

May 1994

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### Recommended Citation

Heaney, Stephen J. (1994) ""You Can't Be Any Poorer Than Dead": Difficulties in Recognizing Artificial Nutrition and Hydration as Medical Treatments," *The Linacre Quarterly*: Vol. 61: No. 2, Article 8.  
Available at: <http://epublications.marquette.edu/lnq/vol61/iss2/8>

# **“You Can’t Be Any Poorer Than Dead”: Difficulties in Recognizing Artificial Nutrition and Hydration as Medical Treatments**

by

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*The President's Commission Report Deciding to Forego Life-Sustaining Treatment comes down squarely in favor of two propositions: 1) artificial provision of nutrition and hydration are medical treatments, and 2) as such, these medical treatments may be foregone by certain categories of patients or their proxies. This latter conclusion is based on roughly consequentialist grounds; the former is more assumed than argued.*

*There is a school of thought opposed to both of these conclusions. After first demonstrating that nourishment is not medicine, a non-consequentialist or natural law argument is employed to show that nourishment may not be foregone insofar as it violates the principle, “First, do no harm.”*

*I was once a member of this school, and this paper was to argue its position. In the end, however, this paper adopts the position that artificial provision of nourishment and hydration can be medical treatments, and as such may be foregone by certain categories of patients, without violating a natural law understanding of “First, do no harm.” Still, exposing my retained sympathies for my former position, the paper attempts to argue for a very careful standard for non-treatment.*

*As a result, the argument of the paper takes four steps. First, I present the argument that artificial provision of nutrition is never medical treatment, giving as much strength to that argument as possible. Second, I show how the focus of that argument leads it astray, and that artificial provision of nourishment is medical treatment. Third, I try to show by what standard patients (or proxies) can legitimately forego this medical treatment. Fourth, I point out where my former position has valid criticisms of certain arguments used by those who hold that such treatment may be withdrawn, and urge great caution in deciding to forego treatment.*

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The President's Commission Report, *Deciding to Forego Life-Sustaining Treatments*,<sup>1</sup> makes it quite clear that it regards the artificial provision of nutrition

and hydration as medical treatment against which a patient or proxy may legitimately decide. This finding is in line with recent American Medical Association guidelines,<sup>2</sup> and an ever-increasing volume of writers in medical ethics.

For those in the "nourishment does not equal medicine" camp, there are several problems in the AMA/President's Commission approach that need to be discussed.

a) What are the *reasons* for considering nourishment and hydration as medical treatments? The literature is largely devoid of such explanations. In fact, the very question is often treated as though the answer is too obvious to discuss. This trait in the literature is illustrated in the following excerpt from an article by two well-respected Jesuit bioethicists; here they are invoking the authority of Gerald Kelly on the principle "no useless remedy is obligatory."

Kelly's application of the principle is instructive. He immediately asks if all artificial means are remedies, or are some, such as intravenous feeding, merely designed to supplant a natural means of sustaining life? He quickly dismisses the speculative difference as irrelevant and insists that in the world of sick people, all artificial means sustaining life are remedies for some diseased or defective condition. Kelly specifically applies this holding to the use of oxygen or intravenous feeding to sustain life in the so-called "hopeless" cases.<sup>3</sup>

This dismissive attitude toward those who hold a different position is stinging. The Commission Report cites yet another source which concludes that "distinguishing feeding as more obligatory to provide for these patients is psychologically rather than ethically based."<sup>4</sup>

Such a suggestion — that if we could just get over this mental hang-up about food then we would all be in agreement — is particularly insulting to those who have struggled hard to clarify meaningfully the distinction between food and medicine. In fact, those who consistently distinguish between the two are convinced that collapsing nutrition into the category of medical treatment misses — or worse, ignores — several fundamental ethical points. Which brings us to the second question.

b) How do these ethicists understand and interpret the ethical questions and principles involved? For instance, what *is* medical treatment? What can we expect from it? Are there different expectations of nutrition and hydration? In emphasizing a benefit/burden or proportionality analysis, what has happened to the Hippocratic injunction, "First, do no harm"?

When I originally set out to write this paper, my position was that nutrition and hydration are *never* medical treatment. I have since altered my position, but I still have some fundamental sympathies with the arguments leading to my former position. What I would like to do in this paper is 1) present my original argument, giving as much strength to that argument as I can; 2) show where it goes wrong; 3) show what sorts of patients (or proxies) can legitimately refuse this medical treatment; 4) point out where my original position properly criticizes certain arguments used by those who hold that provision of nourishment can be medical treatment.

