

Revised Edition, 1999

# **NUTRITION AND HYDRATION: MORAL CONSIDERATIONS**

**A Statement of The Catholic Bishops of Pennsylvania**

## **FOREWORD**

It is well known that there has been a great deal of discussion at every level in our Church and in society at large concerning "advance medical directives." These issues are already having a profound effect on the way in which we live. They influence not only our loved ones who are dying, but the very manner in which we view human life in general. Since all of us are mortal, these are issues which will also have an immense impact on each of us personally. Because of this, the Catholic Bishops of Pennsylvania have collaborated in the composition of the following statement which is an effort on our part to fulfill our responsibilities as bishops to give guidance to all the Catholic faithful of this state who are entrusted to our care. It is also our hope that these observations and the principles on which they are based will be of help to all who recognize the importance of deliberating at length on the moral aspects of the difficult question of providing food and fluids to patients. Our statement is intended to express, as well as we are currently able, the teaching of the Catholic Church as it affects these admittedly difficult cases. As we here profess our faith that all human life is sacred since it comes from God, we pray that all who read our statement will join us in our resolve truly to care for those in need among us.

Anthony Cardinal Bevilacqua Archbishop of Philadelphia

The Feast of Our Lady of Guadalupe December 12, 1991

## **INTRODUCTION**

Recent court decisions and the enactment of federal and state laws governing advance medical directives (living will or durable power of attorney) have given many the impression that anything the courts or the civil laws allow is morally acceptable. The issue of the withholding or withdrawal of nutrition and hydration in particular has become controverted. We, as Catholic Bishops and fellow Pennsylvanians, hope that what follows will be of help to many of those who are confused about the present situation, but we especially seek to offer guidance to the Catholic faithful entrusted to our pastoral care.

God's plan for humanity is not the blindness of a predetermined fate, but a plan of love involving all human beings, not as objects but as

participants. The call to respond to the moral law is not a call to legalistic obedience; it is the call to live those actions and intentions which enable us to share eternal happiness. "The highest norm of human life is the divine law itself - eternal, objective, and universal - by which God orders, directs, and governs the whole world and the ways of the human community, according to a plan conceived in his wisdom and love. God has enabled man to participate in this law of his so that, under the gentle disposition of divine Providence, many may be able to arrive at a deeper and deeper knowledge of the unchangeable truth."(1)

The teaching authority of the Church is not an exercise in legal power. Rather, it is given to the Church so that she can exercise her sacred obligation to penetrate and proclaim the truth, to know the reality of God's plan for our salvation and to set us free to discover and enjoy that which in the end will make us most happy. The attainment of that end involves faith, but it is not a totally blind faith nor is this moral law simply a series of flat commands. God calls us as we are - as his children capable of responding to him in love and with ever deepening understanding. The function of the Church, therefore, is not simply to command but also to persuade, and to do so out of a love and concern which mirrors the love and concern of God himself.

The sources of moral teaching are divine revelation and the use of our God-given ability to reason and to come to the truth. Reason and faith are intimately related and that relationship is evident in the topic that we now address. Medical practice deals with the most basic issues of life and death, issues that concern the health, welfare and even the salvation of humanity. The vocation to care for the life and health of others is a call to serve the most basic good of every person - life itself. True concern for health involves not only the welfare of the body, but the deepest welfare of the whole person. It should come as no surprise that the very best medical care and the application of the highest moral principles will inevitably coincide and can never be in conflict with each other.

Life and death decisions are a matter of concern not only to those immediately affected by them but to every one of us as well. As Catholic Bishops it is our responsibility to present the teaching of the Church in moral matters, since we are charged with the duty of providing pastoral guidance for the faithful who must live the Christian message in contemporary society. In 1980, the Magisterium addressed the general question of euthanasia in the decree of the Congregation for the Doctrine of the Faith, *Jura et Bona*. That decree enunciates certain important principles applicable to the present discussion, but it does not address the specific issue of the

withdrawal of nutrition and hydration. On one hand, we are clearly obliged as Catholics to adhere to the guidance of the Magisterium. On the other hand, the present complex issue has not yet been explicitly dealt with by the Holy See. That simple fact, however, does not mean that the faithful are free to act as though there were no guidelines at all. This is all the more reason why the present intervention on our part has been thought necessary.

The purpose of our statement is multiple. [1] We wish to offer guidance to Catholics involved in decision making, especially pastors of souls, those in the health-care profession and its beneficiaries. [2] We wish to offer our teaching as a way of engaging in a dialogue of public policy as it affects all those involved with legislative and judicial decisions. [3] We wish to present the developed tradition of a medical ethic which for centuries has guided doctors and patients alike to achieve the highest standards of health care and moral good. As Bishops we speak as official teachers and spokesmen for the Church, but we speak also as citizens concerned with the welfare of all in our society.

This issue is basic - the care for and preservation of life itself. Modern medicine offers us modes of care and cure once undreamed of, but such advances also raise serious questions demanding essential decisions. Many question whether they must initiate or continue various medical treatments. They wonder if and when it is allowable to stop even the basics of life, such as food and water. Court decisions and proposed legislation on living wills make these issues timely, even though they *cannot* be resolved on legal grounds alone, since they have an inescapable moral significance as well.

Bioethics based on philosophy and legal principles provide some guidance through the maze of problems in health care.(2) Yet it is also clear that philosophy and law alone do not adequately address all of the real concerns and pertinent issues. Religious bioethics makes an invaluable contribution to contemporary moral debates by offering insights into human nature, the purpose of life, the meaning of suffering and education to true virtue. These considerations assist doctors and patients alike to make wise choices both in everyday practice and in the most difficult of cases. Religiously grounded bioethics leads people to place their attention on the right thing to do and frees the autonomy of choice from a vision which can easily become narrow and even dreadfully wrong. We can humanize the face of technology by giving it a moral evaluation in reference to the dignity of the human person, who is called to realize the God-given vocation to life and love.(3)

## **STATE OF THE QUESTION**

Modern medicine continues to deal with age-old questions, even though current knowledge and technologies offer treatments and procedures that would once have been impossible. One such area is the supplying of nutrition and hydration to patients who are incapable of feeding themselves and are unable to take nourishment orally even with assistance. It is now possible to sustain the lives of such patients with a variety of techniques, and so arises the question of the moral obligation to do so. This question of moral obligation touches not only the patient, who has primary responsibility for the reasonable care of health and life, but also those who have responsibility for the patient who is no longer able to exercise self-determination.

The possibilities of sustaining life for extended periods of time raise other questions. Is it possible not only to keep a patient alive, but even to sustain apparent vital signs in patients who are in fact dead? There is ordinarily a moral obligation to do what can reasonably be done to sustain life. There is no similar obligation to sustain apparent vital signs in a patient who is already dead. In the past these questions would not have arisen. The patient who was incapable of taking nourishment, especially the unconscious patient, would have died. At present, however, we have a whole array of methods by which life support can be supplied even for those who are unconscious.

