Father Tom Knoblach, Ph.D.
Consultant for Healthcare Ethics, Diocese of Saint Cloud

On August 1, 2007, the Congregation for the Doctrine of the Faith issued responses to two questions regarding artificial nutrition and hydration (ANH) for patients in a “vegetative state.” These questions were submitted to the CDF by Bishop William Skylstad on behalf of the United States Conference of Catholic Bishops (the full text can be found many places on the Web, including www.ncbcenter.org/CDF-FoodwaterPVS9-14-07.pdf). I will attempt to give some background to this development, although I admit things will get a bit complex in what follows.

Undoubtedly, the controversy surrounding the case of Terri Schiavo was an immediate impetus for presenting these questions to Rome, especially in light of the diverse interpretations given to Pope John Paul II’s allocution on ANH in March, 2004. This allocution had stated that the provision of ANH was not a medical act and was, “in principle, obligatory, as long as and to the extent that it achieved its proper ends of preserving life and alleviating suffering.”

However, this whole area has been a long-standing debate in legal, medical, ethical, and theological circles as technological interventions to sustain life became more successful and available in the 1970s and beyond; and the allocution itself received diverse responses. Despite some claims to the contrary, I regard that 2004 allocution, and this 2007 Response, as a clarification and correction of misinterpretations of the Catholic moral tradition, and not in any way a “revision” or change in that tradition.

Legally, courts at all levels (in the U.S. and abroad) have almost always ruled that ANH is a form of medical treatment that, like any other, may be forgone or withdrawn if it is judged medically futile, is contrary to the patient’s wishes, or is considered excessively burdensome. Vast amounts of literature have debated these points: what do we mean by “futility?” What if a patient’s wishes are contrary to the emerging standard of medical practice, or to those of the family or medical team? What happens if the patient is unresponsive or psychologically impaired? How do we assess “benefit” and “burden” correctly, particularly for patients who will not regain full consciousness?

The Church has consistently applied its moral teaching on ordinary and extraordinary means for the preservation of life to this question. This general distinction regarding means is concisely

summarized in directives 56 and 57 of the U.S. Bishops’ *Ethical and Religious Directives for Catholic Health Care Services* (ERD):

56. A person has a moral obligation to use ordinary or proportionate means of preserving his or her life. Proportionate means are those that in the judgment of the patient offer a reasonable hope of benefit and do not entail an excessive burden or impose excessive expense on the family or the community.

57. A person may forgo extraordinary or disproportionate means of preserving life. Disproportionate means are those that in the patient’s judgment do not offer a reasonable hope of benefit or that entail an excessive burden, or impose excessive expense on the family or the community.

Here again, prudential judgments are essential to apply these general principles and define adequately, in each specific case, what is “reasonable,” “excessive,” “benefit,” and “burden.”

Directive 58 specifically states:

58. There should be a presumption in favor of providing nutrition and hydration to all patients, including patients who require medically assisted nutrition and hydration, as long as this is of sufficient benefit to outweigh the burdens involved to the patient.

The questions recently submitted by the USCCB, then, were specifically related to the question of providing nutrition and hydration, even by artificial means, for patients in a “vegetative” state – that is, a state of minimal consciousness with internal regulation of temperature and respiration, sleep-wake cycles, and other basic life functions, but no discernible awareness of one’s environment or purposeful activity. Such a state can be temporary or more enduring.

In response, the CDF simply restated the teaching of Pope John Paul’s allocution:

The administration of food and water, even by artificial means, is in principle an ordinary and proportionate means of preserving life. It is therefore obligatory to the extent 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.

The assumption here – and the accompanying CDF Commentary addresses this more fully – is that removing ANH would be the actual cause of death. The term “in principle” here means “in itself, all other things being equal,” thus prescinding from other medical conditions or terminal illnesses that the patient may have, which may alter this obligation.

Even if the vegetative state is judged permanent – that is, it is judged with moral certitude that the patient will never recover consciousness – this obligation continues; the mere conviction that the patient will not recover consciousness is not sufficient alone to justify withholding ANH if there are no other complications.

However, the obligation does not hold “in very remote places or in situations of extreme poverty” when it is physically impossible to provide ANH. Further, the CDF notes:

… the possibility is not absolutely excluded that, in some rare cases, ANH 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.

In such cases, the obligation ceases.

These latter points were included to make clear that it is not intrinsically wrong to withhold or withdraw ANH, either; that is, it need not
always
be employed regardless of circumstances. The CDF is striving to engage the complexity of this question, which does not admit of a simple “yes or no” answer. Rather, prudential judgments regarding moral certitude are required, but beginning with the presumption in favor of ANH, even in a permanent vegetative state. “Presumption in favor of” ANH means that,
in principle
, ANH is ordinary care, and that strong, medically-based evidence must be presented why it ought

not
be used in a specific case. Such evidence does exist in some cases; but there must be serious, objective, and patient-centered reasons not to employ ANH.

Note again that these responses by the CDF relate specifically to the question of ANH for patients in a vegetative state – which is, thankfully, relatively rare. While the moral principles used in the Responses and Commentary definitely help to guide discussion about ANH in other circumstances (for instance, in dementia, trauma, or terminal illness), these documents do not authoritatively address these issues.

Like so many moral issues in our day, it is difficult – and often misleading – to oversimplify the matter of ANH and the Church’s teaching. Even a glance at the Internet shows many divergent views on this latest statement. I encourage interested readers to read the CDF’s Response and Commentary carefully. The statement from the National Catholic Bioethics Center (see www.ncbcenter.org
) is also helpful for a more adequate understanding.