

Consortium of Jesuit Bioethics Programs' Symposium on
Artificial Nutrition and Hydration:

Five Unacknowledged Shifts in the Catholic Tradition

James J. Walter, Ph.D.

Austin & Ann O'Malley Professor of Bioethics
Chair of the Bioethics Institute, Loyola Marymount University

The late John Paul II's Allocution to the *International Congress on Life-Sustaining Treatment and Vegetative State: Scientific Advances and Ethical Dilemmas* on 20 March 2004 has been the occasion for significant discussion concerning the use of artificial feeding tubes for patients in a permanent vegetative state (PVS). Briefly, the Pope stated that such tubes were "not a medical act" and their use "always represents a natural means of preserving life" and is part of "normal care." Therefore, in principle their use is to be morally evaluated as ordinary and obligatory. The Pope claimed that, "If done knowingly and willingly" the removal of such feeding tubes is "euthanasia by omission."¹

This papal allocution seemed to represent a departure from the long-standing Roman Catholic bioethical tradition. Consequently, the United States Catholic hierarchy requested a clarification from the Congregation for the Doctrine of the Faith on the issue of feeding tubes. The CDF responded by reaffirming what the pope had argued, namely, that artificial nutrition and hydration was, in principle, an ordinary means of preserving life and therefore obligatory. It also stated the patient in permanent vegetative state must be offered nutrition and hydration.²

The Vatican commentary on this CDF response noted that there are only three conditions when artificial nutrition and hydration might not be morally obligatory: (1) when it would be impossible to provide ANH; (2) when a patient may be unable to assimilate food and liquids; and (3) when 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.³ Recently, Bishop Lori and Cardinal Rigali published an article in which they argued that not everything in the CDF's "Responses" applies *solely* to patients in a "vegetative state." The authors argued that certainly ANH should be offered to patients who have chronic but stable debilitating conditions that are *less* extreme than the "vegetative state."⁴ In June 2008 at the annual meeting of the US bishops, these same two Catholic hierarchs convinced the bishops to begin the process to amend the current edition of the Ethical and Religious

Directives, especially Directive 58, to reflect this broader application of artificial nutrition and hydration.

I will argue that within the last 25 years there have been five unacknowledged shifts away from the longstanding Catholic, traditional method of analyzing our moral obligations during illness and the dying process.⁵ Not all the shifts are found in the papal allocution, though the allocution's author may very well have assumed many of them in what he had to say about ANH.

First, there is an important shift in terminology. The longstanding Catholic moral tradition has used the terms "ordinary" (morally required) and "extraordinary" (morally optional) means (treatment) since the late 16th century, and with the 1980 publication of the Declaration on Euthanasia the terms "proportionate" and "disproportionate" means have been used instead. Both sets of these terms were concerned with a *moral* judgment made by the patient or his/her designated surrogate about the proportion between the benefits and burdens of treatment for a patient; their reference was not the state of technology within medicine, and the use of these terms was not simply the result of a *clinical* judgment. Recently, however, the meaning of these terms has shifted. For example, the Colorado bishops have defined "ordinary" means as those that "have a medically reasonable hope of sustaining life," and "extraordinary" means as those that "have no medically reasonable hope of sustaining life."⁶ The Rhode Island bishops now have introduced a new term called "ordinary *care*"⁷ (not ordinary *treatment*), and they define its meaning as "standard, routine treatment that preserves life and health and that promotes comfort and dignity to the patient." Extraordinary "care" is defined as: "Treatments that are not necessary to sustain life but that might offer some benefit to a patient are morally optional and accepted or foregone depending on the circumstances."⁸ What we see is that the Colorado and Rhode Island bishops have shifted not only the traditional meaning of ordinary and extraordinary means of treatment but also the referent of the terms from a *moral* judgment to a *clinical* judgment.

Historically, the type of analysis used for issues related to end-of-life matters has mostly employed a method that teleologically evaluates the effects of a medical treatment on the patient, including the patient's family and broader society. This ethic has traditionally been patient-centered and focused on an evaluation of benefits and burdens or on whether the intervention was proportionate or disproportionate. This has been the central teaching of the long-standing tradition from the mid-1600s through Pope Pius XII and the 1980 "Declaration on Euthanasia" by the Congregation for the Doctrine of the Faith. However, when one reads the 2004 allocution

by John Paul II, there is a methodological shift to deontology or to principle-based considerations, and the principles are determined by definition or stipulation. Briefly, the pope stated that feeding tubes are “not a medical act” and their use “always represents a natural means of preserving life” and is part of “normal care.” Therefore, their use is to be considered in principle ordinary and obligatory.

