recognized as legitimate by medical ethicists and by law courts.[7] The general rule developed that recognized the right of a competent person to refuse such life prolonging treatment, and to indicate in an advance directive that such treatment not be provided if the patient was incompetent when diagnosed with a terminal illness.[8]

In 1972, the condition PVS was recognized and clinical criteria developed for diagnosis of the condition.[9] Some theologians, joining many medical ethicists and legal authorities, viewed this condition when it is properly diagnosed as equivalent to a terminal condition for purposes of allowing removal of life support or medical treatment, including ANH.[10] Other theologians and Church authorities developed the view that the patient in PVS is a person who, while unconscious, is not suffering from a terminal illness which will otherwise cause death, and who must be provided ordinary care which includes nutrition and hydration, even if it is provided by artificial or mechanical means.[11] This Article will examine the developing Catholic teaching on whether there is a moral obligation to provide ANH to the PVS

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[5] *In re* Quinlan, 355 A.2d 647 (N.J. 1976); *see* William J. Curran, *Defining Appropriate Medical Care: Providing Nutrients and Hydration for the Dying*, *in* BIOETHICS 1, 209 (Thomas A. Shannon ed., 3d ed. 1987) ("The New Jersey Supreme Court first attained national prominence in medicolegal issues of obligation to critically ill patients in the Karen Ann Quinlan case. The high court in New Jersey issued an eminently sensible opinion in that case, allowing the patient's guardian, her father, to use his discretion in removal of life support [a respirator] from his daughter, who was then irreversibly comatose.").

[6] *In re* Storar, 433 N.Y.S.2d 388, 393 (N.Y. Sup. Ct. 1980) *rev'd* 420 N.E.2d. 64 (N.Y. 1981).

[7] Atlanta Archdiocese, *Georgia Man Asks to Turn Off Life-Supporting Ventilator*, ORIGINS 273, 273–79 (1989) (discussing the case of a quadriplegic patient sustained on a ventilator who had "no control over his person and receive[d] no enjoyment out of life" and who requested removal of the ventilator. The Archdiocese concluded that "[t]he consensus of legal, theological and moralistic authorities, however, support[ed] Mr. McAfee's right to refuse further treatment by ventilator, and such refusal in this case would not be the equivalent of suicide. Rather, it can be considered as Mr. McAfee's acceptance of his condition, his wish to avoid the application of a medical procedure disproportionate to the expected results and his desire not to impose excessive expense on his family and the community at large.").

[8] Bouvia v. Superior Court, 225 Cal. Rptr. 297, 300 (Cal. Ct. App. 1986) finding that competent patients have a common law and constitutional right to refuse treatment); *see also In re* Gardner, 534 A.2d 947, 957 (Me. 1987) (suggesting that an advance directive is essentially an equivalent with anticipating informed consent).

[9] The term PVS was coined in 1972 by Jennet and Plum to describe those patients who exhibited brain stem functions but a total absence of activity in the cerebral context. Unlike the eyes-closed, sleep like unconsciousness typically seen with comatose patients, those in a PVS experience alternate eyes-open and eyes closed unconsciousness. "Awake but not aware" is how it can be described. *See* Bryan Jennet & Fred Plum, *Persistent Vegetative State After Brain Damage: A Syndrome in Search of a Name, in* THE LANCET 734, 734–37 (1972).

[10] Richard A. McCormick, *Caring or Starving? The Case of Claire Conroy*, *in* 152 AMERICA 265, 269–73 (1985).

[11] William E. May et al., *Feeding and Hydrating the Permanently Unconscious and other Vulnerable Persons*, 3 ISSUES L. & MED. 203, 203–10 (1987).

patient.

II. CONSENSUS LEGAL AND MEDICAL VIEW ON WITHHOLDING AND WITHDRAWAL OF ANH FROM PERSON DIAGNOSED AS PVS

The case of *Cruzan v. Director* decided in 1990 was the first end-of-life case decided by the United States Supreme Court.[12] The patient who was the subject in the case was a woman who had lapsed into a persistent, vegetative state as a result of serious injuries suffered in an automobile accident seven years earlier.[13] The Court affirmed the state supreme court's opinion, which held that artificial nutrition and hydration could not be withdrawn from a woman in a PVS who was not terminally ill unless there was proof of clear and convincing evidence that she had authorized such termination prior to losing decision-making capacity.[14] Despite upholding the Missouri standards of proof for determining an incompetent patient's prior statements about life sustaining treatment, the Court's opinion reflected the established consensus that a patient, including an incompetent patient, had the right to forgo life-sustaining treatment, including withholding and withdrawal of ANH.[15]

Chief Justice Rehnquist writing for the Court adopted the assumption that provision of ANH constituted medical treatment when considering the scope of withdrawal of life-sustaining treatment from an incompetent patient:

> Petitioners insist that under the general holding of our cases, the forced administration of life-sustaining medical treatment, and even of artificially delivered food and water essential to life, would implicate a competent person's liberty interest [in refusing treatment]. . . . [F]or purposes of this case, we assume that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition.
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> Petitioners go on to assert that an incompetent person should possess the same right in this respect as is possessed by a competent person.[16]

A majority of the Justices in *Cruzan* (the three dissenters and concurring Justices O'Connor and Scalia) went farther and clearly adopted the view that nutrition and hydration was simply one form of medical care.[17] Justice Brennan adopted the view of ANH that has become the dominant view in

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[12] *See generally* Cruzan v. Dir. Mo. Dep't of Health, 497 U.S. 261 (1990).
[13] *Id.* at 265–66.
[14] *See id.* at 284–85; Cruzan v. Harmon, 760 S.W.2d. 408, 426 (Mo. 1988).
[15] *Cruzan*, 497 U.S. at 302 (Brennan, J., dissenting).
[16] *Id.* at 279 (majority opinion).
[17] *Id.* at 287, 302, 304, 307, 331 (O'Connor, J., concurring) (Scalia, J., concurring) (Brennan, J., dissenting).

American law:

> The artificial delivery of nutrition and hydration is undoubtedly medical treatment. The technique to which Nancy Cruzan is subject -- artificial feeding through a gastronomy tube -- involves a tube implanted surgically into her stomach through incisions in her abdominal wall. It may obstruct the intestinal tract, erode and pierce the stomach wall, or cause leakage of the stomach's contents into the abdominal cavity. . . . The tube can cause pneumonia from reflux of the stomach's contents into the lung. . . . Typically, and in this case, commercially prepared formulas are used, rather than fresh food. . . . The type of formula and method of administration must be experimented with to avoid gastrointestinal problems. The patient must be monitored daily by medical personnel as to weight, fluid intake, and fluid output; blood tests must be done weekly.
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> Artificial delivery of food and water is regarded as medical treatment by the medical profession and the Federal Government. . . . The Federal Government permits the cost of the medical devices and formulas used in enteral feeding to be reimbursed under Medicare. The formulas are regulated by the federal Food and Drug Administration as "medical foods," and the feeding tubes are regulated as medical devices[] . . . .[18]

The consensus view among medical authorities is that there is no distinction between nutrition and hydration and other forms of medical treatment.[19] The American Medical Association's Council on Ethical and Judicial Affairs has declared that: "Life-sustaining treatment may include, but is not limited to, . . . artificial nutrition and hydration."[20] Similarly, the courts have concluded that termination of ANH is no different from termination of other forms of mechanical support.[21]

The question arises, when may a patient refuse treatment, and if a patient becomes incompetent when does that patient become eligible to have life-sustaining treatment withheld or withdrawn in accordance with

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[18] *Id.* at 307–08 (internal citations omitted).

[19] *Code of Medical Ethics: Opinion 2.20 - Withholding or Withdrawing Life-Sustaining Medical Treatment*, AM. MED. ASS'N, http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion220.page? (last visited Mar. 13, 2015); *see also In re* Conroy, 486 A.2d 1209, 1235–37 (N.J. 1985) (discussing the risks associated with artificial hydration and nutrition).

[20] AM. MED. ASS'N, *supra* note 19.

[21] *In re Conroy*, 468 A.2d at 1236 ("Analytically, artificial feeding by means of a nasogastric tube or intravenous infusion can be seen as equivalent to artificial breathing by means of a respirator. Both prolong life through mechanical means when the body is no longer able to perform a vital bodily function on its own.").

appropriate surrogate decision-making rules such as established by statutes providing for living wills? A competent patient has the right to refuse any medical treatment subject to the state's interest in preserving life and preventing suicide which limits such claim when based on a constitutional right to privacy or protected liberty interest.[22] For example, in *In re Conroy*, the New Jersey Supreme Court rested the right of a patient to refuse treatment on common law principles of battery, without any reference to constitutional claims.[23] The United States Supreme Court in *Washington v. Glucksberg*, addressing the claim to physician aid in dying, reasoned that the right to refuse treatment whose existence the Court had assumed in *Cruzan* was based on "the common-law rule that forced medication was a battery[] . . . ."[24]

The majority of state courts recognizing a right to refuse life-sustaining treatment have found that right in state common law, usually in the law of battery and the related law of informed consent, applied even after the patient has lost the capacity to make medical decisions.[25] In principle, neither the type of treatment at issue in an end-of-life-cases, nor the diagnosis of the patient is determinative of whether treatment may be withheld or withdrawn.[26] Cases involving withholding or withdrawal of life-sustaining treatment have turned on the facts of the case.[27] Establishing the presence of a terminal illness,[28] or an undue burden in the administration of treatment,[29] or the futility of treatment,[30] are factual conditions which have established the eligibility of an incompetent patient for the withholding or withdrawal of treatment.

A patient may direct future treatment by executing a durable power of attorney for health care which provides authority appointing a surrogate decision-maker and specifying the conditions and kinds of treatment to be administered or to be withheld.[31] A widely used advance directive is the living

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[22] *See id.* at 1235.

[23] *Id.* at 1221–22.

[24] Wash. v. Glucksberg, 521 U.S. 702, 725 (1997).

[25] Cruzan v. Dir. Mo. Dep't of Health, 497 U.S. 261, 269–70 (1990). Chief Justice Rehnquist recognizes "[t]he informed consent doctrine has become firmly entrenched in American tort law. . . . The logical corollary of the doctrine of informed consent is that the patient generally possesses the right not to consent, that is, to refuse treatment." *Id.* With the establishment of a common law right to refuse treatment it is not necessary to determine whether the right is also confirmed by statute or by the constitution of the United States or by a state constitution. *See, e.g.*, *In re* Storar, 420 N.E.2d 64 (N.Y. 1981).

[26] *See, e.g.*, Brophy v. New Eng. Sinai Hosp., Inc., 497 N.E.2d 626, 637 (Mass. 1986); *In re* Jobes, 529 A.2d 434, 446 (N.J. 1987).