## The Argument Against Nutrition as Medical Treatment

Since the majority of the literature on the topic seems to have decided that provision of nutrition and fluids is medical treatment, the first question to be asked would be, what is a medical treatment? Then we can decide whether a particular patient situation adequately fills this bill.

People would, I think, normally define "medical treatment" as an action or group of actions performed to alleviate or neutralize some sort of pathological condition or disease. This would include chemicals or antibiotics meant to cure, or at least hold in abeyance, an invading disease, such as influenza, or internal breakdown, like cancer; surgery or other lesser physical manipulations of damaged parts — setting broken bones, traction, suturing, care of abrasions. Normally, we think of this care as provided by a doctor or other health professional, but it may consist of the Band-Aid or cough syrup provided by "Dr. Mom."

A second question to be answered is, What are the responsibilities of those who have been entrusted with the patient's care? Normally, a relatively mature person has the responsibility for his or her own care. When the person becomes a patient, however — when mental incompetence or physical disability or lack of expertise renders self-care difficult or impossible — one counts on others to provide for certain needs, and these care-givers assume corresponding responsibilities. 1) The patient must be provided with the basic necessities of life. These would include air, protection from exposure, and nourishment and fluids. 2) The care-giver is called on to provide a humanly dignified environment and to reduce the patient's discomforts. For many patients who cannot attend themselves, this might include providing for sanitary needs, or prevention of loss of circulation or bed sores. 3) The patient's pain resulting from this medical condition should be eased, if possible, and 4) the care-giver should attempt to provide appropriate medical treatment, i.e., provide some way of eliminating or stabilizing the condition or disease.

Sometimes, the first two categories are provided under medical supervision; medical personnel, because of their expertise, will know the best ways of providing these things for the patient's overall comfort and well-being. This does not thereby render them medical treatments. If a doctor suggests to me that I walk around to improve my circulation or eliminate indigestion, or even to promote healthy convalescence of sutured muscles, one would call this sound advice, but would be hard-pressed to call walking around "medical treatment."

The question is next asked: If provision of nutrition and hydration to a patient who cannot provide these for himself are to be considered medical treatment, then what do food and water treat? Clearly, food and water treat nothing (with the possible exception of *mal*-nourishment and *de*-hydration). They do not make a sick person well, but rather, *without* them, the person becomes sick and, eventually, dies. For all other conditions, with subsequent medical treatment, the body is running, and then breaks down. Food and water (along with oxygen) are the fuel that keeps the body running. These are basic necessities for life itself; without them, there is properly speaking no ability to become otherwise

diseased or damaged.

For this reason, it is especially peculiar, to those who hold that provision of food and water can never be medical treatments, to find, for example, the carefully worded statements of the Vatican's 1980 *Declaration on Euthanasia* used to promote the denial of such basic care in certain cases. John Paris and Andrew Varga, for instance, construe the following passage from the Declaration as support for this position: "It is also permitted, with the patient's consent, to interrupt these means (treatments), where the results fall short of expectations."<sup>5</sup> One can only ask, what expectations can one have about nutrition and hydration? Surely, no one expects them to cure the patient. How could they ever fall short of the modest expectations one can reasonably demand of them?

### **Moral Principles Involved in the Issue of Withholding Treatment**

Supposing that nutrition and hydration are not properly medical treatments, we must ask: Does it really make a difference to the actual provision of nourishment whether it is regarded as a medical treatment or not? Whichever it is, if it is providing no benefit to the patient, we are obliged to continue to supply it?

If your basic approach is utilitarian or consequentialist, the answer is clearly No. All foreseeable consequences of the action are examined, weighed on the scales of burdens and benefits, and a course of action chosen. This path the President's Commission has taken.<sup>6</sup> Following such a path, there is no way to reach the absolute position — that nutrition and hydration must always be provided for the person who can be nourished — a position which is the mark of the holder of the thesis "provision of nourishment is never medical treatment." One must hold a type of ethical system in which human beings have an inherent value, and certain actions (at least some) say something independently of the intention of the agent. Such a system is natural law (in all its varieties).

Analyzing proportional benefits is not completely foreign to the tradition of natural law but, in that tradition, benefits and consequences serve a secondary function. What is of primary importance is the action itself and its meaning apart from any particular agent who performs it, regardless of any consequences not necessarily attached to that action. In a way, even for the natural law tradition, it does not really make a difference whether or not provision of nourishment is medical treatment. The same moral principles apply in either case.