Decision making is further complicated by questions in regard to determination of death with a view to using organs as material for transplants into other patients. There are questions about the continued cost of long sustained unconscious life in view of the use of time, effort and resources that could otherwise be directed to care or treatment for other types of patients. There are questions also about the condition of unconscious patients (in terms of pain and suffering) and about the grief and suffering of family members who witness the process and who may participate in their care sometimes for months or even years.

## **DETERMINATION OF DEATH**

Even though theology may describe death as the separation of body and soul(4), this separation is not itself visible and directly verifiable. The Church has always had to rely on the use of medical signs or symptoms to determine just when death has occurred. Until recently these signs were simple enough: cessation of heart beat, cessation of respiration, fixed and dilated pupils, no sign of conscious response to external stimuli. We now sometimes find the need for other signs as well. Patients who exhibit all of the classical

signs but who have also experienced severe hypothermia (lowering of body temperature) have been resuscitated even after periods of time that would once have been fatal. Other patients who would have exhibited all of the classical signs do not do so, because they have been attached to respirators or heart-lung machines which supply oxygen and so sustain the vital signs for some time even after true death may have occurred. This has led to the medical need for other signs in addition to those previously universally used. The development of additional criteria is perfectly understandable even from a theological point of view, since it is still the effort to determine the definitive moment of separation of body and soul by means of signs and symptoms.

Advances in diagnosis and in the determination of death have also led to a more exacting distinction between death and various types of unconsciousness.(5) In the effort to find clear indications of death, medicine has developed criteria for brain death. These criteria have developed especially from the need to determine, as closely as possible, the moment of death in organ donors so that the organs may be used as soon as possible before serious decomposition begins.

In most cases the classical criteria are sufficient to determine the fact that death has occurred. Some patients, however, may be alive but do not show signs of life (e.g., victims of hypothermia or those under the influence of barbiturates or anesthetizing or paralyzing drugs). Others may be dead and yet show what appear to be vital signs (e.g., patients who are attached to life support equipment). In the former, life support equipment may be required until their condition can be determined. In the latter, the necessity for any treatment or life support has ceased. In either case there must be an honest effort to determine whether the patient is dead or alive. This is the purpose behind the move to the brain death criteria.

The norms generally adopted in medical care and in the Uniform Determination of Death Act(6) (which, in variously modified forms, has been legislated in many states) are variations of the "Harvard criteria."(7) Moralists have generally accepted these criteria as valid for our present state of knowledge of the nervous system, although newer information may lead to revision, just as new information led to the need for modification of earlier criteria.(8)

If the fact of death can be thus determined, then there is no moral obligation to continue medical treatment or care of any kind, since the person is dead. However, what concerns us here is the treatment that must be given to those who are not dead but who, for whatever reason, cannot supply their own nourishment.

## **STATES OF UNCONSCIOUSNESS(9)**

All states of unconsciousness are often referred to (even by medical personnel) as "coma." This is, in fact, not a correct designation.(10) Coma is but one type of impaired consciousness. There are also others which we should consider because all of them present situations in which problems may arise in terms of the supplying of nutrition and hydration.

A true *coma* is a state of "unrousable unresponsiveness" with no response to external stimuli. The person is not dead, but is in a state of sleep. *This condition is never permanent.*(11) It may last as long as six months, but it will resolve itself into some other state. The person may emerge into consciousness again or sink into another state, such as that which is referred to as the persistent vegetative state. It may take some time, even months, to diagnose the exact condition.

The *persistent vegetative state* (PVS) is deeper than a coma. The coma is a state of sleep; PVS is a form of deep unconsciousness. The cerebrum, the upper part of the brain, gives evidence of impaired or failed operation - and it is this portion of the brain, in its cortex or outer layer, which is responsible for those activities that we recognize as specifically human.(12) Another portion of the brain, the brainstem, is, however, still functioning in the PVS patient. It is this portion of the brain which controls involuntary functions such as breathing, blinking, involuntary contractions, and cycles of waking and sleep. Thus PVS patients may open their eyes and sometimes follow movement with them or respond to loud and sudden noises (although these responses will be neither long sustained nor apparently purposeful). There will be cyclical stages of sleeping and waking, but such activity is a function of the brainstem and is not an indicator of purposeful human activity."(13)

PVS is sometimes referred to as "cerebral death." This is an unfortunate terminology, since it seems to imply that there is "brain death" as described earlier. This is not true. There is a failure of function at one level in the brain, but not all, and *the person in PVS is definitely not dead.* Even medical personnel sometimes refer to such a patient as "brain dead." This is simply not the case.(14)

There is also a state which is referred to as *psychiatric pseudocoma*. This is a state of unconsciousness caused by shock or trauma which lead the victim to close off from the outside world. This may be so severe as to give the appearance of death, but it is not even truly a state of unconsciousness. It is simply total lack of response.

Finally, there is another condition which is referred to as the *locked-in state*. This condition is caused by an interruption in the

descending motor pathways of the nervous system. In this condition, paralysis, not cognitive failure, leads to a lack of ability to communicate."(15) The patient is fully conscious, but simply has no way in which to indicate conscious response. (In some cases, however, depending on where the motor pathways are interrupted, communication may be possible by such means as coded eye blinking.) It takes careful diagnosis not to mistake this patient for the PVS patient. PET scans can distinguish between the locked-in state and the persistent vegetative state. The EEG, however, cannot do so, since the patient in the locked-in state may show an abnormal response, while the PVS patient may produce readings that are near-normal.(16) Patients who have recovered from this condition reveal that they were indeed conscious and well aware of what was going on around them - and had a strong desire to continue to live.

In none of these classes of unconscious patients are we dealing with the dead. All of them are alive and some of them may well be expected to recover. The one case in which recovery becomes most unlikely is that of the PVS patient, and it is this patient who is likely to become the object of decision making in regard to continued treatment or care, or supplying of nourishment.

### **ORDINARY AND EXTRAORDINARY MEANS OF CARE(17)**

"The Catholic moral tradition holds that one is morally obliged to use the ordinary means of sustaining life, but is not obliged to make use of extraordinary means."(18) Ordinary means are those which are available and do not require effort, suffering or expense beyond that which most people would consider appropriate in a serious situation. This would include most of the developed procedures and techniques commonly practiced in medicine and surgery. However, moralists recognize that there are also subjective elements which influence our ability to make moral judgments. Subjective considerations of pain, expense and personal abhorrence may act as obstacles to the fulfillment of this obligation. Furthermore, not all techniques have to be used in every instance. What would usually be ordinary means may, in certain cases, offer little hope of success and may prove more burdensome than beneficial to the user. In such situations one would not be morally obliged to use such means.(19)

The distinction between ordinary means (which we are morally obliged to use) and extraordinary means (which we may choose to use, but are not obliged to) is not based solely on the commonness and availability of the means themselves, although this is taken into account. It is also based on the results that one can expect and on certain serious subjective considerations and attitudes as well. It takes into account the proportion between benefit and burden.