[27] *See, e.g.*, *In re* Dinnerstein, 380 N.E.2d 134, 135–39 (Mass. App. Ct. 1978); Carothers v. Dep't of Insts., Grand Junction Reg'l Ctr., 845 P.2d 1179, 1181 (Colo. 1993).

[28] *See* UNIF. RIGHTS OF THE TERMINALLY ILL ACT § 3, 9 U.L.A. 240 (1987) (establishing that a living will refusing treatment becomes operative when it is communicated to the attending physician and that patient is both terminally ill and incompetent).

[29] *See e.g.*, *In re Dinnerstein*, 380 N.E.2d at 135–36.

[30] *See, e.g.*, *Carothers*, 845 P.2d at 1181.

[31] David A. Powers, *Advance Medical Directives: The Case for the Durable Power of Attorney for Health Care*, 8 J. LEGAL MED. 437, 449 (1987).

will, which usually applies to life sustaining treatment.[32] Living wills generally apply in the case of terminal illness.[33] The Uniform Right of the Terminally Ill Act applies in the case of "terminal condition," which is defined as a condition that is "incurable and irreversible."[34] Some states have specifically provided that living wills apply to some non-terminal conditions such as "irreversible coma" or "persistent vegetative state" as well as to terminal conditions.[35]

Judicial treatment of PVS as a condition qualifying a patient for withholding or withdrawal of life-sustaining treatment generally involves a recognition of the condition as equivalent to terminal illness.[36] Both of the landmark cases involving Karen Quinlan[37] and Nancy Cruzan[38] involved patients who were in PVS when they came to the courts. The legal and medical consensus view has been that a person in a PVS has no chance of return to a cognitive state although the body of the patient can be maintained, often without the use of a ventilator, for many years and sometimes for decades.[39] However, such persons often require the assistance of ANH. Nevertheless, Justice Stevens in his dissent in *Cruzan* stated that every court that had considered a request to terminate life-sustaining treatment for a person in a PVS had approved withdrawal of ANH.[40]

The Supreme Judicial Court of Maine in *In re Gardner* provided a good example of contemporary judicial consideration of requests to discontinue provision of ANH to a person in a PVS.[41] The court found that the patient's mother, acting as his guardian, had the authority to order the removal of a feeding tube as well as other life-sustaining procedures from the patient who was "in a chronic and persistent vegetative state without hope of regaining any cognitive or voluntary bodily functions by any known or anticipated medical procedure."[42] The court found "no reason not to respect Gardener's personal decision and allow the discontinuation of life-sustaining

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[32] *See, e.g.*, TENN. CODE ANN. § 32-11-103(4) (West 2001); *see generally* Susan R. Martyn & Lynn Balshone Jacobs, *Legislating Advance Directives for the Terminally Ill: The Living Will and Durable Power of Attorney*, 63 NEB. L. REV. 779, 787 (1984).

[33] *See, e.g.*, WIS. STAT. ANN. § 154.01(8) (West 2006).

[34] UNIF. RIGHTS OF THE TERMINALLY ILL ACT § 3, 9 U.L.A. 615 (1987).

[35] LA. REV. STAT. ANN. § 40:1299.58.1.A.(3)(b) (2008); IDAHO CODE ANN. § 39-4503(1)(b) (West 2006); TENN. CODE ANN. § 32-11-103(9) (West 2009).

[36] *See, e.g.*, Cruzan v. Dir. Mo. Dep't of Health, 497 U.S. 261, 349 (1990) (Stevens, J., dissenting); *In re* Quinlan, 355 A.2d 647, 655 (N.J. 1976).

[37] *Quinlan*, 355 A.2d at 652–53. Quinlan's cognitive abilities were irreversibly lost due to the destruction of the cognitive part of her brain according to criteria established by the Ad Hoc Committee of the Harvard Medical School. *Id.* at 655.

[38] *Cruzan*, 497 U.S. at 266–68 (majority opinion). The Court observed that Cruzan was "in what is commonly referred to as a [PVS]: generally, a condition in which a person exhibits motor reflexes but evinces no indications of significant cognitive function." *Id.* at 266.

[39] *Id.*

[40] *Id.* at 348–49 (Stevens, J., dissenting).

[41] *In re* Gardener, 534 A.2d 947, 948 (Me. 1987).

[42] *Id.* at 949, 956.

treatment."[43] The court went on to reason that:

> A different result is not warranted simply because the life-sustaining procedure at issue involves the artificial provision of nutrition and hydration. There is no meaningful ground for distinguishing the artificial provision of nutrition and hydration through an NG tube from other forms of life-sustaining procedures such as a respirator, which provides another essential of life, oxygen, or a dialysis machine, which attends to another essential of life, waste disposal.[44]

The consensus view on the appropriateness of withdrawal of nutrition and hydration for a person in a PVS has been based largely on the factual finding that for the patient, the prognosis for return to a cognitive or sapient state is thought to be virtually impossible.[45] There are, however, reports in medical literature discussing patients with a PVS diagnosis who have occasionally recovered some level of consciousness and limited functioning typically occurring, if at all, within four months and rarely after one year.[46] These reports must be considered against a background of uncertainty among physicians making a PVS diagnosis and the confusion of PVS with any prolonged state of unconsciousness.[47]

This Article will now focus on the challenge developed by the Roman Catholic Magisterium to the consensus legal understanding of the appropriateness of withdrawal of nutrition and hydration from persons in PVS. This challenge is in no way based on questions about the accuracy of PVS diagnosis. Rather, this involves a fundamental challenge to the understanding of PVS as a medical condition equivalent to terminal illness. Instead, the position of the Roman Catholic Church is that PVS should be understood as a disability that in no way justifies withholding needed nutrition and hydration.[48] Just as fundamentally, the Church's position is that mechanical provision of nutrition and hydration in the case of the PVS patient does not involve administration of medical care but provision of life-giving sustenance.[49] The Church's view is that the PVS patient is a disabled person who is entitled to provision of basic care including ANH, and not the

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[43] *Id.* at 954.

[44] *Id.*

[45] *See, e.g.*, *In re* Storar, 420 N.E.2d 64, 72 (N.Y. 1981); *In re* Welfare of Colyer, 660 P.2d 738, 740 (Wash. 1983).

[46] Keith Andrews, *Recovery of Patients After Four Months or More in the Persistent Vegetative State*, 306 BRIT. MED. J. 1597, 1597 (1993); *Medical Aspects of the Persistent Vegetative State*, 330 NEW ENG. J. MED. 1499, 1505 (1994); D.J. Wilkinson et al., *Functional Neuroimaging and Withdrawal of Life-Sustaining Treatment From Vegetative Patients*, 35 J. MED. ETHICS 508, 508 (2008).

[47] *See* Martin M Monti et al., *Willful Modulation of Brain Activity in Disorders of Consciousness*, 362 NEW ENG. J. MED. 579, 580 (2010) (discussing the difficulties in diagnosis).

[48] Thomas A. Shannon & James J. Walter, *Assisted Nutrition and Hydration and the Catholic Tradition*, 66 THEOLOGICAL STUD. 651, 653 (2005).

[49] *See generally id.*

equivalent of a terminal patient from whom life-support treatment can be withdrawn.[50]

III. CATHOLIC TRADITION ON REFUSAL OF TREATMENT

The development of medicine as a science and the establishment of theological faculties in the sixteenth century, especially at the University of Salamanca in Spain, produced the occasion for the development of standards in the Roman Catholic tradition for submitting to and refusing medicines and treatment that could prolong life.[51] Drawing on the writings of Thomas Aquinas, the Dominican theologian Francisco de Vitoria identified the basic principles of Catholic medical ethics as rooted in fundamental theological truths, including (1) Human life is a gift of God which is a "great good but not an absolute good[;]" (2) A person "should use all fitting means to prolong life[;]" however, if the means of treatment "impose an excessive burden[]" they are not fitting and need not be used; (3) The ultimate good is God to whom "[a]ll human acts should be ordered[;]" and (4) The person should "be interested in a good life[]" and not a prolonged life.[52]

Francisco de Vitoria, and the theologians who followed him, did not attempt to identify specific treatments a person was obliged to submit to in order to preserve life. However, a significant formulation of a standard to evaluate treatment was proposed in 1595 by Domingo Bañez who developed the distinction between "ordinary" and "extraordinary" means which could be used to determine whether a person was required to accept treatments which were proportionate to the patient's condition.[53] According to these criteria, one is not obligated to use a treatment that is unduly burdensome, or does not provide a substantial benefit to the patient, or is too costly.[54] While new methods of treatment continued to be developed, there remained a general agreement that the foundational principles established by the Salamancan Theologians were valid.[55]

The first Magisterial teaching on the issue of medical treatment was

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[50] UNITED STATES CONFERENCE OF CATHOLIC BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES (5th ed. 2009) [hereinafter USCCB].
In principle, there is an obligation to provide patients with food and water, including medically assisted nutrition and hydration for those who cannot take food orally. This obligation extends to patients in chronic and presumably irreversible conditions (e.g. the 'persisted vegetative state') who can reasonably be expected to live indefinitely."
Id. at 31.

[51] Kevin D. O'Rourke, *The Catholic Tradition on Foregoing Life Support*, THE NAT'L CATHOLIC BIOETHICS QUARTERLY 537, 538 (2005).

[52] *Id.* at 538–39.

[53] John J. Paris, *The Catholic Tradition on the Use of Nutrition and Fluids*, *in* BIRTH, SUFFERING, AND DEATH 189, 199 (Kevin Wm. Wildes et.al. eds., 1992).

[54] *See* O'Rourke, *supra* note 51, at 548–49.

[55] *Id.* at 539.

an address on "The Prolongation of Life" by Pope Pius XII in 1957.[56] The basic requirement established by this address was that one has the right and duty to accept treatment necessary for the preservation of life and health.[57] However, this general rule is limited by the recognition that one is not obligated to submit to burdensome treatment.[58] According to Pius XII: "[N]ormally 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[;]" according to the Pope, "[a] more strict obligation would be too burdensome for most men and would render the attainment of the higher, more important good too difficult."[59] The Pope concluded that one's physical life should be subordinated to spiritual ends.

An authoritative statement on the issue of appropriate decisions about treatment took the form of the *Declaration on Euthanasia* (the "*Declaration*") issued by the Congregation for the Doctrine of the Faith in 1980.[60] The *Declaration* drew a distinction between ordinary versus extraordinary care, a distinction that it equated to proportionate versus disproportionate care.[61] According to the *Declaration*, care may be stopped or withdrawn when the results fall short of reasonable expectations of contribution to the cure or health of the patient.[62] Moreover, treatment could be refused or withheld when the costs of treatment were disproportionate to the benefits produced by the treatment, or when the strain or pain suffered by the patient is out of proportion to the benefits of treatment to the patient:

> Such a refusal 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 expense on the family or the community.[63]

Special notice was taken in the *Declaration* of the terminal patient who may refuse treatment that merely prolongs the dying process.[64] Such a patient, however, must be provided ordinary care.[65] According to the

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[56] *See generally* Le Dr. Bruno Haid, *The Prolongation of Life: An Address of Pope Pius XII to an International Congress of Anesthesiologists*, 4 THE POPE SPEAKS 393, 393 (1958).