According to this tradition, what am I attempting to do in any action? In some way, I am attempting to fulfill myself. This is not self-fulfillment in the sense of self-aggrandizement, but rather in the sense of following my proper nature, of "becoming" in a properly human way. It would make no sense to attempt to fulfill my humanness by attacking humanness in myself or in another; there would be something illogical, something contradictory, about such an attempt. Thus the basis for the Hippocratic rule: "First, do not harm." No action can be ethically correct which, by the intention of the actor or the very meaning of the action itself, attacks a human being. I may attack a disease or condition, but not a human being.

The same principles apply to all actions we do, and thus are equally applicable

to treating a person medically: 1) the treatment might prove beneficial in curing the condition, in which case it is permissible and encouraged; 2) the treatment might actually be detrimental to the patient, causing some damage, in which case it attacks the person, rendering it impermissible; 3) the treatment might be neither helpful nor harmful, at best holding steady, and at worst losing ground to the condition. In this case, I may continue it or end it, based on the grounds of burdens vs. benefits.

This is the crux of the question. Having passed the basic ethical test of "Do no harm," medical procedures are then judged appropriate, measured on the scale of proportion: Does this treatment provide some sort of benefit proportional to the discomfort? Therefore, what makes the withdrawal or non-use of useless treatment permissible is not (simply) that the burdens outweigh the benefits. More fundamentally, it is the fact that withdrawal or non-use *does not attack* the patient; it does no more harm to the patient than what the disease or condition already supplies. Thus, when cancer is marching apace through the body of a patient faster than it can be combated, one may stop the treatment. Why? The treatment is doing no good against the disease. Non-treatment here does not attack the person, even though the patient's death *may* come faster. It does no good to use the treatment; it does no (more) harm to stop it.

What about the denial of nutrition and hydration to a dying patient? Let us take the same cancer patient, being nourished by a nasogastric tube or gastrostomy. Since it does nothing toward curing the patient, why not simply stop it? The response comes back loud and clear: nourishment is not *supposed* to cure the patient, and it never can. In this case, providing it for the patient may do no (more) good, but denial of nourishment *directly harms* the person. Without a medical treatment, a person may (even against improbable odds) survive; without nourishment, one cannot survive. The withdrawal or denial of nourishment and hydration attacks the person by deliberately adding a *new* debilitating condition to the person's health, a condition for which I as care-giver am responsible, not some force of nature or accident. It attacks the person as really as if I placed him in a vacuum, or left him on a mountainside to die of exposure. As Gilbert Meilaender puts it:

Remove him from a respirator and he may die — but then, he may also surprise us and continue to breathe spontaneously. We test to see if the patient can breathe. If he does, it is not our task — unless we are aiming at his death — now to smother him (or to stop feeding him).<sup>7</sup>

Death comes from deprivation of nourishment with the surety of death as the result of having the air sucked out of a room.

There are situations in which nutrition and fluids need not be given, but only if ceasing nourishment does *no more harm*.<sup>8</sup> Only two situations pass the test. a) Giving nutrition or fluids actually causes problems. Here, providing the nourishment constitutes an attack on the person. b) The failure to provide nourishment does no more harm to the patient than the condition that patient already bears, and so it can be weighed proportionally. One instance of this is when the nourishment is not absorbed by the body. Giving such nourishment would be a waste, equivalent to simply throwing it out. A second possibility

would present itself in the situation of a patient very near death. Failure to take in some sustenance will not harm a patient any more than the progressing illness will, and might in fact provide the patient a few hours or days of freedom from tubery, and some peace of mind in preparation for death. Only in these two situations is failure to provide nourishment ethically justifiable, according to this scheme.

### **Can A Patient Ever Refuse Treatment? The Principle of Totality**

It seems clear from the foregoing argument that, as long as one holds that nourishment is *not* medical treatment, the caregiver could not legitimately withhold or withdraw it from a patient. Could a patient, however, *refuse* nutrition, especially if it is artificially provided and such living has proven burdensome, for himself or his family? In such a situation, a clear wish of the patient could release the providers from responsibility. The possibility of ethical refusal would also give such care-givers an opening for a decision to withhold nourishment in the case of an incompetent patient.