## **PRINCIPLES OF DECISION MAKING**

Decisions on the use of appropriate means for the preservation of life and health can sometimes be complex. One way in which to approach them is to ask questions which can illuminate the process and direct the questioner to the best sources for the answers. Those sources involve moral teaching, medical information and the concrete condition and means of the patient and the patient's family. What is being suggested here applies as a help to the decision making process for all patients, including both the conscious and the unconscious. Obviously, however, the process for the unconscious patient will involve the use of some sort of "substituted judgment."(20)

Is the procedure beneficial to the patient in terms of preservation of life or restoration of health? Is it serving a lifesaving purpose? Is it adding a serious burden? Is death already imminent, so that the proposed treatment may add briefly to the life span in such a way as simply to prolong the dying process without actually preserving life? Questions such as these must be directed to experts in the field of medicine, although in difficult cases even the experts may presently be unable to give final answers to all questions.

Is the procedure a grave burden to the patient, and has that burden become unbearable or intolerable? No one can actually answer that question except the patient or, perhaps, the patient's family. At the same time, suffering is a part of every life and has a spiritual and salutary significance. Judgments in this area must be tempered by the presence of the varying degrees of depression that any suffering patient or family may be experiencing. They may need help in overcoming the temptation simply to give up. At this point the pastoral counselor may be of considerable assistance. We must still recognize, however, the subjective aspect of "unbearableness" and must respect moral judgments made in good conscience. If the patient is not competent, then who is to make this sort of judgment? What motives will enter into that decision? Here again the pastoral counselor can be of considerable help and so too is the intimate knowledge that family members might be expected to have of the patient.

We must also realize that moralists and medical personnel may not always be using exactly the same definitions of ordinary and extraordinary means. Medical personnel often use the terms to refer to the means of treatment in themselves, considering them ordinary unless they are experimental or rarely used. The moralist must also take into account those other elements mentioned earlier, that is, the burdens and benefits the particular treatment may have for the patient or for others.(21) Thus the moral terminology is usually more

related to the condition of the patient(22), while the medical terminology is more related to the technique itself. The moral judgment is based on the benefit of the technique for the patient as compared to the accompanying burden, and not simply on the availability of the technique. Clarity on this point can help to remove one source of confusion.

Decision makers should also be aware that the decision to terminate a treatment is usually not *morally* different from the decision not to initiate that treatment in the first place. The same moral norms apply in each instance, but there are circumstantial differences. When treatment is initiated, the prognosis may not yet be clear. No one is able to predict the future course of events. The more definitive the prognosis, the more easily the moral norms can be applied in a concrete manner. However, it may take considerable time to determine that a patient has entered into a persistent vegetative state. The *duration of unconsciousness itself* is an important determinant in both diagnosis and prognosis. Maximum treatment is required in the earliest stages, while full or partial recovery still remains a greater possibility. Even the location or extent of brain or brainstem damage may not be an accurate indicator in every instance. Time and treatment are both required. In general, the younger the patient, the more likely is recovery. After three months the chance of recovery always lessens. Recovery after six months of the vegetative state is probably less than 1 in 100, and after twelve months almost never.(23)

It is most often when the treatments have run their course and the patient is clearly not going to recover that the decisions must be made. Prognosis and the condition of the patient may be clearer than they were at first. Even then, there is still a serious obstacle to easy decision making. No matter how clear the case may be by the time a decision is made, the decision to withdraw a treatment or some form of care already in progress is psychologically more difficult, since it is always hard for the survivors not to feel that its withdrawal was the cause of death.

## **PROVISION OF NUTRITION AND HYDRATION**

### **Feeding Methods**

There are various ways to supply nourishment to the unconscious. The general categories would include at least these three: Oral feeding, enteral feeding and parenteral feeding.

*Oral feeding* simply means that food (which may be pureed) or drink can be placed in the mouth and the patient will then swallow it. For some patients, even in the persistent vegetative state, this may be enough, provided that the swallowing reflex is sufficiently

unimpaired. At times, however, the medical staff will prefer not to use this method, even in cases where it could be used, since it can be quite time consuming for a staff that may already have a large number of patients to care for.(24)

*Enteral (within the bowel) feeding* means that the nourishment is placed directly into the upper end of the small intestine. This can be accomplished by means of a nasogastric (through the nose and into the stomach) or nasoduodenal (through the nose and into the upper end of the small bowel) tube, or it can also be done through a gastrostomy ( an opening directly into the stomach) or jejunostomy (an opening into the upper part of the small bowel). This method does not usually result in complications and, even if some complications do arise, they are usually not of a serious nature(25), but the method does presuppose that the gastrointestinal tract is intact and functioning.

*Parenteral (outside the bowel) feeding* refers to the supplying of nourishment intravenously. This may be done when the gastrointestinal tract is not intact or does not function. It may be accomplished for a short time by means of tubes inserted into the peripheral veins (e.g., in the arms or legs), but this can easily lead to thrombosis (clotting). Therefore, if it is to be used for longer periods, it is done by inserting a tube into the central venous system.(26) There is need for daily monitoring of nutrients, waste products and blood chemistry until the patient becomes stable, after which monitoring can be less frequent. This method of nutrition also carries with it greater risks of complications. Metabolic complications may arise, resulting in bone disease, liver dysfunction or other problems. There may also be nonmetabolic complications, such as thrombosis or the introduction of infecting organisms. However, the relative simplicity of this method is evidenced by the fact that in some situations it has been used as a form of home care allowing some types of conscious patients to resume many of their normal activities.

### **Decisions in Relation to Nutrition and Hydration**

There are instances in which it is relatively easy to apply moral principles to the decision to withhold or withdraw nutrition. In the case of a terminal cancer patient whose death is imminent, for instance, the decision to begin intravenous feeding or feeding by nasogastric tube or gastrostomy, may also mean that the patient is going to endure greater suffering for a somewhat longer period of time - without hope of recovery or even appreciable lengthening of life. Weighing the balance of benefits versus burdens makes it relatively easy to decide that this could fall into the category of

extraordinary means and that such feeding procedures need not be initiated or may be discontinued.

We are faced with a different set of questions when we begin to examine the case of the long-term patient who must be fed by some of the means described above (i.e., those more complicated than assisted oral feeding). The question of patients in the persistent vegetative state is particularly important. *There is no question here of "brain death," even though that term is so frequently misused in the media (who cannot always be expected to know better) and by medical practitioners (who certainly ought to know better).* The PVS patient is alive, but unconscious and, therefore, unable to take nourishment without assistance. It is clearly *not* a question of deciding to stop treatment because the patient has died.

Questions relative to the supplying of nutrition and hydration are often qualified by the term "artificial." The discussion thus tends to center on whether *artificial* nutrition and hydration are to be continued or not in certain cases. It is not, however, the question of whether a type of care is artificial or natural that makes the difference in terms of its continuance or discontinuance. The fact is that every mode of taking in food and drink is, to some extent, artificial. This is the case whether we speak of the patient receiving parenteral feeding or the honored guest at a banquet for royalty - a banquet which observes every nicety of the most sophisticated table manners and requires a certain expertise in the recognition of all appropriate cutlery. Both situations provide nourishment and both also use some artificial means to supply it. The real question, when it comes to decision making for the unconscious patient, depends in the final analysis on something other than a distinction between artificial and natural means. If the supplying of nutrition and hydration is of benefit to the patient and causes no undue burden of pain or suffering or excessive expenditure of resources, then it is our duty to take and to provide that nutrition and hydration. If the burdens have far surpassed the benefits, then our obligation has ceased.