[57] *Id.* at 396–98.

[58] *Id.* at 397.

[59] *Id.* at 395–96.

[60] Franjo Cardinal Seper, *Declaration on Euthanasia*, VATICAN CONGREGATION FOR THE DOCTRINE OF THE FAITH 1, 10 (1980), http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19800505_euthanasia_en.html.

[61] *Id.* at 8–10.

[62] *Id.* at 9.

[63] *Id.* at 9–10.

[64] *Id.* at 4.

[65] *Id.* at 10.

Declaration:

> When inevitable death is imminent in spite of the means used, it is permitted in conscience to take the decision to refuse forms of treatment that would only secure a precarious and burdensome prolongation of life, so long as the normal care due to the sick person in similar cases is not interrupted.[66]

Again, no bright line is established distinguishing ordinary from extraordinary medical treatment. The "normal care due to the sick person" must always be accepted and provided.[67] What constitutes ordinary medical care "due to the sick person" would be subject to the determination whether the benefits gained are greater than the burdens experienced by the patient.[68] "Ordinary care," which is sometimes "referred to as comfort care, palliative care or nursing care[,]" can be distinguished from "ordinary medical care."[69] Ordinary care, which must be provided to all patients, includes "simpl[e] health and hygiene measures, food and water, bathing, assistance with the elimination of bodily waste, turning a patient in bed, keeping a patient [dry, warm or cool as appropriate]."[70]

IV. DECONSTRUCTING THE CONSENSUS ON DECISIONS TO FORGO LIFE-SUSTAINING TREATMENT

Modern medical technology has complicated the dying process. Medical technology has developed machinery and drugs that forestall death. In the past, infectious diseases and simple human debilitation led to death with little opportunity for intervention. Increasingly, chronic diseases provide occasion for intervention and use of medical technology that facilitates the extension of a patient's life, sometimes indefinitely.

At the same time, it has become possible to maintain the physical functioning of a patient's body, even though the patient has lost the capacity for conscious awareness. These medical technological developments have led to the development of legal rules and procedures for surrogate decision making about the medical needs and treatment of unconscious and incompetent patients.[71] These include legal rules and procedures permitting the withholding and withdrawal of life-sustaining treatment from non-competent patients, including patients permanently unconscious.[72]

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[66] *Id.*
[67] *Id.*
[68] *Id.* at 9.
[69] D. BRIAN SCARNECCHIA, BIOETHICS, LAW, AND HUMAN LIFE ISSUES 375 (2010).
[70] *Id.*
[71] *In re* P.V.W., 424 So. 2d 1015, 1020 (La. 1982) (suggesting that courts will assure that proper decision making processes were followed and there was a reasonable and defensible decision made).
[72] *Id.*

The legal and medical ethical foundational values underlying the legal rules and practices governing life-sustaining treatment decisions include autonomy, dignity, and bodily indignity.[73] These decisions are properly controlled by the individual as a matter of actual choice, or by surrogates using a process of substituted judgment determined by a patient's former communication of choice, or by decisions in the best interest of the patient.[74]

The early legal analysis and the development of principles by medical ethicists have relied on a conceptual scheme that classified treatment in a manner reflective of Roman Catholic teaching. Early cases in the contemporary development of the law and ethics dealing with decisions regarding life-sustaining treatment distinguished between "extraordinary" treatment, which could be foregone at the patient's or surrogate decision-maker's request, and "ordinary" treatment which was deemed mandatory in all cases.[75]

This distinction has largely been abandoned in legal and medical ethical discourse. Over time, it became clear that a treatment was classified as "extraordinary" when it was new, scarce, costly, and "ordinary" when it was more generally available and less costly.[76] Perhaps most significant was the fact, which was important in the *Quinlan* case, that a specific treatment could be regarded: as "extraordinary" when applied to a terminal or bodily compromised patient, and viewed as "ordinary" when provided to a patient with a reasonable likelihood of recovery.[77]

Just as the Catholic classification shifted to capture the significance of the contribution of a treatment to the health and well-being of the patient, courts and medical ethicists began to refer to that treatment as "proportionate" and "disproportionate."[78] This approach was specifically adopted by a California appeals court, which reasoned:

> Under this approach, proportionate treatment is that which[] . . . has at least a reasonable chance of providing benefits to the patient, which benefits outweigh the burdens attendant to

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[73] DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 26 (1983) ("In its work on the ethical issues in health care the Commission discussed the importance of three basic values: self-determination, well-being and equity."); *see also* RAANAN GILLON, PHILOSOPHICAL MEDICAL ETHICS 164 (John Wiley & Sons ed., 1990) ("[I]n their relationships with their patients doctors must remember that apart from any special moral obligations they have the standard moral obligations that all of us have to each other: to respect each other's autonomy, not to harm each other (non-maleficence), to be just, and to benefit at least some others (beneficence).").

[74] *In re* Storar, 420 N.E.2d 64, 68 (N.Y. 1981).

[75] *In re* Storar*,* 433 N.Y.S.2d. 388, 393 (Sup. Ct. 1980), *rev'd* 420 N.E.2d. 64 (N.Y. 1981) ("Medical ethics currently permit and support the termination of extraordinary means of treatment on life support systems where there is no hope of a cure and where this is the wish of the patient and his family.").

[76] *See In re* Quinlan, 355 A.2d 647, 668 (N.J. 1976).

[77] *Id.* ("[U]se of the same respirator or like support could be considered 'ordinary' in the context of the possibly curable patient but 'extraordinary' in the context of the forced sustaining by cardio-respiratory process of an irreversibly doomed patient.").

[78] Barber v. Superior Court, 195 Cal. Rptr. 484, 491 (Cal. Ct. App. 1983).

> the treatment. . . . On the other hand, a treatment course which is only minimally painful or intrusive may nonetheless be considered disproportionate to the potential benefits if the prognosis is virtually hopeless for any significant improvement in condition.[79]

There is another distinction in law and medical ethics which gained importance, that is the difference between an "affirmative act" intended to cause a patient's death, and an "omission" or a failure to intervene when a patient's life is threatened by disease or medical condition.[80] In law and medical ethics, affirmative acts are deemed killing, and failures to intervene are viewed as allowing to die (allowing nature to take its course), rather than as causing death.[81] In law, withholding or withdrawing ANH will generally be regarded as an "omission" which carries no legal liability absent conditions establishing a duty to provide such care.[82] However, Catholic teaching condemns both an affirmative action or omission (such as denial of fluids or food) intended to cause a person's death in order for that suffering to be eliminated.[83]

The ambiguity in this distinction between act and omission is reflected in the situation where ANH is withdrawn. This was recognized, for example, by the New Jersey Supreme Court:

> The distinction is particularly nebulous, however, in the context of decisions whether to withhold or withdraw life-sustaining treatment. In a case like that of [the patient], for example, would a physician who discontinued nasogastric feeding be actively causing her death by removing her primary source of nutrients; or would he merely be omitting to continue the artificial form of treatment, thus passively allowing her medical condition, which includes her inability to swallow, to take its natural course?[84]

The Court concluded:

> Whether necessary treatment is withheld at the outset or withdrawn later on, the consequence -- the patient's death -- is the same. Moreover, from a policy standpoint, it might well be unwise to forbid persons from discontinuing a treatment under circumstances in which the treatment could permissibly be withheld. Such a rule could discourage

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[79] *Id.*
[80] *Id.* at 490.
[81] *Id.*
[82] *Id.*
[83] Seper, *supra* note 60, at 4.
[84] *In re* Conroy, 486 A.2d 1209, 1234 (N.J. 1985).

> families and doctors from even attempting certain types of care and could thereby force them into hasty and premature decisions to allow a patient to die.[85]

Perhaps one of the most significant divisions between law/medical ethics and Catholic moral teaching has been their different conclusions on the issue of foregoing medical treatment as contrasted with withholding or withdrawal of ANH. The early legal decisions on forgoing life-sustaining treatment initially involved treatment and machines used in intensive care, such as respirators in the *Quinlan* case.[86] In these cases, there was general agreement between legal authorities, professional medical ethicists, and Catholic moral theologians.[87] Over time, courts as well as medical ethicists were asked to decide whether it was permissible to forgo ANH (i.e., hydration and nutrition delivered by intravenous lines, nasogastric tubes, or gastrostomy tubes).[88] Some medical ethicists maintained that medically delivered ANH was basic comfort care similar to providing basic hygiene, which was mandatory for all patients.[89] A distinction was drawn between invasive and high technology interventions, which were burdensome and could be withdrawn, and simple mechanisms such as intravenous lines facilitating provision of fluids and nutrients.[90] However, discontinuing provision of nutrition and hydration (an omission) was seen by some as equivalent to providing a lethal injection of drugs (commission) because just as a lethal drug causes death, starvation and dehydration causes death independent of any underlying illness or injury.[91]

Beginning in the early 1980s, courts in the United States began holding that withholding or withdrawing hydration and nutritional support

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[85] *Id.*

[86] *See generally In re* Quinlan, 355 A.2d 647 (N.J. 1976).

[87] *Id.* at 656.

[88] *See generally* Mary Ann Garvey, *Withdrawal of Nutrition and Hydration from an Incompetent Patient: Legal Developments Leading to Cruzan*, 23 J. HEALTH L. 225, 225 (1990).

[89] *See* Ronald Hamel & Michael Panicola, *Must We Preserve Life?*, *in* ARTIFICIAL NUTRITION AND HYDRATION AND THE PERMANENTLY UNCONSCIOUS PATIENT 79, 82 (Georgetown University Press 2007) ("Some of those attempting to revise the tradition define artificial nutrition and hydration as care, basic care or minimal measures for sustaining life and then assert that providing care is always morally obligatory. For example, in its 1981 document, "Questions of Ethics Regarding the Fatally Ill and Dying," the Pontifical Council on Health Affairs stated: "[T]here remains the strict obligation to apply *under all circumstances* those therapeutic measures which are called 'minimal': that is, those which are normally and customarily used for the maintenance of life (alimentation, blood transfusions, injections, etc.). To interrupt these *minimal measures* would, in practice, be equivalent to wishing to put an end to the patient's life' . . . .").