The Catholic tradition, of which I am a part, following natural law principles, has provided some answer to this question, set out fairly clearly by Pope Pius XII as the principle of totality.<sup>9</sup> This principle indicates that I may destroy a part—even a healthy part—of my body for the sake of the whole. The “whole” here may refer, not just to the body, but to the spiritual whole as well. In other words, for the greater personalistic good, I may destroy a part of my body. This greater personalistic goal must be of great importance, and *achievable by no other means*. An important limitation is attached to this principle, however: I may not destroy the life of the whole body for the sake of the whole, or for the sake of a part. This would be equivalent to the Vietnam justification, “We destroyed the village in order to save it.” Save it for what, if it no longer exists? The same applies to my earthly life—which properly speaking is the realm of ethics. The denial of nutrition and hydration is precisely that—an attack on the life of the person.

We have already seen two situations in which deprivation of nourishment—by regular or artificial means—does not constitute an attack on the person. The area of real concern, however, is when the food does nourish, it does no harm, and is artificially administered. Having been at one point solidly in the “nourishment does not equal medical treatment” camp, I now hold that artificial provision of nourishment is medical treatment. What forced me to alter my position?

### **When Provision of Nourishment IS Medical Treatment**

The difficulty for those who say that provision of nourishment is never medical treatment, and thus its withdrawal never justified (except in the two situations listed), lies in where their arguments focus; the solution lies in changing that focus. In developing as strong a case as I can for this position, I have tried to put the focus in the same place as its strongest advocates. That focus is on the nutrition and hydration itself. Nourishment and fluids are not in themselves medicines or treatment for any malady except their lack.

The real question, however, lies not with the nutrition or hydration, but in the

means of delivery. The procedure that raised these questions in the first place is the provision of nutrition and hydration by artificial means: by intravenous tube, by nasogastric tube, by gastrostomy tube. There are some who would object to this distinction by saying that delivery through a few inches of plastic tubing or by medical personnel does not thereby magically transform the food into medicine. While this observation is correct, however, the objection misses the point. The key issue here is that the means of delivery is itself a treatment for some condition.

What, for example, does dialysis treat? It treats kidney failure. It does this, not by making the kidneys better, but by performing the kidney's functions. A person is generally held to be within his or her ethical rights to dispense with further treatment if it becomes disproportionate to the benefits obtained.

What does tube feeding treat? It treats an inability to ingest (enough) nourishment. This may be due to unconsciousness, or an inability to swallow, or the fact that food by mouth would cause the patient harm. In other words, it performs the same kind of function that dialysis or a respirator might perform: it does the job of a non-functioning part of the body. Thus, it is medical treatment, and its non-use may be perfectly legitimate in more cases than the two outlined earlier, without thereby incurring the stigma of doing the patient harm. According to George Annas,

A gastrostomy tube is *not* [to use the words of Paul Brophy's guardian ad litem] "a need common to all human beings"; it is an intervention required by Mr. Brophy *because of his injury*; and if it is withheld, Mr. Brophy will die as surely from the "natural course" of his illness as Karen Ann Quinlan would have had she been removed from her ventilator (instead of being carefully weaned from it).<sup>10</sup>

He further remarks: "Food and water may be 'basic,' but deprivation of air is at least as basic and withholding it will lead to death as surely, and much more swiftly."<sup>11</sup>

### Grounds for Legitimately Foregoing Nutrition and Hydration

Having decided that artificial means of providing nutrition and hydration are medical treatments, the question remains: When can they legitimately be foregone? The patient in the persistent vegetative state is one instance of a very difficult circumstance: the person with long-term (possibly permanent) inability to eat and drink, yet who is not dying.

As Daniel Callahan put it, "The time to curtail abuses in the future is to begin now in trying to go through those steps that will draw lines very carefully."<sup>12</sup> For those who hold that even artificial means of provision of nourishment and fluids does not equal medical treatment, the line has already been crossed; once you can stop feeding someone, there is no logical or ethical difference between this and supplying a lethal injection. Since, as we have seen, artificial provision of nutrition and hydration *is* medical treatment, the line has not necessarily been crossed, but we appear to have come right up to it. What needs to be found is some standard of non-treatment.