A distinction is also often made between treatment and care. In the case of the patient in the persistent vegetative state, some would hold that we are obliged to continue to supply the proper *care*, but are not obliged to continue *treatment*.<sup>(27)</sup> The reason for this statement is that treatment in this instance is no longer useful in resolving the unconscious state of the patient. For many, then, it becomes a question of whether feeding constitutes treatment or care. If the former, then it may be discontinued. If the latter, it must continue. Statements by the Pontifical Council on Health Affairs and the Pontifical Academy of Sciences both hold to this distinction and

say that treatment may be discontinued, *but they then go on to explain that they view the supplying of nutrition and hydration as care - which must, therefore, be continued* (presupposing, of course, the distinctions already made in reference to the question of excessive burdens).(28)

There is, however, another way to look at this. In the case of the imminently terminal patient one would suppose that treatment is intended to reverse the course of the disease or, at least, to better the condition of the patient. If it no longer does that, then its discontinuance is no more than a clear recognition of its futility. Even feeding methods other than oral thus become futile and can be stopped so as to attend more to the comfort of the one who is dying. In certain clearly defined cases, then, even certain types of care might become extraordinary if they were futile or excessively burdensome.

*However, the patient in the persistent vegetative state is not imminently terminal* (provided that there is no other pathology present). The feeding - regardless of whether it be considered as treatment or as care - is serving a life-sustaining purpose. Therefore, it remains an ordinary means of sustaining life and should be continued. In other words, the mere distinction between treatment and care does not of itself resolve the moral problem. Rather, its resolution still remains within the scope of the usual norms of ordinary and extraordinary means. Whether it is viewed as treatment or care, it would be morally wrong to discontinue nutrition and hydration when they are within the realm of ordinary means.

What obligations, then, do exist? The moral obligation to preserve life and health falls immediately on the one whose health it is. Is one morally obliged to submit to procedures to supply nutrition and hydration? Or are they in the category of extraordinary care, and therefore not obligatory? Of course, in the case of the PVS patient, these decisions will be made by others, since the patient is incapable of making them. Obviously, the primary focus should be on the patient. With this in mind, then, we can begin to find our moral response by answering the questions proposed earlier, when we discussed the process of decision making.

### **Questions Related to the Medical Condition of the Patient**

*Is the procedure (supplying of nutrition and hydration) beneficial to the patient in terms of preservation of life or restoration of health?* Supplying nourishment sustains life; it does not of itself restore health to a former state. However, it is clearly beneficial in terms of preservation of life, since death would be inevitable without it and life will continue with it.

*Is it serving a life-saving purpose?* There is no doubt about the fact that it is, since the patient could not survive without it and is unable to supply it for himself.

*Is it adding a serious burden?* In almost every case the answer is negative. The means of supplying food in themselves are all relatively simple and - barring complications - generally without pain.

While there should be a presumption in favor of medically assisted nutrition and hydration, the judgment can legitimately be made that, in a particular case, they can be extraordinary. \*

*Is death already imminent, so that the proposed procedures (supplying of nourishment, in this case) may add briefly to the life span in such a way as simply to prolong the dying process without actually preserving life?* The pathological condition which has caused the persistent vegetative state or which is concurrent with it may threaten imminent death. Or it may be such as simply to make it impossible for the patient to care for himself. In this latter case the condition would not in itself be immediately life-threatening, but the lack of nourishment would be. Supplying nourishment would not be an instance of simply prolonging the dying process without actually preserving life. Life would be preserved at length and not merely temporarily prolonged while waiting for an imminently terminal condition to complete its course.

### **Questions Related to the Internal Disposition of the Patient**

*Is the procedure a grave burden to the patient, and has that burden become unbearable or intolerable?* In terms of the gravity of any burden, it is always the one who bears the burden who is in the best position to answer this sort of question. In the present case, however, we are dealing precisely with a patient who is incapable of giving any answer. So far as can be determined by observation, the unconscious patient is not experiencing the anguish that would be borne by a conscious person in these or similar circumstances. The parts of the brain responsible for the specifically human qualities of anticipation and anguish that so affect human pain are precisely those parts which are not now functioning. As to the intensity of any *physical* pain due to the increased atrophy of muscle, the discomfort of immobility, the feelings arising from various medical procedures, etc., there would seem to be no way at the present time to render final and definitive judgment, although the external signs in the unconscious patient do not indicate excessive discomfort which cannot be relieved by those who have charge of the patient's care.

The question as to whether the patient in the persistent vegetative state feels pain is not an easy one to address, since the patient is the very one who is incapable of answering any question about the

situation. Some of the problem, of course, is based on the way in which we view pain. There is a distinction between pain as a physical sensation and pain as the affective response associated with human suffering.(29) The response of the vegetative patient to noxious stimuli would indicate that there is a physical response to pain or discomfort. However, physical evidence also indicates that the affective level of human suffering is not present. Experience with such patients shows no behavioral indication of such suffering. Postmortem examinations usually reveal a degree of damage to the cerebral hemispheres sufficient to preclude the experience of suffering. PET scanning also shows a metabolic rate in the cortex so reduced as to be incompatible with consciousness.

We can say, therefore, that all appearances would generally seem to indicate that there is no excessive pain involved in the feeding process. The feeding procedures *themselves*, except where there may be some serious complications, may involve *some* discomfort, but nothing excessive (this can be determined from the reactions of conscious patients who for one reason or another, have undergone such procedures). Feeding methods do not generally carry with them the sometimes serious discomfort which would be found in the patient on a respirator.

As to the discomfort of being in this condition for years, unable to communicate and unable to help oneself, it is not possible to make a final and decisive comment. If, indeed, the patient is unconscious then there is no awareness of these inabilities and, consequently, none of the anguish that would attend them. However, we should note that some of what is being said is conjecture, since we have no way of knowing what is going on in the mind of the unconscious person. If we could indeed establish that there is pain, and that there is, in fact, considerable pain, then our answers might be quite different. That question, however, remains to be answered, although present consensus argues against the existence of such pain, mental or physical.(30)

### **Questions Related to Family and Caregivers**

*What motives will enter into "substituted judgments" given by others on behalf of the patient?* There is no doubt that a family undergoes considerable pain as it watches a loved one who remains for months or years in the persistent vegetative state. It is not at all unusual that members of that family find themselves, at times, wondering if death would not be a better alternative for the one who is afflicted. This feeling can and does arise out of love, compassion and concern for the sick person. It is also, almost always, influenced as well by the internal struggle experienced by those who are well. They experience the pain of loss as the person they love is now removed

from conscious communication with them. They experience their own exhaustion if they are very directly involved in the care for the patient. All of these are emotions that one would expect to find in such a situation. The family members, however, must be careful not to allow their own fears or frustrations to become the basis for the moral decision making that now falls to them. They must exercise for the one who is ill the same stewardship of life that is the obligation of each of us in our own regard. The desire to escape from our own burdens cannot become the source of a decision which would end the life of someone else.