[90] Richard P. Becker, *Hypodermoclysis and Proctoclysis as Basic Care*, THE NAT'L CATHOLIC BIOETHICS QUARTERLY 649, 649–59 (2011). The author suggests that while enteral nutrition and hydration (involving insertion of a tube into the stomach or the intestines) may be mandatory under the changed guidelines, parenteral nutrition given by an IV directly into the bloodstream, thus bypassing the gastric tract, is not. *Id.*

[91] Brophy v. New Eng. Sinai Hosp., Inc., 497 N.E.2d. 626, 641 (Mass. 1986) (Nolan, J., dissenting). With withdrawal of a feeding tube from a permanently unconscious patient, "the cause of death would not be some underlying physical disability like kidney failure or the withdrawal of some highly invasive medical treatment, but the unnatural cessation of feeding and hydration." *Id.*

would be regarded as the same as foregoing the use of mechanical life support.[92] For example, the California appellate court, cited earlier in this Article, reasoned that: "Medical procedures to provide nutrition and hydration are more similar to other medical procedures than to typical human ways of providing nutrition and hydration. Their benefits and burdens sought [sic] to be evaluated in the same manner as any other medical procedure."[93]

Courts and medical ethicists also rejected the argument that foregoing ANH was an independent cause of death. One medical ethicist reasoned: "Many medical tools, e.g., respirators, antibiotics, and nasogastric tubes, constitute special interventions necessary to preserve some patients' lives because their underlying conditions have created needs for assistance in breathing and eating or a susceptibility to infection."[94] While there is concern that withholding ANH will cause discomfort and pain on the part of the patient, clinical reports allay the concern.[95] In the alternative, appropriate medication can eliminate any such pain.[96]

In a book called *Birth, Suffering, and Death*, an article entitled, *The Catholic Tradition on the Use of Nutrition and Fluids*, by John Paris and Richard McCormick, both Jesuits writing on medical ethics argued that there was a significant departure from the accepted consensus between the legal/medical ethical and Catholic moral teaching on ANH in the arguments set out in the amicus brief by the New Jersey Catholic Conference in the New Jersey case *In re Jobes*.[97] This case involved a 31-year-old woman who was severely brain damaged, but not terminally ill and whose family requested the removal of her feeding tube.[98] The Conference's purpose was to set out Catholic teaching on provision of ANH in order to influence the court and assist the development of law and medical ethics: "The conference has a keen interest in the case at hand particularly since the disciplines of theology, law and medicine intersect here; hence it hopes that the moral and philosophical insights of Catholic ethical teaching may be helpful to the court . . . ."[99] The New Jersey Catholic Conference argued that there was a distinction between burdensome mechanized treatment that could be withdrawn from a terminally ill patient, and ANH provided to a severely brain injured, but not terminal patient.[100] The Conference maintained the ANH was not "medical treatment"

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[92] *See, e.g.*, Barber v. Superior Court, 195 Cal. Rptr. 484, 490 (Cal. Ct. App. 1983) (comparing administration via mechanical devices to medication and nourishment).

[93] *Id.*

[94] Rebecca S. Dresser & Eugene V. Boisaubin, *Ethics, Law and Nutritional Support*, 145 ARCHIVES INTERNAL MED. 122, 122–24 (1985).

[95] Louise A. Printz, *Terminal Dehydration, a Compassionate Treatment*, 152 ARCHIVES INTERNAL MED. 691, 700 (1992).

[96] John E. Ruark et al., *Initiating and Withdrawing Life Support*, 318 NEW ENG. J. MED. 25, 28 (1988).

[97] Paris, *supra* note 53, at 192.

[98] *In re* Jobes, 529 A.2d 434, 437 (N.J. 1987).

[99] William F. Bolan, *Providing Food and Fluids to Severely Brain Damage Patients*, *in* 16 ORIGINS 582, 582–84 (1987).

[100] *See generally id.*

but "ordinary care" whose provision was required. According to the brief:

> The conference maintains that nutrition and hydration, being basic to human life, are aspects of normal care, which are not excessively burdensome, that should always be provided to a patient. Nutrition and hydration are clearly distinguished from medical treatment. Medical treatment is aimed at curing a disease. Nutrition and hydration are directed at sustaining life. Medical treatment is therapeutic; nutrition and hydration are not, because they will not cure any disease. For that fundamental reason we insist that nutrition and hydration must always be maintained.[101]

The Conference argued that the intentional withdrawal of ANH involves an intent to cause the death of the patient, since the withdrawal of ANH will cause death without regard to the underlying illness or injury.[102] The brief argued:

> A person who withdraws these ordinary means to preserve life is instrumental in bringing about the death of the patient. When the patient dies, death does not come from the original disease. The patient dies of starvation. When this is done with the intention to end or shorten the life of the patient, it is intentional euthanasia.[103]

The Court's opinion *In re Jobes* gave no apparent consideration to the argument of the Conference that ANH is different from other life-sustaining treatments. In a footnote, the Court reports that: "Two medical ethicists who testified in this case disagreed over whether there is a meaningful distinction between withdrawing nasogastric tubes and other life sustaining medical treatment like respirators[;]" the Court summarily responds: "[W]e reject such a distinction."[104]

The most significant opinion establishing the authority of a surrogate to withdraw ANH from a PVS patient was delivered by the United States Supreme Court in the *Cruzan* case in 1990.[105] This case involved the petition of the parents of a patient requesting "the withdrawal of their daughter's artificial feeding and hydration equipment after it became [clear] that she had virtually no chance of recovering her cognitive faculties[]" after suffering severe injuries sustained in an automobile accident.[106] Justice O'Connor succinctly stated the principle in the case relevant to this discussion: "[A]

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[101] *Id.* at 583.
[102] *Id.*
[103] *Id.*
[104] *In re* Jobes, 529 A.2d 434, 444 n.9 (N.J. 1987).
[105] Cruzan v. Dir. Mo. Dep't of Health, 497 U.S. 261, 280 (1990).
[106] *Id.* at 265.

protected liberty interest in refusing unwanted medical treatment may be inferred from our own prior decisions, and that the refusal of artificially delivered food and water is encompassed within that liberty interest."[107]

The United States Catholic Conference again communicated its opposition to having withdrawal of ANH treated the same as mechanized life prolonging treatment in an amicus brief in the *Cruzan* case.[108] The brief stated: "The conference's considered judgment . . . is that 'the law should establish a strong presumption in favor of their use,' because 'food and water are necessities of life for all human beings and can generally be provided without the risks and burdens of more aggressive means for sustaining life.'"[109] The brief went on to suggest that denying fluids and food to a PVS patient was in fact discrimination against a disabled person: "Recognizing that 'negative judgments about the 'quality of life' of unconscious or otherwise disabled patients have led some in our society to propose withholding nourishment precisely in order to end these patients' lives,' the bishops urge that society 'take special care to protect against such discrimination.'"[110]

In its opinion in the *Cruzan* case, the United States Supreme Court remanded the case to the lower court for an evidentiary determination of the patient's preference regarding provision of ANH.[111] The circuit judge found a basis for determining the patient's wishes regarding life-prolonging treatment and allowed discontinuation of the liquid diet fed through a stomach feeding tube.[112] The patient died twelve days later.[113] Bishop James McHugh of Camden, New Jersey, provided an assessment of Catholic teaching at the point of the *Cruzan* decision.[114] He emphasized the difference between legal rules governing decisions about medical treatment and the moral principle that governs such decision-making.[115] It is important to note that Bishop McHugh regarded the Church's teaching at the time of the *Cruzan* decision to be open to conflicting views on the issue of provision of ANH to PVS patients.[116] In the next section of this Article, the resolution of these differing views will be traced as clarification of the standards for withdrawal of ANH from a PVS patient that have been developed in pronouncements by different offices in the Church.

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[107] *Id.* at 287 (O'Connor, J., concurring) (internal citation omitted).
[108] *USCC Brief in Nancy Cruzan Case*, *in* 19 ORIGINS 345, 345 (1989).
[109] *Id.*
[110] *Id.*
[111] Cruzan v. Dir. Mo. Dep't of Health, 497 U.S. 261, 281 (1990).
[112] Tamar Lewin, *Nancy Cruzan Dies, Outlived by a Debate Over the Right to Die*, N.Y. TIMES (Dec. 27, 1990), http://www.nytimes.com/1990/12/27/us/nancy-cruzan-dies-outlived-by-a-debate-over-the-right-to-die.html.
[113] *See id.*
[114] *See generally* Bishop James T. McHugh, *Statement after Nancy Cruzan's Death*, *in* 20 ORIGINS 518, 518 (1991).
[115] *See generally id.*
[116] *Id.* at 519.

Bishop McHugh began his analysis by observing that a patient in a coma or PVS is neither "brain-dead" nor in the dying process.[117] These patients are not able to take food and water in the usual way, so they are provided nourishment and fluid through a mechanical process. Bishop McHugh stated: "The problem is that at the present time we know that a PVS patient is living, is brain-damaged and disabled, but given nourishment and liquids and nursing care, such a patient may live for many years."[118] It is at this point that Bishop McHugh recognized the existence of conflicting views in Catholic ethical thinking on the provision of ANH to PVS patients at the time of the *Cruzan* case:

> Among Catholics, the issue seems to come down to two different approaches and two different conclusions. The first approach sees the PVS patient as incapable of thought or ability to respond to his or her environment and considers this absence of cognition and affection as an inability to exercise one's spiritual faculties and possibly a danger to one's overall spiritual [growth], that is, union with God. Furthermore, since the brain damage seems to prevent normal swallowing, this approach holds that the person is in fact already dying from the inability to swallow. A number of Catholics who hold this position agreed with withdrawing nutrition and hydration from Nancy Cruzan and other similar patients.[119]

Bishop McHugh himself agreed with the alternative view, which has since been adopted by a significant segment of the Magisterium:

> The second approach sees the PVS patient as living but as seriously disabled. Food and water does not cure the PVS patient; it maintains life. It does not cause suffering for the patient nor is it considered exceptional or experimental medical technology. If the nutrition is discontinued then the patient will die because a new cause of death has been introduced, [lack of nourishment or starvation].[120]

V. DEVELOPMENT OF CATHOLIC TEACHING ON WITHDRAWAL OF ANH FROM THE PVS PATIENT

This section of this Article will examine the development over the last 50 years of the teaching of the Magisterium of the Roman Catholic Church on the subject of providing nutrition and hydration to patients. This

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[117] *Id.* at 518.
[118] *Id.*
[119] *Id.* at 519.
[120] Bishop James T. McHugh, *Death and Dying Issues*, ETERNAL WORLD TELEVISION NETWORK (Mar. 11, 1991), http://ewtn.com/library/BISHOPS/DEATHISS.HTM.

review will show a steady development of teaching on the subject and reveal that Pope John Paul II's statement on the subject in 2004 was not a deviation but an important step in developing authoritative guidance on provision of ANH to PVS patients.

