

## Feeding decisions, the *sensus fidelium* and Catholic healthcare professionals

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I recently had to pay \$100/ day (\$200/day on week-ends and holidays) to have a geriatric aide help my debilitated uncle eat breakfast and the evening meal. He was in an upscale skilled nursing facility but nursing leadership could not guarantee the extra attention and encouragement he needed to take in enough food and fluids to remain hydrated and nourished. I was forced to reflect on the care being received by thousands of our elderly who lack knowledgeable family advocates or the financial resources to receive what should be basic care.

Feeding decisions come in many varieties and not all are linked to artificially administered nutrition and hydration. Health care professionals committed to health, wellbeing and good dying need to reflect on the nursing and ethical challenges present in each of the situations below. I have used these scenarios in many professional settings and each time was struck by the diversity of opinions about what qualified as an ethically good response. One of the scenarios below is a clear example of suicide by omission as described in the Declaration on Euthanasia and another describes the sort of individual in a permanent vegetative state who is the object of the papal allocution on artificial nutrition and hydration and the response by the Confraternity for the Doctrine of the Faith.

In Roman Catholic tradition, the *sensus fidelium* is the "sense of the faithful," one of the valid sources of truth in Catholic theology. This source of truth represents the combined beliefs, consciences and experiences of good and honest Catholics. It operates in a close relationship of mutual conditioning with all of the other varied components of the Roman Catholic tradition. When it comes to feeding decisions Catholic health care professionals are obligated to reflect on the situations in which individuals with altered nutrition and hydration find themselves. In doing so, as committed Christians, they have the opportunity to enrich their insights with the Church's magisterial teaching and the best of theological thought.

In my experience, as both a nurse and ethicist, the growing tendency today to abdicate medical decisionmaking to patients and families—even when their expectations are unrealistic and their decisions ill-advised—is simply wrong. The primary object of all clinical decisionmaking ought to be to secure the patient's interests, health, wellbeing, good dying—and to do this in a manner that respects the integrity of all who participate in the decisionmaking process, patient, family, *and* health care professionals. To the extent this is true, health care professionals must continually reason prudentially about

what constitutes good care and make appropriate recommendations to patients, families and their Church.

- Mrs. Gleason is a 92 year old nursing home resident with end-stage dementia. Until now she has been spoon fed. She was admitted to the hospital for recurrent aspiration pneumonia and respiratory difficulties. She has been receiving intravenous fluids. Her altered blood chemistries and frail condition result in her being considered for placement of a PEG feeding tube before being discharged back to the nursing home. She has no family.
- Mr. Suarez is a 49 year old attorney who was found collapsed at the foot of his stairs at home two weeks ago. He had a massive cerebral head bleed and surgery revealed extensive, irreversible neurologic damage. His medical condition is now stabilized and his doctors are asking his family if they want to “peg and trach him”—in which case he might live for some time with good nursing care. The other option is to transition at this point to primarily palliative goals (not administer medical nutrition and hydration), in which case he will most likely die within 7-21 days. His wife is certain that he would not want to live in his present condition, “he always lived in his mind,” but the suddenness of his condition leaves her wondering if a decision to transition to purely palliative goals isn’t premature.
- Jean Bridges is a 24 year old survivor of an accidental strangling episode. Jean has a long history of schizophrenia and while hospitalized for dehydration was found dangling over her bedside with her posey vest restraint around her neck. This was 15 months ago and she has now been diagnosed as being in persistent vegetative state. Her case manager approaches her parents for the first time asking if they had ever considered stopping her medical nutrition and hydration.
- Ms. Apold is an educated, articulate, and until recently, healthy 78 year old, single woman. She does have advanced osteoporosis. A recent fall resulted in a leg fracture. She has lived a rich and full life and sees nothing but diminishment in her future with a life increasingly constricted to her apartment. When she told someone that she wished she could just fall asleep and never wake up, her friend told her that she should just stop eating and drinking—if she really wants to die. Her friend works for hospice and Ms. Apold is now asking this hospice to care for her until she dies.
- Mr. Phan was found dead in his bed at home. Aged 97, Mr. Phan lived alone in an apartment in the city. He had no family of record but friendly neighbors. His closest neighbor described Mr. Phan’s multiple health problems, congestive heart failure, chronic obstructive pulmonary disease, diabetes mellitus, peripheral vascular disease and said that she

had noticed him really “slowing down” the past year. “I used to bring him food all the time but he just seemed to lose his appetite this year and most of what I brought him was untouched. He wouldn’t hear of going to a nursing home. Should something else have been done?”

- Mr. Spivac, aged 80, has the type of dementia which has resulted in his being physically assaultive. He was dismissed from nine residential treatment facilities because the staff’s inability to control his behavior. His assaultive behavior is now being managed pharmacologically which has simultaneously impaired his physical functioning. His wife, whom everyone describes as “long-suffering,” is now repeatedly asking the doctors and nurses not to help feed her husband. “Bring him a tray but don’t encourage him. He never wanted to live like this.” He is physically able to feed himself and to swallow but needs encouragement to eat and drink enough to keep him nutritionally balanced. Staff believe that eating is one of his few pleasures at this time. His wife stated that society is going to have to decide what to do with all the people we are now “warehousing” in nursing homes.