There are, of course, other far less worthy motives which can inspire people to decide to terminate nutrition for the unconscious patient. Anger, spite, greed, culpable lack of concern and a host of other motivations can also be part of our human decisions. For this reason it is also desirable that the benefit of the doubt be given to the continued sustenance of the life of the unconscious person.

We must, however, take into real account situations in which the family has reached the moral limits of its abilities or its resources. In such a situation, they have done all that they can do and they are not morally obliged to do more. They would then have reached the limits of ordinary means. However, in the society in which we live this does not present a fully convincing argument. Resources are available from other sources and these can often be tapped before a family reaches dire financial straits. Such assistance has been and continues to be available.

### **EUTHANASIA OR ALLOWING TO DIE**

It would be unwise to complete our consideration of these questions without addressing the question of euthanasia. The word once referred to the effort to help make one's dying process easier. It has come finally to refer to some sort of intervention which actually brings about death.

Etymologically speaking, in ancient times *euthanasia* meant an *easy death* without severe suffering. Today one no longer thinks of this original meaning of the word, but rather of some intervention of medicine whereby the sufferings of sickness or of the final agony are reduced, sometimes also with the danger of suppressing life prematurely. Ultimately, the word *euthanasia* is used in a more particular sense to mean "mercy killing," for the purpose of putting an end to extreme suffering, or saving abnormal babies, the mentally ill or the incurably sick from the prolongation, perhaps for many years, of a miserable life, which could impose too heavy a burden on their families or on society.

It is necessary to state clearly in what sense the word is used in the present document.

By euthanasia is understood an action or an omission which of itself or by intention causes death, in order that all suffering may in this way be eliminated. Euthanasia's terms of reference, therefore, are to be found in the intention of the will and in the methods used.(31)

Alleviation of suffering through the purposeful destruction of the life of the sufferer is clearly contrary to true Christian respect for life and Christian love of neighbor. Yet, in our own time, this solution is proposed more and more frequently and even by doctors, whose very profession should be geared to the preservation of life."(32) It has been said that in the Netherlands as many as one sixth of all deaths are attributable to euthanasia.(33)

The movement toward murder as a solution to problems has already begun in the societal attitude toward the killing of the unborn. It is rapidly entering into the realm of the "hopelessly" ill. It can just as easily be extended to include the seriously handicapped, either physically or mentally. In none of these cases is it a question of the good of the patient, but more a question of the exercise of a questionable autonomy founded in equally questionable "rights" of the individual. Decisions such as this are all too easily based on the desires or fears or even inconvenience of others and the patient's wishes may not even enter into the question. That is certainly the case with abortion, and can just as easily become the case with the incurably ill. In both cases the decision is based on an attitude that there is such a thing as a human life not worthy to be lived. Those who are defective in some way are destroyed rather than cared for. It is an attitude which easily dehumanizes not only the victim but the perpetrator as well.(34)

In 1986 the Council of Ethical and Judicial Affairs of the American Medical Association stated that "it is not unethical to discontinue all means of life-prolonging medical treatment" for patients in irreversible comas. This statement has the weight of whatever prestige that Council holds, even though it was not the decision of a referendum of the members and does not tell us anything about how many of the members would support it. Nor should one be misled into thinking that the statement is based on the fact that such patients are suffering some sort of severe pain caused by the care that is being given them. This has already been discussed above, with the conclusion that there is usually no excessive pain due to such feeding. In fact, that same Council in 1990 said:

One aspect of the debate about stopping treatment in PVS focuses on a concern that the afflicted person would experience suffering

after treatment is stopped (e.g., will experience dyspnea after removal of a respirator or face discomfort associated with starvation and dehydration after removal of a feeding tube.) The most obvious contradiction to this projection is that, by definition, in PVS both the person's capacity to perceive a wide range of stimuli and the neocortical or higher brain functions that are needed to generate a self-perceived affective response to any such stimuli are destroyed. Pain cannot be experienced by brains that no longer retain the neural apparatus for suffering.(35)

But if the pain of the inability to breathe or the pain of starvation and dehydration cannot be felt, then there is no reason at all to support the contention that the removal of nutrition and hydration is being done out of concern for the sufferings of the patient. It must, therefore, be based upon something else; and what is that something else if not the decision that the life of this particular patient is not worth living? Sad to say, the intent is not to relieve suffering but, rather, to cause the patient to die. Nor can it be argued that it is merely the intention to "allow" the patient to die, rather than to "cause his death." The patient in the persistent vegetative state is not thereby in a terminal condition, since nutrition and hydration and ordinary care will allow him to live for years. It is only if that care is taken away - and barring any other new disease or debilitation - that the patient will die. It is the removal of the nutrition and hydration that brings about the death. This is euthanasia by omission rather than by positive lethal action, but it is just as really euthanasia in its intent.

There is a vast difference between allowing a terminal patient to die and doing something to hasten the death. We find no moral problem in those situations in which treatments are withdrawn because they have become an excessive burden rather than a benefit to the terminal patient. We find no moral problem in the withdrawing even of nutrition and hydration from the patient if the supplying of them is futile or excessively burdensome.(36) It is morally wrong, however, to take these extreme cases and make them the norm for all cases of persistent vegetative state patients, when treatment or care will allow that patient to continue to live and will do so without a burden of excessive pain or suffering. In such cases their removal is tantamount to passive euthanasia (killing by omission).

Much of the contemporary discussion seems to have lost sight entirely of the difference between allowing to die when no treatment or care can any longer save the patient and murder by omission. Recalling the moral truth that one is not obliged to employ means that are either futile or too burdensome, but must never intentionally act against innocent human life, we see a clear moral distinction

between *intending and allowing*. The latter is permissible in some circumstances - those involving extraordinary means - the former is always immoral and therefore forbidden.

## **CONCLUSION**

As a general conclusion, in almost every instance there is an obligation to continue supplying nutrition and hydration to the unconscious patient. There are situations in which this is not the case, but those are the exceptions and should not be made into the rule. We can and do offer our sympathy and support to those who must make such hard decisions in those difficult cases. We cannot and do not offer our support to those who are willing to remove from patients the means of sustaining nourishment on the ground that their lives are not worthy of our continued care and concern.