In 1981, the Pontifical Council of Health Affairs issued a statement on "Question of Ethics Regarding the Fatally Ill and Dying."[121] This working group report was in response to questions raised by hospital chaplains, doctors and nurses about the *Declaration*. The working group, while acknowledging the terminology "ordinary" and "extraordinary" care was somewhat outmoded in scientific and medical practice, it remains indispensable in theological analysis since once a measure is judged "extraordinary" from a theological perspective there is no obligation to provide such treatment.[122] This report is significant for its determination that provision of nourishment to a patient is an obligatory minimal measure. The report states:

> [T]here remains the strict obligation to apply under all circumstances those therapeutic measures which are called "minimal": that is, those which are normally and customarily used for the maintenance of life (alimentation, blood transfusions, iniections [sic], etc.). To interrupt these minimal measures would, in practice, be equivalent to wishing to put an end to the patient's life.[123]

The same conclusion was reached by the Pontifical Academy of Science in 1985 by a working group on *The Artificial Prolongation of Life and the Determination of the Exact Moment of Death*.[124] This report was drafted by an international group of doctors and scientists who met in Rome in October 1985 at the invitation of the Pontifical Academy of Science.[125] The report's principal premise is that treatment is required if there is a possibility of recovery, but it may be interrupted if there is no benefit to the patient.[126] However, the report concluded the ANH must be provided to the PVS patient "[i]f the patient is in permanent coma, irreversible as far as it is possible to predict, treatment is not required, but care, including feeding, must be provided."[127]

The issue of providing nutrition and hydration to the terminal patient

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[121] *See generally Questions of Ethics Regarding the Fatally Ill and the Dying*, THE PONTIFICAL COUNCIL OF HEALTH AFFAIRS 1, 1–13 (June 27, 1981), http://www.academiavita.org/_pdf/magisterium/councils/pontifical_council_cor_unum/fatally_ill_and_dying.pdf

[122] *Id.* at 4.

[123] *Id.* at 4–5. Alimentation is the process of affording nourishment.

[124] *Working Group on the Artificial Prolongation of Life and the Determination of the Exact Moment of Death*, THE PONTIFICAL ACADEMY OF SCIENCE 1, 113–14 (Oct. 19–21, 1985), http://www.casinapioiv.va/content/dam/accademia/pdf/sv60pas.pdf.

[125] *Id.* at xii–xvi.

[126] *Id.* at 114.

[127] *Id.*

was directly dealt with in *The Charter for Health Care Workers* (the "*Charter*") issued by the Pontifical Council for Pastoral Assistance to Health Care workers and approved by the Congregation for the Doctrine of the Faith in 1995.[128] The *Charter* consists of directives based on papal statements and authoritative texts published by various departments of the Roman Curia.[129] These directives permit withdrawal of treatment that is burdensome or merely prolonging life from a terminal patient.[130] Ordinary treatment, however, must be provided even to the terminal patient so long as it is not burdensome. The issue of ANH is specifically addressed: "The administration of food and liquids, even artificially, is part of the normal treatment always due to the patient when this is not burdensome for him: their undue suspension could be real and properly so-called euthanasia."[131]

On March 10–17, 2004, the Pontifical Academy for Life and the World Federation of Catholic Medical Associations met and issued a joint statement on the vegetative state: "*Life-Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas*."[132] This statement was issued three days before Pope John Paul II's allocution on the subject of ANH and PVS patients. The joint statement provided an assessment of the diagnosis of PVS, which was distinguished from other compromised mental states such as coma and minimally conscious state.[133] A vegetative state was defined as "a condition marked by: a state of vigilance, some alternation of sleep/wake cycles, absence of signs of awareness of self and surroundings, lack of behavioral responses to stimuli from the environment, maintenance of autonomic and other brain functions."[134] The statement reported that "VS [vegetative state] patients do not require technological support in order to maintain their vital functions[]" and cannot be considered terminal patients.[135] The statement specifically addressed the issue of ANH and the PVS patient: "VS [vegetative state] patients have the right to[] . . . basic care, including hydration, nutrition, warming and personal hygiene[] . . . ."[136] The withholding of ANH from a PVS patient was condemned as ethically impermissible: "The possible decision of withdrawing nutrition and hydration, necessarily administered to VS patients in an assisted way, is followed inevitably by the patient's death as a direct consequence. Therefore,

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[128] *See generally The Charter for Health Care Workers*, THE PONTIFICAL COUNCIL FOR PASTORAL ASSISTANCE TO HEALTH CARE WORKERS (1995), https://www.ewtn.com/library/CURIA/PCPAHEAL.HTM.

[129] *Id.*

[130] *Id.*

[131] *Id.*

[132] *International Congress on* "*Life-Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas*," THE PONTIFICAL ACAD. FOR LIFE & WORLD FED'N OF CATHOLIC MED. ASS'NS (Mar. 10–17, 2004), http://www.vatican.va/roman_curia/pontifical_academies/acdlife/documents/rc_pont-acd_life_doc_20040320_joint-statement-veget-state_en.html.

[133] *Id.*

[134] *Id.*

[135] *Id.*

[136] *Id.*

it has to be considered a genuine act of euthanasia by omission, which is morally unacceptable."[137] The statement does not discuss possible complicating factors that can arise in specific cases such as a particular patient's inability to assimilate nutrients or a danger to a particular patient posed by the need to surgically insert a feeding tube.

Pope John Paul II's allocution on *Life-Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas* was delivered on March 20, 2004, to the participants at the International Congress, which had issued the joint statement on the vegetative state that was discussed above.[138] It is this speech on which additional Magisterial statements by the Congregation for Doctrine of the Faith and directives issued by the United States Conference of Catholic Bishops are based. Pope John Paul II began by affirming the traditional teaching that ordinary or proportionate means to preserve life are morally obligatory, while extraordinary or disproportionately burdensome means are not.[139]

The Pope then addressed the specific case of the PVS patient and the provision of nutrition and hydration: "The sick person in a vegetative state, awaiting recovery or a natural end, still has the right to basic health care (nutrition, hydration, cleanliness, warmth, etc.), and to the prevention of complications related to his confinement to bed."[140] The Pope stated from an ethical point of view there is no distinction between mechanized or artificial provision of nutrition and hydration and natural feeding: both constitute ordinary and proportionate care. The Pope said:

> I should like particularly to underline how the administration of water and food, even when provided by artificial means, always represents a natural means of preserving life, not a *medical act*. Its use, furthermore, should be considered, in principle, *ordinary* and *proportionate*, and as such morally obligatory, insofar as and until it is seen to have attained its proper finality, which in the present case consists in providing nourishment to the patient and alleviation of his suffering.[141]

The "in principle" language and the subsequent text indicate that there may be occasions when withholding ANH from a patient would be proper. Such situations are suggested within the statement such as when

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[137] *Id.*

[138] Pope John Paul II, Address to the Participants in the International Congress on "Life-Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas (Mar. 20, 2004), http://w2.vatican.va/content/john-paul-ii/en/speeches/2004/march/documents/hf_jp-ii_spe_20040320_congress-fiamc.html.

[139] *Id.*

[140] *Id.*

[141] *Id.*

nutrients are no longer assimilated by the patient's body or when surgery or the operation of feeding machines threaten the patient's life or otherwise become disproportionately burdensome in relation to any benefit from receiving nutrition or hydration.

It is arguable that the Pope's address was meant to respond to the diversity of opinion on the issue of providing ANH to the PVS patient, which was noticed by Bishop McHugh in his comments on the *Cruzan* case. Significantly, the Pope distinguished ANH from other medical treatment that prolongs life, he concluded that there is a moral distinction, no matter whether the law treats them the same, in the context of refusing treatment.[142] In addition to preserving life, the Pope maintained that providing ANH may prevent suffering experienced from dehydration or starvation.[143] However, medical authorities maintain that such suffering, if it is experienced, can be alleviated by administration of pain medication.[144] The principal teaching set down by the Pope is that provision of ANH to the PVS patient is ordinary care, proportionate, and therefore morally obligatory.[145]

It is immoral to withhold or withdraw ANH from the PVS patient, absent its failure to provide nourishment, or without a showing that it imposes a disproportionate burden in a specific case, no matter how long the patient has persevered in the vegetative state:

> The evaluation of probabilities, founded on waning hopes for recovery when the vegetative state is prolonged beyond a year, cannot ethically justify the cessation or interruption of minimal care for the patient, including nutrition and hydration. Death by starvation or dehydration is, in fact, the only possible outcome as a result of their withdrawal. In this sense it ends up becoming, if done knowingly and willingly, true and proper euthanasia by omission.[146]

The Pope's allocution on ANH and the PVS patient gave rise to arguments in support and in opposition by theologians, which will be discussed in the next section of this Article. However, one critique that has become less persuasive is that of John Paris, James Keenan, and Kenneth Himes who argued in an article in *Theological Studies* that the allocution lacks Magisterial authority.[147] These authors concluded that it is a mistake to attribute "magisterial authority to a speech that is inconsistent with the

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[142] *Id.*
[143] *Id.*
[144] Franklin G. Miller & Diane E. Meier, *Voluntary Death: A Comparison of Terminal Dehydration and Physician-Assisted Suicide*, ANNALS OF INTERNAL MED. 128, 559–62 (1998).
[145] Pope John Paul II, *supra* note 138.
[146] *Id.*
[147] John J. Paris et al., *Quaestio Disputata: Did John Paul II's Allocution on Life-Sustaining Treatment Revise Tradition?*, 67 THEOLOGICAL STUD. 163, 163–68 (2006).

Church's traditional position on end-of-life care. . . . [because] it is by official doctrinal statements proclaimed to the universal Church—not by comments made to private groups—that the Church teaches."[148] However, the development of the Church's teaching on ANH and the PVS patient has been evolving as it has dealt with this very specific subject. Moreover, it is significant that subsequent statements and adoption of standards by institutions of the Magisterium give support to a claim of authority for the position enunciated in Pope John Paul II's speech on the subject of ANH and the PVS patient.

On August 1, 2007, the Congregation for the Doctrine of the Faith issued a response to a request from the U.S. Bishops for a statement whether it is morally obligatory to provide ANH to a PVS patient, except when nutrients and fluids cannot be assimilated by the patient, or cannot be administered without causing significant discomfort to the patient.[149] The Congregation responded that it was morally obligatory to provide ANH to the PVS patient:

> The administration of food and water even by artificial means is, in principle, an ordinary and proportionate means for preserving life. It is therefore obligatory to the extent to which, and for as long as, it is shown to accomplish its proper finality, which is the hydration and nourishment of the patient. In this way suffering and death by starvation and dehydration are prevented.[150]

In a *Commentary* on nutrition and hydration provided with its "Response," the Congregation explained the benefit of ANH and the fact that in it, ANH is not usually burdensome:

> Patients in a "vegetative state" breathe spontaneously, digest food naturally, carry on other metabolic functions, and are in a stable situation. But they are not able to feed themselves. If they are not provided artificially with food and liquids, they will die, and the cause of their death will be neither an illness nor the "vegetative state" itself, but solely starvation and dehydration. At the same time, the artificial administration of water and food generally does not impose a heavy burden either on the patient or on his or her relatives. It does not involve excessive expense[] . . . and is proportionate to accomplishing its purpose, which is to keep the patient from

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[148] *Id.* at 168.

