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# The Catholic Moral Tradition on Providing Food and Fluids

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Catholic documents, and specifically the Vatican *Declaration on Euthanasia* of 1980, frame the discussion on care of the terminally ill with the fundamental assertion that life is a gift which we hold in trust, not a possession over which we have absolute dominion.<sup>1</sup> It is our moral responsibility to nourish, preserve and protect life, while acknowledging our human limitations—ultimately the limitation of death itself. The Catholic position on the use of life-sustaining treatment in the care of the terminally ill derives from these basic convictions about life and death.

To recognize that life is a gift and death an unavoidable end to human life as we experience it day by day is not yet to tell the whole story. Catholics believe that, despite the universal human experience of death as a mysterious and fearsome rupture, it is also the only passage to the fullness of life. As believers, Catholics try to comfort each other and encourage one another to welcome that fuller life in Christ even in the throes of fear and pain. In these moments people become aware of their vulnerability as human beings. They learn that to be human—especially in a health care setting where there is so much sickness and death—is to live as gracefully as possible the tension between trying to eliminate threats to life and health and accepting the fact that some life threats cannot be eliminated.<sup>2</sup>

Broadly speaking, any intervention which will eliminate a threat to life or health, e.g., antibiotics, can be said to be life-sustaining, as can any treatment which supplements a physiological function, e.g., insulin or blood products. However, the treatment decisions which have caused the most consternation are those that artificially supplant vital functions, such as kidney dialysis machines and especially respirators.

Among the questions about whether to provide certain life-saving treatments to patients, the most difficult, perhaps, are those that ask about the withholding and withdrawing of nutrition and hydration provided through IVs or feeding tubes. These questions will be addressed here within the context of traditional Catholic teaching on the terminally ill. That is, we will not treat these questions as if they required their own kind of justification, but as questions already covered by the principles which govern the use of ordinary and extraordinary means. Catholic moral discourse on these questions reflects a strong emphasis on the morally decisive importance of the patient's well-being in all decisions about continuing or withdrawing life support treatments. Because there are a number of important ways in which the situation of a severely disabled newborn infant differs from adults who are near death, I will not attempt to address here the special case of the seriously ill newborn.

### **Catholic Teaching on Ordinary and Extraordinary Means**

Since the moral theologian, Banez, introduced the terms "ordinary" and "extraordinary" means into the discussion of our duties regarding the preservation of life at the end of the 16th century, we have learned that we are obligated to take "ordinary means" to sustain our life and health, but we are not obligated to take "extraordinary means". The theological commentary which followed Banez attempted to clarify what these terms meant in practice by identifying what should count as extraordinary (e.g., surgery before antiseptics and anesthetics). Some treatments were declared extraordinary because too painful, repulsive to the patient or expensive. Early definitions of ordinary means as "what nature intends" or "what is generally available to all", turned out to be less helpful in the context of clinical medicine. In the 1940s and early '50s, Gerald Kelly reviewed the history of these basic moral terms and formulated working definitions more apt for evaluating the practice of modern clinical medicine.<sup>3</sup>

His updated definitions made a distinction between ordinary means and extraordinary means which labeled "extraordinary" those which "cannot be obtained or used without excessive expense, pain, or other inconvenience, or which, if used, would not offer a reasonable hope of benefit", and *ordinary*, those which "offer a reasonable hope of benefit and which can be obtained and used without excessive expense, pain or other inconvenience".<sup>4</sup>

### **Cronin Reworked Definitions**

Daniel Cronin reworked Kelly's definitions in a way which gave slightly more emphasis to specific circumstances and the uniqueness of the individual patient:

Ordinary means of conserving life may be defined as those means commonly used in given circumstances, which this individual in his present physical, psychological and economic condition can reasonably employ with definite hope

of proportionate benefit.

Extraordinary means of conserving life may be defined as those means not commonly used in given circumstances, or those means which this individual in his present physical, psychological and economic condition cannot reasonably employ, or, if he can, will not give him definite hope of proportionate benefit.<sup>5</sup>

Both of these sets of definitions reflect clearly the importance of the patient's assessment of what is extraordinary—too much to bear when compared with the therapeutic outcomes which can be realistically hoped for. This clear emphasis is, in fact, characteristic of Catholic moral teaching on the care of the gravely ill.

Contemporaneous with Kelly's and Cronin's work, Pope Pius XII identified ordinary means with means which do not involve any "grave burden for oneself or another". "A more strict obligation would be too burdensome for most men and would render the attainment of the higher, more important good too difficult," he discerned.<sup>6</sup>

While the patient's duty in light of these principles was often difficult to discern in practice, the doctor's was even more complicated. He had a special duty to the profession of medicine and the larger family of humankind to stave off all temptations to "defeatism" under the threat of pathology, and thus to take aggressive steps to preserve life.