Respect for personal autonomy is a basic principle of medical ethics. This principle reinforces the duty of hospital personnel to secure the consent of patients or their surrogates before initiating or discontinuing treatment. It does not reduce them to mere functionaries who can do no more than carry out the orders of the patient or the patient's surrogate. The purpose of medicine is no more the mere satisfaction of patients' or surrogates' desires than the purpose of teaching is to give students only what they explicitly desire to learn. As a student of medicine the physician has a knowledge of health and the effects of disease. As a professional the physician is dedicated to keeping patients healthy or, at least, to relieving their suffering. When there are alternative treatments or courses of action, the physician will lay out the advantages and disadvantages of the various choices, and shows respect for the autonomy of patients not by merely acceding to their wishes but by telling them the truth and enabling them to make the right decisions. Neither the patient nor the surrogates of the patient have the moral right to withhold or withdraw treatment that is ordinary. Neither does the physician have the right to do so simply because the patient or the surrogates ask or demand this. In this perspective the physician responds to patient desires only if those desires accord with the proper professional and moral judgment as to what will promote the health, preserve the life or prevent the suffering of the patient. The physician's duty has not been properly done if there has been no effort to persuade the patient to follow the proper course of action. If the patient decides to refuse excessively burdensome or futile treatment, the physician may properly comply with that request. If the patient decides to refuse ordinary treatment, there may, in some instances, be little that the physician can do to prevent this, but there remains at least the duty to attempt to persuade the patient otherwise or, failing that, for the physician to

remove himself from the case so as not to be guilty of complicity in suicide.

It is important to recall that historically the practitioners and researchers in medical science have steadfastly and, in some cases, heroically striven to offer the very best of care to their patients. If some solution to a medical problem were not available, they gave their time, energies and sometimes even their lives and fortunes to find it, to invent it, to discover some way to preserve their patients' lives and alleviate their suffering. It is our hope that medical science will remain faithful to this wonderful heritage which has been of inestimable advantage to humanity. Using the talents that God has given them, those who have dedicated their lives to providing health care to their fellow human beings need to know that their work is respected and valued by all of us. The fact that there remains so much to do, even though so much has already been achieved, should not discourage them nor deter them from the search for further solutions to problems that we still face. New procedures may have to be found to resolve difficulties of suffering and discomfort. Cost effective and affordable treatments and care need to be developed so that the burden of caring for the ill will not impoverish families nor add unreasonably to their burdens. Diagnostic methods should be studied so that we can begin to ascertain with better certainty the pain that may actually be suffered by the unconscious. The tradition of health science shows that physicians and nurses have not avoided solving problems which human sickness and disease have presented in the past. We are confident that that same tradition will inspire present and future health care providers to do the same.

We ask also that those in the judicial and legislative fields bring their expertise to bear on these cases and that they will do so with full attention not only to the law alone but to the basic norms of morality and full respect for human life which ought to supply the proper basis for good law. Because of new circumstances generated by medical and scientific advances, there has been serious interest in advance medical directives such as the living will and durable power of attorney. It is quite reasonable to want to leave instructions regarding one's own health care in the event of incapacitation. It is not necessary to submit to procedures which are truly extraordinary or futile. But we caution all those involved in legislation and judgment that laws must have their true foundation in those same principles which guide our moral decisions. Recent court opinions have come very close to agreeing that simply because the patient wishes, nutrition and hydration can be discontinued, even when there is not a question of something that is overly burdensome or simply futile to the patient. The law and legal decisions should

never be such as to encourage the removal of the essential means of life and thus yield to a clear intent to bring about death and not merely to the willingness to yield to the fact of human life that all must die and that the day will come for each of us when this is inevitable. The laws must be just and must be based on unequivocal principles which identify the taking of innocent human life and make it illegal, with full recognition that it is already immoral. We should be most cautious and develop these principles very carefully since many of the arguments we have heard in favor of the removal of nutrition and hydration from one group of patients, those in the PVS for example, could easily be applied in the cases of other groups, such as the retarded, the elderly, the incurably crippled, and any other whose diseases modern medicine has not yet been able to cure. Naturally, it would be irresponsible to stand by idly and let such a tragedy occur.

Finally, we appeal to those whose loved ones are in this sad state of unconsciousness. We ask them to allow their pain to give life to an even greater desire to serve those whom they love. We offer our support, our consolation and our sympathy and we offer also our prayers and our spiritual support. We ask them to trust in the mercy and goodness of God in this situation just as they must do in every situation in life. We join with them in accepting the joy and the burden of stewardship for God's gift of life. We pray that they and we alike may hold lovingly to the gift of life itself, so that when the time comes for us to leave this world and enter into the fullest love of God, we may bring with us that deepest love of life which begins here and finds its fulfillment there.

## **NOTES**

1. Vatican II, *Dignitatis humanae*, 7 December 1965, n. 3. Translation from Austin Flannery, O.P., *Vatican Council II, The Conciliar and Post Conciliar Documents*, St. Paul Editions, Boston, MA ((c)1975 by Harry J. Costello and Reverend Austin Flannery, O.P.), p. 801.
2. What we teach is firmly rooted in the religious conviction (widely endorsed far beyond the Roman Catholic communion) that human life is sacred, that it comes from God and that the direct and deliberate taking of innocent human life is a most basic sort of moral wrong.
3. The Congregation for the Doctrine of the Faith emphasizes the need for science and technology to be at the service of the human person in *The Instruction on Respect for Human Life in Its Origin and On the Dignity of Procreation*, Vatican Polyglot Press, Vatican City, 1987, p. 7.

4. The terms "body" and "soul" as they are used here are not, of course, medical terms. They are philosophical terms which have been incorporated into the theological tradition in order to express the reality of the spiritual and physical components which together make up the whole person.
5. A listing of various types of unconsciousness may be found in *The Merck Manual of Diagnosis and Therapy*, Robert Berkow, M.D., Editor-in-Chief, Fifteenth Edition, Merck Sharp & Dohme Research Laboratories, Rahway, New Jersey, 1987, pp. 1331-1335.
6. "Uniform Determination of Death Act," *President's Commission For the Study of Ethical Problems in Medicine and Biomedical Research, Defining Death*, 1981, at 72-73.
7. The Harvard criteria came from a study conducted at Harvard Medical School in 1968. The criteria were not intended to replace the classical indicators of death, but were developed specifically for use in those cases where the determination of death might be questionable. Basically, the criteria came down to the following: (1) There should be total unawareness to externally applied stimuli, even those which are painful. (2) Observations of at least one hour by physicians reveal no spontaneous muscular movements or spontaneous respiration or response to any stimuli. If a patient on a mechanical respirator has normal carbon dioxide tension and has been breathing room air through the respirator for at least ten minutes, the respirator may be turned off for three minutes in order to observe whether there is any spontaneous effort at breathing. (3) There are no elicitable reflexes. The pupil is fixed and dilated and does not respond to light or pinching of the neck. Ocular movement and blinking are absent. There are no stretch, tendon, plantar or noxious stimuli responses. (4) The proper administration of an electroencephalogram (EEG) gives a flat reading. This criterion is considered confirmatory, but is never a sufficient indicator in itself. (5) All of these tests should be repeated 24 hours later, with no change. (More recent versions of the criteria limit the time to 12 or even 6 hours duration.) (6) The validity of these criteria is also cast into doubt if the cause of the condition is hypothermia or drugs which depress the central nervous system. [This summary of the criteria is based upon the description given by Thomas J. O'Donnell, S.J., in *Medicine and Christian Morality*, Alba House, New York, 1976, pp. 112-114. Cf. "A Definition of Irreversible Coma: Report of the Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death," in *Journal of the American Medical Association* {hereafter referred to as