For some insight into this area, let us turn to Richard McCormick's 1974 article, "To Save or Let Die." The thrust of his argument is that human



living is for human relationships, for knowing and loving the world around us and those people we encounter in it. He reminds us that "life is not a value to be preserved in and for itself," but rather "is a value to be preserved only insofar as it contains some potentiality for human relationships." When this potentiality no longer exists or would be completely submerged in "the mere effort for survival," we can judge that such a life has reached its potential, and that any means to keep it going are "extraordinary" or disproportionate.<sup>13</sup>

So the two focal points in this analysis would be 1) is there no more potential for properly human living or relationships? and 2) will the living remain buried in merely staying alive? If one or both of these criteria are met, then the patient may be allowed to die through lack of treatment. Two very important points of clarification need to be raised here, however.

a) Adoption of this standard and the subsequent choice against nutrition do not amount to saying "It is better to be dead than alive."<sup>14</sup> Rather, the patient is saying, "It is better to *live* this way rather than that." As McCormick himself puts it, such a choice "need involve only a thoroughly Christian assertion that there are values greater in life than living, that we all retain the right to decide how we shall live while dying."<sup>15</sup>

b) Adoption of this standard is not equivalent to saying that certain non-dying patients, especially ones in persistent vegetative states, are therefore merely vegetables, and that it is of no use maintaining a merely biological existence.<sup>16</sup> As Gilbert Meilaender notes, such a view is unnecessarily dualistic, separating personhood from the body.<sup>17</sup> Edward Bayer concurs. Speaking from the Catholic metaphysical tradition, he points out that it is not just the soul who is the person, but body and soul together make one being, one person. The body is not a belonging like a coat, nor could one legitimately claim that killing the body does not kill the person.<sup>18</sup> Even Catholic authors can make the same mistakes. McCormick himself apparently slips on this issue. Interpreting (with John Paris) his own 1982 testimony before the President's Commission on Ethical Problems in Medicine, McCormick writes the following:

[T]he question was asked whether there was any moral difference between removing a respirator, antibiotics or artificial feeding from Karen Ann Quinlan. The reply from the Catholic tradition was clearly, "No." If, for example, she were to contract pneumonia, there would be no need to use antibiotics because she would stand to gain nothing from such an intervention. A similar argument could likewise be made with regard to the continued use of feeding through the nasogastric tube.<sup>19</sup>

Several things are wrong with this interpretation. The first we mentioned earlier: what are the expectations of each of these treatments? If we expect them to bring the patient back to perfect health, then naturally these limited measures will "do the patient no good." This is not a reasonable expectation from the antibiotics, or from feeding. The second problem is that the argument implies that the treatment affects only the body, and the *real* patient, the person, remains somehow unaffected. This is a dualistic attitude, at odds with a proper understanding (or certainly with a Catholic understanding) of the person.

The third point comes even if we assume that no dualism is intended. The basic

point is that McCormick's comments seem to be saying, "This person has so little, it's not worth trying to retain." Analogously, one might argue that, if the poverty level is ten thousand dollars per year, and person P is only bringing home ten dollars a week, we could prevent person P from receiving his paltry sum because "it is not doing him any good." It seems to me that even this ten dollars is doing the person some good, that without it one is definitely worse off, and (relative to our patient, and in the words of Flanner O'Connor), "You Can't Be Any Poorer Than Dead."

This seems to be the point that several other writers are making, especially in regard to patients who are just plain not dying, such as the PVS patient, who will continue to live indefinitely as long as the care-giver provides the necessities of life—air, nutrition and protection. Given the fact that PVS patients do occasionally (albeit rarely) recover, these patients do retain some potential for human relationships, although the chance that these relationships might be regained is admittedly very small. Still, it is something. This being the case, we should consider Gilbert Meilaender's arguments against withdrawal of artificial means of nourishment in cases of persistent vegetative state. Stopping a respirator is not quite the same as stopping nutrition. With a respirator, the person can spontaneously begin breathing.<sup>20</sup> There is the possibility of weaning a person from a respirator, even one in a coma or PVS. There is no such possibility with artificial means of supplying nourishment. You cannot take a patient off it without the patient's being conscious. Another difference lies in the accessibility. If you do not make the patient's diaphragm work, at least the air is right there for him to breathe should he be able to do so on his own, even if he is unconscious. Not so with food. The patient does not live in an environment of food, ready for intake should his spontaneous bodily apparatus start drawing it in. It must be supplied, and in this regard ceasing to provide nutrition and hydration takes on more the flavor of denying the patient air, not just assistance in breathing.