[149] *Responses to Certain Questions of the United States Conference of Catholic Bishops Concerning Artificial Nutrition and Hydration*, OFFICES OF THE CONGREGATION FOR THE DOCTRINE OF THE FAITH (Aug. 1, 2007), http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20070801_risposte-usa_en.html.

[150] *Id.*

> dying of starvation and dehydration. It is not, nor is it meant to be, a treatment that cures the patient, but is rather ordinary care aimed at the preservation of life.[151]

The Congregation concluded its *Commentary* by identifying the exceptions to the general rule of moral obligation to provide ANH to a PVS patient.[152] The first is the simple lack of equipment or materials necessary for ANH; or it may simply be unavailable "in very remote places or in situations of extreme poverty, the artificial provision of food and water may be physically impossible[] . . . ."[153] In particular cases, the patient may receive no nutritional benefit from ANH: "[T]he possibility [is not] excluded that, due to emerging complications, a patient may be unable to assimilate food and liquids, so that their provision becomes altogether useless."[154] Finally, in a specific case, the mechanics of ANH may be burdensome: "[T]he possibility is not absolutely excluded that, in some rare cases, artificial nourishment and hydration may be excessively burdensome for the patient or may cause significant physical discomfort, for example resulting from complications in the use of the means employed."[155]

The sources and content of the moral guidance provided by the Magisterium include the teachings of bishops.[156] The United States Catholic Conference of Bishops ("USCCB") provides guidance for moral and ethical questions for health care workers and institutions in the principles they have set out in the *Ethical and Religious Directives for Catholic Health Care Service*.[157] The current edition of *Ethical and Religious Directives*, approved in November 2009, contains a revision of Directive 58, which has incorporated the magisterial teaching of Pope John Paul II's allocution and the Congregation's "Response" to questions on provision of ANH to PVS patients.[158] The principle that the provision of ANH to PVS patients is a moral obligation is clearly set out:

> In principle, there is an obligation to provide patients with food and water, including medically assisted nutrition and hydration for those who cannot take food orally. This obligation extends to patients in chronic and presumably irreversible conditions (e.g., the "persistent vegetative state")

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[151] *Commentary*, OFFICES OF THE CONGREGATION FOR THE DOCTRINE OF THE FAITH, http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20070801_nota-commento_en.html (last visited Mar. 30, 2015).

[152] *Id.*

[153] *Id.*

[154] *Id.*

[155] *Id.*

[156] *See* STEPHEN B. BEVANS, AN INTRODUCTION TO THEOLOGY IN GLOBAL PERSPECTIVE 112 (Orbis Books 2009) ("The [M]agisterium, as we understand it here, are the bishops of the church in union with the pope.").

[157] *See generally* USCCB, *supra* note 50.

[158] *Id.* at nn.40, 41.

> who can reasonably be expected to live indefinitely if given such care.[159]

Drawing on Catholic principles that limit the obligation to provide medical measures that can produce their intended effect and that are not excessively burdensome or disproportionate, Directive 58 sets out with some specificity when provisions of ANH to a PVS patient can become morally optional:

> Medically assisted nutrition and hydration become morally optional when they cannot reasonably be expected to prolong life or when they would be "excessively burdensome for the patient or [would] cause significant physical discomfort, for example resulting from complications in the use of the means employed." For instance, as a patient draws close to inevitable death from an underlying progressive and fatal condition, certain measures to provide nutrition and hydration may become excessively burdensome and therefore not obligatory in light of their very limited ability to prolong life or provide comfort.[160]

One of the underlying premises not fully articulated in the directive is the view that ANH is ordinary care and not a medical intervention whose effect is prolonging life.[161] Another premise is that while surgical procedures may be needed to facilitate ANH, the actual provision of nourishment and fluids is normal care and not a medical intervention being carried out to cure illness or restore a patient to good health.[162] There is a rejection of the distinction between artificial feeding and natural or conventional eating.[163] Finally, the view taken by the Church's teaching is that the provision of nutrition, which is necessary for sustaining life, is at issue, not cure for illness.[164]

VI. ETHICAL AND THEOLOGICAL DEFENSE AND CRITICISM OF MAGISTERIAL TEACHING ON THE MORAL OBLIGATION TO PROVIDE ANH TO PVS PATIENTS

While the Congregation "Response" to certain questions and the USCCB issuance of Directive 58 support and codify the position developed in Pope John Paul II's statement, there has been continuing dispute among

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[159] *Id.* at 31.
[160] *Id.* (citation omitted).
[161] John M. Travaline & Thomas V. Berg, *Perspectives on Directive 58*, 78 THE LINACRE QUARTERLY 8, 10–11 (2011).
[162] *See generally* USCCB, *supra* note 50, at 29–31 (explaining medical technology and the premises of the establishment of artificial nutrition and hydration).
[163] Travaline & Berg, *supra* note 161.
[164] *Id.*

theologians about the proper approach to ANH, particularly in the case of the PVS patient. As one commentator has noted:

> While the revision of directive 58 provides a clearer articulation of the use of artificial nutrition and hydration, indicating that its use is ordinary, proportionate, and therefore, in principle, morally obligatory, it has not diminished the intensity of debate among medical ethicists [particularly moral theologians] on the issue.[165]

The basic differences among theologians involve both the nature of ANH and the condition of the PVS patient. Those theologians who favor the Magisterial view of the moral obligation, in principle, to provide ANH to the PVS patient, view provision of ANH as ordinary care to be provided to PVS patients out of respect for their personhood and their human dignity.[166] Those challenging the developing magisterial view regard provision of ANH (particularly where mechanical means such as a surgically implanted feeding tube is used) as medical treatment that can be withheld or withdrawn because it is disproportionate treatment in view of its lack of benefit in improving the health or medical condition of the PVS patient.[167]

A defense of the Magisterium's teaching was provided by Donald Henke, a professor of moral theology at Kenrick-Glennon Seminary in St. Louis.[168] Henke uses the term "persistent unconsciousness" rather than "persistent vegetative state" because he maintains that the term "vegetative" carries pejorative connotations.[169] He also prefers the term "assisted" rather than "artificial" when referring to ANH.[170]

Henke maintains the assertions that ANH is a medical treatment rather than care reflects a strategy of legal advocates to bring ANH within the category of "prolonged medical treatment," which can be refused by a patient or be withdrawn by a surrogate.[171] According to Henke, deliberate linguistic choices were meant to have legal significance:

> [B]efore 1983, nutrition and hydration were merely food and water and, more importantly, classified as an aspect of basic

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[165] *Id.* at 9; *see also* KELLEY ET AL., *supra* note 2, at 200 ("There are a number of reasons why traditional catholic teaching permitting the nonuse of feeding tubes for pus and other similar patients ought not to be changed.").

[166] Travaline & Berg, *supra* note 161, at 10–12.

[167] Donald E. Henke, *Artificially Assisted Hydration and Nutrition From Karen Quinlan to Nancy Cruzan to the Present: An Historical Analysis of the Decision to Provide or Withhold/Withdraw Sustenance From PVS Patients in Catholic Moral Theology and Medical Practice in the United States* 1, 234 (2004) (unpublished D.Th. dissertation, Pontificia Universitas Lateranensis), http://www.revdonaldhenke.com/classes/MTH_514/Microsoft%20Word%20-%20COMPLETEDISSERTATION01.pdf.

[168] *See generally* Donald E. Henke, *Persistent Unconsciousness and the Use of Assisted Nutrition and Hydration: Medical and Moral Reflections*, 78 THE LINACRE QUARTERLY 138, 138 (2011).

[169] *See generally id.* at 148 (describing Pope John Paul II's view of unconsciousness versus vegetative).

[170] *Id.* at 139.

[171] *See id.* at 140–41.

> nursing care. After 1983 [the year of Nancy Cruzan's automobile accident], once it became clear that, like Karen Quinlan, the lives of unconscious patients could be maintained if they received food and water, a shift took place in medical thought and practice. From this point forward, by medical and legal means, an attempt was made to reclassify the delivery of assisted food and fluids as a medical treatment and no longer an aspect of basic nursing care.[172]

Henke maintains that this shift in language involved a strategy to bring ANH under the general rule permitting withholding or withdrawal of life-prolonging medical treatment because

> [b]asic nursing care is something that is normally provided to all patients regardless of their physical condition, e.g., things like good hygiene, a comfortable room temperature, alleviating pressure points, and at one time, food and fluids. Medical treatments, on the other hand, were interventions that could be accepted or refused according to the desires of the patient or surrogate.[173]

Henke observed that the most controversial aspect of the papal allocution was the statement that food and fluids, even if assisted by artificial means, are "an ordinary and proportionate means of preserving life."[174] Henke identified the underlying premise of the Pope's declaration as the principle of the Catholic moral tradition that holds that ordinary means of preserving life are morally obligatory and this includes all medicine and treatments "which offer a reasonable hope of benefit and which can be obtained and used without [undue burden of] expense, pain, or other inconvenience."[175]

Ultimately, Henke bases his defense of the Magisterial teaching on the moral obligation to provide ANH to the PVS patient on the value of human life and the human dignity of the person:

> [H]uman life, even in a persistently unconscious condition, remains a gift from God; and it is not completely our own to dispose of . . . the Church tries to uphold the dignity of the human person and to model the type of health care that all human beings deserve simply because they are human.[176]

Henke concludes:

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[172] *Id.* at 144 (emphasis added).
[173] *Id.*
[174] *Id.* at 149.
[175] *Id.*
[176] *Id.* at 153.

> The clarifications from the Vatican, and now the U.S. Conference of Catholic Bishops on end-of-life care, charge us to honor human life, particularly when it is most vulnerable and to resist practices that, even if motivated by a form of compassion, nevertheless intend to end the life of a person whose life is judged to be devoid of sufficient quality.[177]

Criticism of the Magisterium's teaching on ANH and PVS patients, particularly Pope John Paul II's statement on the subject was the focus of an article *Reflections on the Papal Allocution Concerning Care For PVS Patients*, by Kevin O'Rourke, a bioethicist at the Stritch School of Medicine at Loyola University, Chicago.[178] O'Rourke maintained that provision of ANH to a PVS patient does not benefit the patient because it preserves mere biological life (a physical functioning alone) and does not restore the patient to a state in which the person can pursue the higher goals of life which require cognitive functioning.[179] According to this view, ANH is futile in the case of the PVS patient because it is ineffective in restoring the health of the patient, and because it is disproportionately burdensome and therefore has no benefit.[180]

O'Rourke maintained that the Papal Allocution was not an infallible proclamation and it is appropriate to subject it to criticism.[181] O'Rourke's view is that it was a "reformable statement" by a Church authority and his critique is meant to identify those facts which are relevant to this "reformable statement."[182] O'Rourke attempts to identify specific errors in the statement that undermine its authority and conclusions. O'Rourke begins by questioning the statement's equating vegetative state ("VS") with PVS. The statement says that there basically is no difference in the diagnosis but only "'a prognostic judgment that recovery is statistically speaking more difficult[,]'" in the case of a PVS diagnosis.[183] On the contrary, O'Rourke maintains that: "In fact, the transition from VS to PVS is based on more than statistics. It is based upon a presumption that the condition of the patient is irreversible, and this presumption is based upon neurological evidence."[184]

O'Rourke goes on to challenge the Allocution's assertion "that decisions to remove life support should not be made on the basis of 'quality

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[177] *Id.*

[178] Kevin D. O'Rourke, *Reflections on the Papal Allocution Concerning Care for PVS Patients*, *in* ARTIFICIAL NUTRITION AND HYDRATION: THE NEW CATHOLIC DEBATE 1, 165 (Christopher Tollefson ed. 2008).