- JAMA}, 205: 337-340, August 5, 1968.] That brain death includes loss of total brain function, - including that of the brainstem - is widely accepted. (Cf. *Uniform Determination of Death Act*, 1981; Fred Plum, M.D., and Jerome B. Posner, M.D. *The Diagnosis of Stupor and Coma*, Third Edition, Third Printing, (Philadelphia: F. A. Davis Company, 1982), pp. 315-316; Benedict M. Ashley, OP, Kevin D. O'Rourke, OP *Health Care Ethics*, Third Edition (St. Louis: Catholic Health Association, 1989), pp. 366-368.
8. As Doctor C. Everett Koop points out, there is need for continuing revision of norms for the determination of death. He says: "I think the situation can be very briefly summarized this way: what used to be called brain death wasn't brain death; it was the cessation of electrical activity on the cortex or thinking part of the brain as measured by electroencephalography. Today, brain death, which has tremendous relationship to procurement of organs for transplantation, means not only death of the cortex but total brain death, including the brain stem." (C. Everett Koop, *To Live or Die? Facing Decisions at the End of Life*, Servant Books, Ann Arbor, Michigan, 1987, p. 41.)
  9. A brief description of states of unconsciousness may be found in *The Merck Manual*, pp. 1331-1335. A slightly more detailed one is given by Fred Plum, M.D., and Jerome B. Posner, M.D., *The Diagnosis of Stupor and Coma*, Third Edition, Third Printing, F.A. Davis Company, Philadelphia, PA, 1982, pp. 1-9.
  10. Even the Harvard Medical School committee, in its development of the criteria for brain death, led to some confusion in its use of the term "irreversible coma" as though this could be equated with death. The comatose patient is *not* dead. One could, however, excuse that lapse since the document was written more than 20 years ago when there may still have been lacking some of the refinement of terminology that has since emerged.
  11. Cf. Council on Scientific Affairs and Council of Ethical and Judicial Affairs, "Persistent Vegetative State and the Decision to Withdraw or Withhold Life Support," in *JAMA*, 263: 427, January 19, 1990. The text reads: "Abrupt loss of consciousness usually consists of an acute sleep-like state of unarousability called coma that may be followed either by varying degrees of cognitive and physical recovery or by severe, chronic neurological impairment. The stage of coma itself, however, is invariably temporary and in progressive disease is often absent altogether."

12. The lack of function of the cerebral cortex is confirmed by the lack of human behavioral responses and by the lack of normal metabolic activity. The former can be seen by external observation, the latter can be confirmed by the use of positron emission tomography (PET scans), which measure the brain's use of glucose. It should be noted that an EEG may offer evidence of cortical activity, but it should also be kept in mind that the EEG is capable of measuring activity only on the outer-most centimeter of the brain's tissue. Even though current techniques for examining the condition of the brain become increasingly sophisticated, it should be noted that in many instances the real extent of brain damage cannot be fully assessed until a post mortem examination can be done.
13. It should be noted that this state is referred to as "vegetative," but that this should not be taken to mean that the person has become a "vegetable." This latter term is often used in a pejorative sense, when, in fact, the word "vegetative" refers rather to a level of functioning that is at an involuntary level and is sufficient to continue vital life processes, such as respiration, digestion, sometimes swallowing, etc.
14. That the PVS patient is *not dead* seems clear from the few reported cases in which such patients have revived either permanently or temporarily. On March 29, 1990, the Associated Press reported the case of a patient in Madison, WI, who had been a PVS patient for eight years and was accidentally revived when given a dose of Valium during the course of dental work. Combinations of drugs have kept him in lucid states for periods of 10 to 12 hours at a time since then. *Time* (March 19, 1990, pp. 70-72) reported the case of a woman whose husband had requested the courts for permission to remove life sustaining equipment after doctors told him that she was in persistent vegetative state. The courts refused, and six days later she woke up and is now in normal condition, except for some minor memory lapses.
15. *JAMA*, 263: 428, January 19, 1990.
16. *Ibid.*, p. 428.
17. Relying on natural law and divine revelation, Catholic moral teaching has identified two basic moral principles as expressive of the moral truth regarding the preservation or taking of innocent human life within the area of medical activity. The first of these -- one is obliged to use every *reasonable* means to preserve human life -- recognizes human limitations and poses the non-absolute duty to pursue and promote human life. The second -- one may never, for any reason, directly

intend to take innocent human life -- recognizes what is always in man's power, and absolutely forbids intentional acts of killing. The first principle makes possible the distinction made between extraordinary and ordinary means in the Church's discussion of medical-moral issues. It is this principle which allows us to recognize the fact that in certain instances an *already dying* patient may be allowed to die. The second principle forbids intentional acts of killing the innocent such as: direct abortion, infanticide, murder, genocide, suicide and euthanasia. (Cf. *Gaudium et Spes*, 27, 51) It should also be noted quite carefully that such intentional acts may involve either commission or omission. (Cf. *Jura et Bona, Declaration on Euthanasia, II*).

18. A history of the tradition of ordinary and extraordinary means can be found in Daniel Cronin's *The Moral Law in Regard to the Ordinary and Extraordinary Means of Conserving Life (Dissertatio ad lauream in Facultate Theologica Pontificiae Universitatis Gregoriana)*, Rome, 1958. This work has been recently reprinted by the Pope John Center, Braintree, MA, under the title, *Conserving Human Life*, 1991.
19. For a discussion of ordinary and extraordinary means see: Pope Pius XII, "The Prolongation of Life," *The Pope Speaks*, 1958; O'Donnell, *op.cit.*, p. 55; Sacred Congregation for the Doctrine of the Faith, *Jura et Bona, IV* (Declaration on Euthanasia), 5 May 1980; Ashley and O'Rourke, *op.cit.*, pp. 380-384. Although the terms "proportionate" and "disproportionate" are used in *Jura et Bona*, in place of "ordinary" and "extraordinary," we agree with Ashley and O'Rourke that the terms ordinary and extraordinary "are as accurate as any other terms when used with a view to particular patients and with the realization that from an ethical perspective, they have a different meaning than when used from a medical perspective." (Cf. *Health Care Ethics*, p. 382)
20. The concept of "substituted judgment" comes into play when one is unable to make necessary decisions for oneself. This is clearly the situation in the case of the unconscious patient. Others (e.g., immediate family members, relatives, legal proxy, etc.) are asked to attempt to make the *morally correct judgment* that the unconscious person would have made, had this been possible. This does not imply that the judgment of the conscious person is simply set aside and the judgment of another person is accepted in its place. Rather, the purpose of the process is to consult with those who presumably would have the best knowledge and insight into what the patient would have desired had this judgment been within his present