Third, historically, particularly up to about 1950, when one got seriously ill, one died. However, the moralists of the past did not cast their teaching on ordinary-extraordinary means as applicable only in the context of dying. For them, the obligation to preserve one’s life was cast in terms of the general context of illness and the prolongation of life. A shift in analysis seems to stem from John Paul II’s Evangelium vitae in which he, in talking about aggressive medical therapies that are disproportionate or too burdensome, says “in such situations, when death is clearly *imminent and inevitable*, one can in conscience” refuse treatments.⁹ Thus, Evangelium vitae seems to restrict when treatments might be forgone or withdrawn to the situation of imminent and inevitable death only.

Fourth, imbedded in the distinction between ordinary and extraordinary means of medical technology is the possibility of an equivocation on the term “ordinary.” When we discuss medical interventions, we frequently discuss some of them in *clinical or medical* terms as routine, standard, the treatment of choice, standard of care, or ordinary. However, no determination has yet been made on the effect of such an intervention on the patient or on others. From the perspective of the Catholic tradition, this is where the *moral* evaluation begins. Thus, the *moral* definition of “ordinary means” is concerned with what is the impact on the patient, what benefits or burdens will the treatment bring to the patient or to others, what is the likely outcome of the intervention, what is the cost, both psychological and economic for the patient and his or her family? The equivocation on the term “ordinary” set the context for the presumption of use of artificial nutrition and hydration. For example, in 1986, the Committee for Pro-Life Activities of the then NCCB noted that food and water are necessities of life. And since they can be provided without risks and burdens associated with more aggressive life-supporting interventions, there should be a presumption in favor of their use. A final difficulty with this fourth shift concerns determining to what we have presumptive or *prima facie* obligations. In the tradition, one had a presumptive obligation *to preserve one’s life*, not a presumptive obligation *to accept or take any particular medical technology*, e.g., mechanical ventilators, heart transplants,

or artificial nutrition and hydration. In recent statements over the last 25 years, however, patients have a presumptive obligation to take artificial nutrition and hydration.

Finally, the Pontifical Academy of Sciences in 1985 noted: “If the patient is in a permanent irreversible coma, as far as can be foreseen, treatment is not required, but all *care* should be lavished on him, *including feeding*.”¹⁰ Note here that “feeding” is not placed within the category of “medical treatment” but is defined as “care,” which indicates that such interventions are not subject to the normal moral criterion of proportionality between benefits and burdens. This position is repeated in John Paul II’s 2004 allocution in which the pope stated that such tubes were “not a medical act” and their use “always represents a natural means of preserving life” and is part of “normal care.” Therefore, their use is to be morally considered in principle as ordinary and obligatory. Other than the three exceptions stated by the CDF in its commentary on ANH, the person’s medical condition is not relevant in making a determination about the use of feeding tubes because the food and water delivered through such tubes is ordinary care and provides a benefit—“nourishment to the patient and alleviation of his suffering.” Such a shift to the requirement that artificial nutrition and hydration *must be used* (not a presumption to be used) essentially takes the decision about this intervention out of the patient-centered approach that has so characterized the historical tradition of the past.

¹ The allocution “Care for Patients in a ‘Permanent’ Vegetative State” by John Paul II can be found on the Vatican web site:

http://www.vatican.va/holy_father/john_paul_ii/speeches/2004/march/documents/hf_jp-ii_spe_20040320_congress-fiamc_en.html or in *Origins* 33(April 8, 2004): 737 and 739-40.

² Congregation For The Doctrine Of The Faith, “Responses To Certain Questions Of The United States Conference Of Catholic Bishops Concerning Artificial Nutrition And Hydration” can be found at:

http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20070801_risposte-usa_en.html.

³ Congregation For The Doctrine Of The Faith, “Commentary” can be found at:

http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20070801_nota-commento_en.html.

⁴ Cardinal Justin Rigali and Bishop William E. Lori, “On Basic Care for Patients in the ‘Vegetative’ State: A Response to Dr. Hardt and Fr. O’Rourke,” *Health Progress* 89(May-June, 2008): 70-72. Emphasis in original. Also, see idem, “Human Dignity and the End of Life,” *America* 199(August 4-11, 2008): 13-15.

⁵ For a more complete discussion of four of these shifts, see Thomas A. Shannon and James J. Walter, “Assisted Nutrition and Hydration and the Catholic Tradition,” *Theological Studies* 66(2005):653.

⁶ Ronald Hamel, “Advanced Directives and ANH,” *Health Care Ethics USA* 16(Summer 2008): 16.

⁷ Cardinal Rigali and Bishop Lori also use this same term in their *America* article, *op. cit.*, p. 14.

⁸ Hamel, *op. cit.*, p. 16.

⁹ John Paul II, “Evangelium vitae,” Origins 24(April 6, 1995): §65 (emphasis added).

¹⁰ The Pontifical Academy of Sciences, “The Artificial Prolongation of Life,” Origins 15 (December 5, 1985): 415 (emphasis added).