[179] *Id.* at 174.

[180] *Id.* at 172.

[181] *Id.* at 165.

[182] *Id.*

[183] *Id.* at 168 (quoting Pope John Paul II, *supra* note 138).

[184] O'Rourke, *supra* note 178, at 168.

of life' 'because the intrinsic value and personal dignity [of the person] does not change, no matter what the circumstance[] . . . .'"[185] O'Rourke maintains that the Allocution confuses "quality of life," which is intrinsic in all humans with "quality of functioning" that can change and which is subject to evaluation when making decisions about life prolonging treatment.[186] O'Rourke cites the statement of Pope Pius XII discussing decisions on whether or not to utilize or withhold life support, which the Pope said depends on the "circumstances of persons, places, times, and culture."[187] Moreover, O'Rourke notes that one of the sources quoted with approval in the Allocution itself, the Pontifical Council "Cor Unum," "referred to this analysis of circumstances as judging 'the quality of life[,]'" which is relevant for making treatment decisions.[188]

O'Rourke challenges the basic assumption of the Allocution including the assertion that there is some hope of benefit from the prolonging of life for a patient in a PVS, even if it is unlikely that the patient will recover consciousness.[189] According to O'Rourke this claim is based on the premise that life (biological life) is an "intrinsic good" or a "great benefit" or "that human life is an incommensurable good" and there is always a possibility of recovery no matter that there is a contrary medical judgment.[190] O'Rourke maintains that medical evidence has established that there is no reasonable basis to believe there is a possibility of recovery after a professional diagnosis of PVS: "In most cases of PVS, moral certitude that the patient will not recover is possible . . . ."[191] Finally, contrary to the suggestion in the Allocution that withdrawal of ANH may cause pain in the PVS patient, O'Rourke cites contemporary studies that show "removing [ANH] from patients in PVS or prolonged coma does not cause pain."[192]

O'Rourke's criticism of the Allocution claims a theological basis in the Thomastic anthropology of the human person. Thomas Aquinas makes a distinction between human acts (*actus humanus*) and acts of man (*actus hominus*).[193] "Human acts are acts [involving] the intellect and will; acts of man are bodily acts not [controlled] by the intellect and will[]" (these involve mere "physiological . . . activity, such as circulation of the blood or digestion.").[194] O'Rourke maintains that: "If a person does not have the ability nor the potency to perform human acts now or in the future, then that person

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[185] *Id.* at 169.
[186] *Id.*
[187] *Id.* (quoting Haid, *supra* note 56).
[188] O'Rourke, *supra* note 178, at 169 (quoting THE PONTIFICAL COUNCIL OF HEALTH AFFAIRS, *supra* note 121).
[189] O'Rourke, *supra* note 178, at 171.
[190] *Id.*
[191] *Id.* at 172.
[192] *Id.* at 174.
[193] *Id.* (citing 2 ST. THOMAS AQUINAS SUMMA THEOLOGICA 584 (Fathers of the English Dominican Province trans., Christian Classics 1981)).
[194] O'Rourke, *supra* note 178, at 174.

can no longer strive for the purpose of human life and it does not benefit the person in this condition to have life prolonged."[195] O'Rourke argues that:

> If it is morally certain that persons cannot and will not perform [human] acts of this nature now or in the future, then the moral imperative to prolong their lives no longer is present. Hence, it is not "a great benefit" for the patient, for the family nor for society, to prolong their lives.[196]

O'Rourke concludes: "[T]here is no moral obligation to prolong the life of persons in vegetative state from which they most likely will not recover."[197]

Jason Eberl in an article in the *National Catholic Bioethics Quarterly* has undertaken a defense of O'Rourke from the charge that "non-utilization of ANH for PVS patients fail to recognize 'the patient's inherit dignity as a human being and his or her status as a child of God.'"[198] Eberl concedes that physical or bodily life is indeed an intrinsic good of the human person; but while valuable in itself, it is instrumental to a higher spiritual good.[199] Prolonging the bodily life of a PVS patient "interferes with a PVS patient's attainment of her ultimate good, since her soul cannot engage in the purposeful human activity of understanding and loving God until it separates from the body and enters a new mode of existence and intellection awaiting the body's resurrection."[200]

Eberl supports O'Rourke's view that the patient is a human person whose life has inherent dignity, but whose life is no longer meaningful since the person can no longer engage in purposeful human activity toward the person's ultimate end.[201] Applying the Catholic ethical criteria recognizing the distinctions between ordinary and extraordinary, proportionate and disproportionate, benefit and burden, and futile and beneficial treatment, Eberl concludes:

> ANH for properly diagnosed PVS patients should be typically construed as "extraordinary" treatment, due to its inability to help [benefit] a patient to an embodied condition in which she can engage in purposeful human acts toward her ultimate end . . . ANH is *futile*, and its prevention of the soul's timely departure from its body so that the person may pursue her ultimate end may be disproportionately *burdensome*.[202]

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[195] *Id.*
[196] *Id.*
[197] *Id.*
[198] Jason T. Eberl, *Extraordinary Care and the Spiritual Goal of Life: A Defense of the View of Kevin O'Rourke, O.P.*, 5 THE NAT'L CATHOLIC BIOETHICS QUARTERLY 491, 500 (2005).
[199] *Id.* at 500.
[200] *Id.* at 500–01.
[201] *Id.* at 500.
[202] *Id.* at 501.

VII. A CLOSE AND CAREFUL READING OF CURRENT MAGISTERIAL TEACHING ON ANH FOR PVS PATIENTS

Some commentators such as Thomas Shannon and James Walter maintain that the Papal Allocution on provision of ANH to PVS patients involves a change or shift in Church teaching from a "presumption" to an "obligation" to provide, in principle, ANH to the permanently unconscious patient.[203] A careful consideration of Church actions and pronouncements, however, shows a shift from a not clearly defined position on this issue to a more certain standard establishing a moral obligation in principle, to provide PVS patients food and fluids by mechanical means.

For Catholic health care workers and institutions, the Congregation's *Responses* and the USCCB's Directive 58 provide the primary texts for considering the obligation to provide ANH to PVS patients. One commentary has identified two significant canons of the present Code of Canon Law, which are relevant for interpreting the Congregation's *Responses*.[204] Canon 18 provides that: "Laws which establish a penalty or restrict free exercise of rights . . . are subject to strict interpretation[,]" and Canon 52 stipulates: "A singular decree has force only in respect to the matters which it decides and for the persons for whom it was given."[205] In this commentary the assertion is made that: "[T]he application of the [Congregation's] response, because it limits the free exercise of rights, will only apply to a restricted number of cases, specifically to patients with a firm diagnosis of PVS."[206] Directive 58, however, has much greater breadth since it "extends to patients in chronic and presumably irreversible conditions (e.g., the 'persistent vegetative state') who can reasonably be expected to live indefinitely if given such care."[207]

Perhaps the more significant language for determining the Magisterium's teaching is the phrase that begins the text of Directive 58. This phrase "in principle" as used in the Directive means that there are exceptional instances in which the provision of ANH are not obligatory. This reconciles the rule establishing a moral obligation to provide ANH to the PVS patient with the general ethical principles underlying Catholic moral teaching including that one must accept and provide ordinary care that is not disproportionate or excessively burdensome. The directive itself establishes the general terms of the exceptions to the rule including (1) when ANH cannot be expected to prolong life (e.g. when the patient's body can no longer assimilate nutrition); (2) when ANH would be excessively burdensome for the patient (e.g. when the device used to deliver ANH interferes with the

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[203] Shannon & Walter, *supra* note 48, at 653.

[204] *See* John J. Hardt & Kevin D. O'Rourke, *Nutrition and Hydration*, 88 HEALTH PROGRESS 6 (2007), http://cha.matrixdev.net/publications/health-progress/article/november-december-2007/nutrition-and-hydration.

[205] *Id.*

[206] *Id.*

[207] USCCB, *supra* note 50.

activity of the patient's organs); or (3) when ANH causes significant physical discomfort, (e.g. resulting from complications in the use of the mechanical device delivering ANH).[208]

Perhaps the most important exception is when a PVS patient develops a terminal illness, often considered to be a diagnosed condition likely to result in the patient's death within six weeks. Directive 58 specifically provides that "as a patient draws close to inevitable death from an underlying progressive and fatal condition, certain measures to provide nutrition and hydration may become excessively burdensome and therefore not obligatory in light of their very limited ability to prolong life or provide comfort."[209]

One commentator has provided an example of the type of situation, in the case of a dementia diagnosis where the burden of employing mechanical means to effectuate ANH would be considered disproportionately burdensome and not obligatory:

> "[F]or example, a patient who is ninety-five years old, has a severe heart disease and diabetes in addition to dementia, is still able to eat by hand feeding to maintain [nutrition and] hydration, yet is losing weight. In such a patient PEG tube insertion could rightly be considered an extraordinary measure and thus is not mandatory."[210]

Similar considerations are likely to arise in cases involving a PVS diagnosis. Directive 58 uses the terms "when [ANH] cannot reasonably be expected to prolong life . . . ."[211] The Congregation "Response" uses the terms: not able "to accomplish its proper finality, which is the hydration and nourishment of the patient."[212] Another case is presented by the commentator: "If a patient is losing weight, has a PEG tube inserted, and *continues* to lose weight, the PEG tube is not required."[213]

The Magisterial teaching is clear: in principle, there is a moral obligation to provide ANH to the PVS patient. However, to the extent that the Magisterial teaching is captured in Directive 58, this does not mean that life must be prolonged with unnecessary suffering. As a statement of Magisterial teaching, this directive takes seriously both the recognition of the human dignity of the PVS patient, and the obligation not to abandon the severely mentally-compromised patient diagnosed with PVS.

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[208] *Id.*
[209] *Id.*
[210] John S. Howland, *A Defense of Assisted Nutrition and Hydration in Patients with Dementia*, 9 THE NAT'L CATHOLIC BIOETHICS QUARTERLY 697, 708 (2009).
[211] USCCB, *supra* note 50, at 31.
[212] OFFICES OF THE CONGREGATION FOR THE DOCTRINE OF THE FAITH, *supra* note 149.
[213] Howland, *supra* note 210, at 708.