The point here is that there does seem to be a real difference (Gerald Kelly's comments notwithstanding) between medically assisted nutrition and hydration and any other form of medical treatment, including other life-sustaining measures. Statements by the Pontifical Academy of Sciences and the New Jersey bishops calling for maintenance of nutrition and hydration as part of normal care seem to have had this distinction in mind.<sup>21</sup>

Furthermore, there is the real danger of creeping euthanasia, based on unsound principles or unprincipled actions. There does seem to be a progression (not to be confused with "progress") toward making more and more medically supervised activities optional, which becomes particularly dangerous for the incompetent patient. David Wikler notes the parallel march toward looser and looser standards in regards to the types of patients for whom medical treatments become "optional": first it was for "brain dead" patients, with a corresponding redefinition of what constitutes death; then it was the PVS patient dependent (or at least thought to be dependent) on a respirator, until today it is a question of removing *all* artificial means of life-support, even for a patient who "had not yet reached the last stage of dementia."<sup>22</sup>

The line separating us from the on-coming traffic of so-called "mercy killing"

is difficult to see when the conditions are so foggy and we are justifiably frightened when we try to dance on a line we can hardly see. Still, the line is there, and it is our task to stake it out, so that we will not become guilty of altering our understanding of medical treatment to the point where we think of denial of nutrition and hydration as "the only effective way to make certain that a large number of biologically tenacious patients actually die."<sup>23</sup> We must take care not to think of the dying or the permanently unconscious as bodies taking up space, as empty human shells that just will not kick off.

While I retain sympathies for those who oppose foregoing nutrition and hydration, however, and advocate in most situations its retention until death is imminent, we must keep in mind the fact that, while death is not preferable to life, some ways of living are better than others; that, while it may be difficult to see the burden that a PVS patient could possibly experience by being maintained on artificial life-support, it may well be that other burdens are too heavy to be borne. Families are just as much affected by McCormick's principle that living should not be buried in the simple maintenance of existence; families have lives as well, and there is a point at which they become buried in their loved one's simple survival unless the patient or the guardians are permitted to say, "That is enough." What is required is that they take with the utmost seriousness the injunction, "First, do no harm."

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5. John Paris and Andrew Varga, "Care of the Hopelessly Ill," *America*, September 22, 1984, p. 141. Cf. Sacred Congregation for the Doctrine of the Faith, *Declaration on Euthanasia*, May 5, 1980. Interestingly, Paris and Varga seriously misinterpret this passage. They have taken the words "such means" to signify *any* treatments, especially life-sustaining ones. It is clear from the immediately preceding passage, however, that "such means" indicates experimental and highly risky treatments which do not accomplish hoped-for results.
6. President's Commission, *Deciding to Forego Life-Sustaining Treatment*, p. 80, n. 110.
7. Gilbert Meilaender, "On Removing Food and Water: Against the Stream," *Hastings Center Report*, December, 1984, p. 12.
8. Joanne Lynn and James Childress suggest several types of situations in which artificial delivery of nutrition and hydration may be denied: when the treatment is futile, when it offers no possibility of benefit, and when it presents a disproportionate burden. Two of these must be rejected by those who do not consider nutrition a medical treatment, for failing the "Do no harm" test. See Lynn and Childress, "Must Patients Always Be Given Food and Water?" *Hastings Center Report*, October, 1983, pp. 18-19.
9. Pius XII, *Discorsi*. See "To Urologists," p. 198; "To Plastic Surgeons," p. 722; "To Pharmacologists," pp. 695-96; "To Catholic Medical-Biologists Union of St. Luke," p. 46; "To

Histologists," p. 198. For a clear, concise layout of this principle as conceived in the writings of Pius XII, see Edward J. Bayer, *Rape Within Marriage: A Moral Analysis Delayed* (Lanham, MD: University Press of America, 1985), pp. 67-74.

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15. McCormick, "Caring or Starving?" p. 272.

16. Bonnie Steinbock interprets John Paris' testimony in the Clarence Herbert case to be just such a claim. See Steinbock, "The Removal of Mr. Herbert's Feeding Tube," *Hastings Center Report*, October, 1983, p. 15.

17. Meilaender, p. 12.

18. Edward Bayer, "Perspectives from Catholic Theology," in Lynn, ed., *By No Extraordinary Means*, pp. 89-90.

19. Paris and McCormick, p. 360.

20. Meilaender, p. 12.

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22. David Wikler, "Not Dead, Not Dying? Ethical Categories and Persistent Vegetative State," *Hastings Center Report*, February/March 1988, p.41.

23. Daniel Callahan, "On Feeding the Dying," *Hastings Center Report*, October, 1983, p.22.

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