- capacity. It should be quite evident, however, that the surrogate decision maker would not be making a correct moral judgment if he were to concur in a suicidal intent on the part of the now unconscious patient.
21. Cf. Pope Pius XII, *The Prolongation of Life* op. cit. where he notes: "Normally one is held to use only ordinary means - according to the circumstances of persons, places, times and cultures - that is to say, means that do not involve any grave burdens for oneself or for another."
  22. It should be emphasized that in determining whether a particular means is ordinary or extraordinary one measures the benefits and burdens of the means for a **particular patient**. Therefore, the application of the principle is always "case specific."
  23. Cf. Fred Plum, M.D., "Artificial Provision of Nutrition and Hydration: Medical Description of the Levels of Consciousness," in *Critical Issues in Contemporary Health Care*, Pope John Center, Braintree, MA, 1989, pp. 55-59. Cf. also Plum and Posner, *op.cit.*, pp. 344-345. It should be pointed out, however, that there have been cases of recovery even after periods of years, as noted earlier.
  24. It should be noted that the use of feeding methods other than oral may sometimes be optional. Even when this is presented as needed for the "convenience" of the staff, it should not be assumed that this is necessarily meant in any self-centered way. Frequently enough, what is convenient for the staff also makes it possible to give each patient more overall attention and better care. It should also be noted, however, that a patient should not be put on optional methods of feeding other than oral, and then have the burdensomeness of these methods used as the excuse for discontinuing feeding altogether, even when it may be possible to return to oral feeding!
  25. Cf. *Merck Manual*, pp. 904-907.
  26. A standard method would be to introduce a catheter through the wall of the chest and into the vena cava. This is a much more serious process than we usually tend to imagine when we think of intravenous injection. This is, in fact, a surgical procedure and the proper placement of the catheter is verified by X-ray. Cf. *Merck Manual*, pp. 907-91 1.
  27. One example of this distinction can be found in *The Report of the Pontifical Academy of Sciences on the Artificial Prolongation of Life*, 1985. The text of this report may be found in *Origins*, December 5, 1985, and in *Conserving Human Life*, The Pope John Center, Braintree, MA, pp. 305-307. The

- document reads, in part: "By the term treatment the group understands all those medical interventions available and appropriate in a specific case, whatever the complexity of the techniques involved. 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. If it is clinically established that there is a possibility of recovery, treatment is required. If treatment is of no benefit to the patient, it may be interrupted while continuing with the care of the patient. By the term, "care," the group understands ordinary help due to sick patients, such as compassion and spiritual and affective support due to every human being in danger." Cf. also *Jura et Bona IV(Declaration on Euthanasia)*.
28. The statement of the Pontifical Academy of Sciences is quoted in the preceding note. The statement of the Pontifical Council has this to say: "On the contrary, there remains the strict obligation to continue by all means those measures which are called 'minimal,' which are intended normally and customarily for the maintenance of life (alimentation [feeding], blood transfusions, injections, etc.). To interrupt these minimal measures would be equivalent, in practice, to wishing to put an end to the life of the patient." (Quoted by Orvifle N. Griese in *Conserving Human Life*, p. 172.)
29. What is said here about pain can be verified by reading such sources as: Michael P. McQuillen, M.D., "Can People Who Are Unconscious or in the 'Vegetative State' Perceive Pain?" in *Issues in Law and Medicine*, Spring 1991, Vol. 6, No. 4, pp. 373-383; "Position of the American Academy of Neurology on Certain Aspects of the Care and Management of the Persistent Vegetative State Patient," in *Neurology*, 125 (1989), quoted by Kevin O'Rourke, O.P., in "Should Nutrition and Hydration Be Provided to Permanently Unconscious and Other Mentally Disabled Persons?" in *Issues in Law and Medicine*, Fall 1989, Vol. 5, No. 2.; Council on Scientific Affairs and Council on Ethical and Judicial Affairs, "Persistent Vegetative State and the Decision to Withdraw or Withhold Life Support," in *JAMA*, 263, January 19, 1990, pp. 426-429.
30. Since there is no way in which we can enter into the mind of the patient who is unconscious, we cannot offer definitive statements about pain. Some authors would seem to indicate that there may be pain. For example, we read "Pain is a complex phenomenon, neither necessary nor sufficient to explain suffering. An analysis of the neuroscience of pain leads to the conclusion that pathways sufficient for the perception and modulation of pain need not rise nor descend to levels

- generally thought necessary for consciousness. Pain may be expressed not only in language, but also in autonomic and motor behavior that can be shown to correlate in a linear fashion with subjective pain sensation. Patients rendered unconscious by anesthesia, or who recover from traumatic coma, manifest memories of their time without consciousness. Although by definition the unconscious patient cannot tell you that he perceives pain, available data suggest that he may; therefore, you cannot know that he doesn't." (McQuillen, *op cit.*, p. 383.) Others, however, would hold that such pain is impossible (cf. Council on Scientific Affairs and Council on Ethical and Judicial Affairs, "Persistent Vegetative State and the Decision to Withdraw or Withhold Life Support," in *JAMA*, 263, January 19, 1990.)
31. Sacred Congregation for the Doctrine of the Faith, *Jura et Bona, II (Declaration on Euthanasia)*, 5 May, 1980, translation from Austin Flannery, O.P., *Vatican Council II, More Post Conciliar Documents*, The Liturgical Press, Collegeville, MN ((c) 1982 by Harry J. Costello and Reverend Austin Flannery, O.P.), p. 512.
  32. In the medical literature itself there is clear and growing evidence that even doctors are beginning to look at the killing of patients as an alternative to treating or caring for them. In one editorial piece in *JAMA* (259, January 8, 1988, p. 272, "It's Over, Debbie"), a doctor describes his own intentional killing of a suffering patient, who *did not* ask him to do this. In a special article in *The New England Journal of Medicine* (320, no. 13, pp. 844-849, "The Physician's Responsibility Toward Hopelessly Ill Patients") ten of a group of twelve authors (all medical doctors) concluded that "it is not immoral for a physician to assist in the rational suicide of a terminally ill person."
  33. Quoted by C. Everett Koop, M.D., Sc.D., "Decisions at the End of Life," in *Issues in Law and Medicine*, Fall 1989, Vol. 5, No. 2, p. 226.
  34. Koop (*op. cit.*, p. 227) quotes from Doctor Leo Alexander writing in the *New England Journal of Medicine* in 1948 in reference to the euthanasia program in Nazi Germany. Once any life was deemed worthy of not living, then it merely became a question of an authority which would determine just how many groups of people would eventually fit into that category. Alexander wrote: "This attitude in its early stages concerned itself merely with the severely and chronically sick. Gradually the sphere of those to be included in this category was enlarged to encompass the socially unproductive, the ideologically unwanted, and finally all non-Germans. But it is

- important to realize that the infinitely small wedged-in lever from which this entire trend of mind received its impetus was the attitude toward the nonrehabilitable sick."
35. Council on Scientific Affairs and Council on Ethical and Judicial Affairs, "Persistent Vegetative State and the Decision to Withdraw or Withhold Life Support," in *JAMA*, 263, January 19, 1990, p. 428.
  36. The supply of nutrition and hydration can rightly be judged an extraordinary means because of futility, for example, when death is imminent (provided it no longer serves even as a palliative); and in cases where the patient is unable to assimilate what is being supplied.

\* This sentence was added in the 1999 revision.

(c) 1999 Pennsylvania Catholic Conference

Reprint permission is granted in limited circumstances. Contact [info@pacatholic.org](mailto:info@pacatholic.org) for more information.