VIII. JUDICIAL RECOGNITION OF CATHOLIC TEACHING ON PROVISION OF ARTIFICIAL (ASSISTED) NUTRITION AND HYDRATION

The issue of limits on withholding and withdrawal of artificial or assisted nutrition and hydration developed principally in relation to PVS patients. However, the issue of ANH increasingly is raised in relation to other diagnostic conditions, not only those involving recognized terminal illness by patients requiring mechanical support, but those involving loss of cognitive capacity far short of PVS. There are, moreover, efforts by patient advocates to take an even more aggressive attitude toward withholding nutrition and hydration. It has been argued that even spoon feeding be withheld from those with severe cognitive impairments.[214] In a recent article in the New York Times entitled *Complexities of Choosing an End Game for Dementia* the author describes efforts of patients with Alzheimer's disease to direct withholding of the "ordinary means of nutrition and hydration[]" including spoon feeding or ordinary provisions of liquids.[215] The article reports that "now ethicists, lawyers and older adults themselves had begun a quiet debate about whether people who develop dementia can use VSED [voluntarily stopping eating and drinking] to end their lives by including such instructions in an advance directive."[216]

It is, however, an opinion addressing the withholding of ANH from a patient diagnosed with advanced Alzheimer's disease, which provides the most significant legal analysis of the significance of the teaching of the Roman Catholic Magisterium condemning withholding of ANH.[217] The opinion of the New York Supreme Court for Monroe County, in *In re Zornow*, considered the issue of withholding treatment from a Roman Catholic, ninety-three-year-old woman suffering from advanced Alzheimer's.[218] The court's opinion reprints the major documents of the Magisterium dealing with the issue of ANH which are given extensive analysis by the court including the *Code of Canon Law*, the *Catechism of the Catholic Church*, promulgations by the Congregation for the Doctrine of the Faith, including the 1980 *Declaration of Euthanasia*, the "Responses" to certain questions of the USCCB, concerning ANH, and its accompanying *Commentary* approved by the Cardinal and the Bishops of the Congregation.[219]

New York law recognizes advance directives and the appointment of

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[214] Carol Taylor & Robert Barnet, *Hand Feeding: Moral Obligation or Elective Intervention?*, HEALTH CARE ETHICS USA, 12, 14 (2014).

[215] Paula Span, *Complexities of Choosing an End Game for Dementia*, N.Y. TIMES (Jan. 19, 2015), http://www.nytimes.com/2015/01/20/health/complexities-of-choosing-an-end-game-for-dementia.html?_r=0.

[216] *Id.*

[217] *In re* Zornow, 919 N.Y.S.2d 273 (N.Y. Sup. Ct. 2010); *see also In re* Zornow, 943 N.Y.S.2d 795 (N.Y. Sup. Ct. 2011). A similar analysis and conclusion from the point of Jewish Law (Halacha) and the case of the critically ill was provided in Borenstein v. Simonson, 797 N.Y.S.2d 818 (N.Y. Sup. Ct. 2005).

[218] *See In re Zornow,* 919 N.Y.S.2d at 275.

[219] *See generally id.* at 282–85.

a proxy to make health care decisions for incompetent persons.[220] In the absence of such an appointment, a state statute, the New York Family Health Care Decisions Act ("FHCDA") applies a presumption of termination of life-sustaining treatment, including nutrition and hydration for a mentally incompetent person, without the patient ever having indicated a desire for such termination.[221] The court observed that this statute reflects a major change from "*who* and under *what* standards life sustaining treatment may be terminated for a mentally incompetent [patient]."[222] Although a patient could choose to have ANH withheld by an advance directive, in conformity with the consensus view on the right to direct withholding of ANH, absent such a directive, New York had adopted a presumption in favor of life.[223] The court described the previous presumption in favor of providing ANH: "Previously, absent indication from the principal to the contrary, a 'presumption of life' applied. Here, [in the new statute] absent such indication, a 'presumption of termination' applies, especially by deprivation of artificially administered food and water."[224] The court reasoned that this change reflects a shift toward a "quality of life" judgment, which is anathema to the Roman Catholic tradition.[225] According to the court, "[u]nder the statue, the 'quality of life ethic' has become the automatic main ethic while the 'sanctity of life ethic' is given the affirmative burden to 'opt out.'"[226] In this case, the court found that the medical orders on life-sustaining treatments pursuant to the FHCDA providing for withholding of ANH were unauthorized and violated the patient's religious belief and prior request to be artificially administered nourishment and liquids.[227] Here, the patient was a daily communicant at Mass, and the court determined that food and water directives should be made in accordance with the patient's Roman Catholic religious beliefs.[228]

Close examination of the documents setting out the Church's teaching led the court to the conclusion that:

> The Catholic Church does not define or consider artificial administration of food and water as extraordinary or even medical "treatment," but it is always defined as ordinary care. Further, it does not allow the termination of food and water despite a vegetative state or an advanced Alzheimer's condition where the patient is not dying, or if dying, the death

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[220] *Id.* at 277.

[221] *Id.* Under the Family Health Care Decisions Act ("FHCDA"), "absent [an] indication from the principal to the contrary, . . . a 'presumption of termination[,]'" rather than a presumption of life, applies to life-sustaining treatment for a mentally incompetent, especially by deprivation of artificially administered food and water. *Id.*

[222] *Id.* at 277.

[223] *Id.* (internal citation omitted).

[224] *Id.*

[225] *Id.* at 277–79.

[226] *Id.* at 277–78.

[227] *Id.*

[228] *Id.* at 276–78.

> is not so imminent, such that the cause of death becomes the starvation or dehydration, rather than the imminent underlying condition.[229]

The court observed that while the patient in the case was not unconscious, her mere lapse into unconsciousness would not alter the obligation to continue to provide ANH.[230] The court reasoned: "However, if she were to become permanently unconscious, and not in the actual process of dying from the underlying condition, the administration of food and water, which her religion believes is always to be considered comfort or basic care, even if administered artificially, is obligatory."[231]

The court noted that the statute identified a standard providing when food and water is not required that was generally consistent with Roman Catholic teaching: (1) when providing food and water is considered an extraordinary burden; and (2) when life expectations is less than six months and the patient is unable to take food and water orally.[232] The court observed, however, that the Church rejects the six month life expectancy rule unless the cause of death were in fact a result of the underlying condition:

> The Catholic Church, in addition to considering artificial administration of food and water as never extraordinary or even medical "treatment," as aforesaid, also does not allow the termination based upon a six-month "quality of life," where, again, the cause of death is by starvation or dehydration, rather than the imminent underlying condition.[233]

The court went on to observe that the statute allowed deprivation of food and water to a patient when its administration "would cause inhumane pain, suffering, or other burden, under circumstances in which it would be considered extraordinarily burdensome to a patient . . . who . . . has an irreversible condition[] . . . ."[234] The court noted that the fact of an "irreversible condition" is irrelevant for application of the Catholic standard of terminal condition or burdensomeness of treatment.[235] According to the court:

> The existence of an irreversible condition is not in itself a valid or particularly helpful criterion for the Catholic Church, unless death is imminent coupled with a futility to administer food and water either due to emerging complications of the

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[229] *Id.* at 278.
[230] *Id.* at 278–79.
[231] *Id.*
[232] *Id.*
[233] *Id.* at 279.
[234] *Id.*
[235] *Id.*

> inability of the person's system to assimilate the food and water, or "in some rare cases [where] artificial nourishment and hydration may be excessively burdensome for the patient or may cause significant discomfort, for example resulting from complications in the use of the means employed."[236]

In a subsequent opinion in the *Zornow* case, the Supreme Court of New York clarified the question of whether a physician's judgment that it was not medically appropriate to insert a feeding tube would justify withholding of ANH.[237] The court ruled that the physician's judgment of medical appropriateness does not override the obligation to provide ANH to the PVS patient or person with significant cognitive impairment.[238] The court noted that the opinion of revisionist theologians on the issue that was contrary to the official teaching of the Church was irrelevant to the court's analysis.[239] Instead the court ruled that "the guardians are directed to consult in the future with theologians or priests, who are more traditional, knowledgeable, and adhere to the Magisterium's authoritative standard[] . . . ."[240]

The court summed up the legal obligation of guardians who are obligated to make treatment decisions in conformity with Catholic teaching:

> However, the difficult task for the guardians is to determine under Catholic principles when her medical conditions changes [or exists], such that the treatment is extra-ordinary rather than ordinary. Extra-ordinary treatment may be denied to avoid excess or needless pain to the patient in allowing her to die a natural death without mercy killing, euthanasia, or doctor /surrogate assisted suicide. The important distinction is that the underlying medical condition is causing the natural death.[241]

The court further warned that there is a need to distinguish the understanding of withholding ANH in terms of the legal and medical consensus from the understanding developed by Catholic teaching:

> [M]edical conditions will require a judgment by the guardians [of Catholic patients] of whether the corrective treatment is "ordinary" versus "extraordinary". Those terms used in Catholic theology, differ greatly from the same words used for medical purposes. It was primarily here, in arriving at that moral evaluation that the court required consultation

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[236] *Id.*
[237] *In re* Zornow, 943 N.Y.S.2d 795 (N.Y. Sup. Ct. 2011).
[238] *Id.*
[239] *Id.*
[240] *Id.*
[241] *Id.*

> with "a priest or someone well trained in Catholic moral theology." Catholics are morally obligated to accept ordinary treatment, but, although not required, may refuse extra ordinary treatment, even if the underlying secondary condition causes death. Accordingly, the guardians may deny or withhold extra ordinary treatment.[242]

Administration of ANH to a patient is considered ordinary treatment and must be administered unless there is evidence of conditions of terminal illness, burdensomeness or futility.

IX. CONCLUSION

The issue of withholding or withdrawing nutrition and hydration from the PVS patient, or a patient diagnosed with advanced Alzheimer's disease, has become a significant area of dispute between the consensus legal and medical authorities and the teaching of the Roman Catholic Church's Magisterium. Consensus legal and medical authorities maintain an irrelevancy of distinguishing between nutrition and hydration and other forms of medical treatment. Life-sustaining treatment that may be withheld from a patient includes ANH. Statutes providing for withholding life-sustaining treatments generally treat patients with a diagnosis of PVS the same as patients with a diagnosis of a terminal condition.

The teaching of the Magisterium is that provisions of nutrition and hydration, whether natural or by artificial means is ordinary care, which is a means of preserving life. Such care must be administered to a person in a vegetative state, or with other significant mental impairment, except where it cannot be assimilated by the patient's body or cannot be administered without causing significant burden such as physical discomfort. The Magisterium has also declared that a patient in a PVS, as is the case with other patients with cognitive impairment, is a person with fundamental dignity and must receive ordinary and proportionate care, which includes provision of ANH.

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[242] *Id.* (internal citation omitted).