Kelly observed that some doctors adopted what he called a "moderate" moral posture regarding their responsibility to the terminally ill patient; others, an "extreme" posture. He cites a doctor who, in his view, characterizes the moderate posture:

My duty, as I see it, is to preserve life, to fight for a patient's life with every resource at my command, remembering always that 'a man's never licked till he's licked.' But there comes a time when he *is* licked. If a doctor has trained judgment and experience and that desperate dislike of defeat which is instilled into each of us, he knows sometimes, because he knows his pathology, that every human thing has been done: that he cannot preserve life—that the decision has been taken from him.

And then his duty, I think, is just as clear—to make that patient comfortable by sedatives if he can, regardless of anything else and how much it takes to do so.<sup>7</sup>

Those with what Kelly called the "extreme" attitude would see their duty in simpler, more categorical terms: to preserve life as long as possible by any means at their disposal. When attending to a dying patient or permanently comatose patient, the moral task of the "extremists" was simple; they had one rule to follow. The "moderates" by contrast, had the task of assessing whether a particular treatment was likely to be of any benefit to *this* patient, and thus, whether it was worth the pain, effort and expense. The problem with relying on a single moral principle that requires us to preserve life with all the means available in a period of advanced biotechnology is that after a while all means become *ordinary in practice*.

### Situations of Life-Sustaining Treatments

When technologically complex life-sustaining treatments became

increasingly easy to provide clinically and financially, we ended up sanctifying with the moral principle, "Do everything", what in many cases we were doing for an essentially nonmoral (if not, in some circumstances, immoral) reason; ease and convenience of administration. We felt we should "do everything", but we got to the point where we were no longer asking the moral reason why. So now we have to ask, is it because it is easy for us, or because it is the right thing to do for the patient? Over time, the moral concerns found in papal statements and theological commentary about the "grave burden" imposed on the dying patient by certain treatments were stifled by the "technological imperative" posing as a moral imperative. Now we have to look more closely at the moral imperative; what are we, indeed, obligated to do for the patient?

The Vatican *Declaration on Euthanasia* which came out in 1980, recognized the shift in the meanings of *ordinary* and *extraordinary* and the resulting confusion. They drew from the ongoing theological inquiry into these issues the concepts *proportionate* and *disproportionate* in order to clarify the moral meaning of ordinary and extraordinary. In the words of the *Declaration*, a judgment can be made as to whether a particular medical intervention is a proportionate or disproportionate means of sustaining life by

studying the type of treatment to be used, its degree of complexity or risk, its cost and the possibilities of using it, and comparing these elements with the result that can be expected, taking into account the state of the sick person and his or her physical and moral resources.

It is important to interpret the *Ethical and Religious Directives* in light of this refinement of terms in Catholic moral tradition as it has developed in response to medical science.<sup>8</sup> Directive 28, for example reads, "The failure to supply the ordinary means of preserving life is equivalent to euthanasia. However neither the physician nor the patient is obliged to the use of extraordinary means." In the light of the *Declaration*, this directive requires that life-sustaining measures which are not *disproportionately* burdensome (*ethically* extraordinary) be provided for the patient, but does *not* require the provision of those which are burdensome or without realistic hope of benefit. Moreover, Directive 33 explicitly rules out treatments which are disproportionate, that is, unjustifiable in terms of predictable benefit to the patient when all of the factors affecting the patient's condition are taken into account. "Unnecessary procedures, whether diagnostic or therapeutic, are morally objectionable. A procedure is unnecessary when no proportionate reason justifies it. *A fortiori*, any procedure that is contra-indicated by sound medical standards is unnecessary." Even if a physician should judge it advisable to continue a particular life-sustaining treatment, the patient (or family member on behalf of an incompetent patient) can refuse treatment which is excessively burdensome.

Those who raise ethical questions in regard to withholding or

withdrawing life support in this era of modern medicine are usually asking what we ought to *do for* a patient, or what we are justified in *not doing for* a patient. The questions are about treatment, medical interventions by the practitioners of medical science to remove or mitigate threats to the patient's life and health. There is often the unspoken assumption that when "nothing more can be done," physicians have no further obligation to the patient. But a moral tradition that gives decisive weight to how a particular treatment affects a patient's comfort and moral support also carries implied obligations to provide for those needs as long as the terminally ill patient continues to live.

### **Withholding Intravenous and Tube Feeding**

The most pressing of the new questions about the artificial supplanting of vital functions is that of replacing natural eating and drinking with artificial nutrition and hydration systems.<sup>9</sup> It is pressing because the procedures have been perfected to the point where it is not difficult to keep numbers of people on feeding systems for long periods of time.<sup>10</sup> It is also pressing because the moral line between medical intervention for therapeutic ends and ordinary hygienic care, in the case of nutrition and fluids, cannot easily be drawn. At times it looks like ordinary care; at other moments, in other cases, it looks more like treatment which is futile and possibly burdensome as well. In still other cases it looks like both at once: perhaps a gesture of ordinary care, and if so, required; but perhaps futile, and if so, unjustified. Some of us are tempted to seek refuge from this ambiguity in a moral posture which requires us always to feed.

Commenting on a study of physician attitudes on withdrawal of nutrition and fluids from terminally ill and comatose patients, Bayer noted that almost all of the doctors surveyed said that they would start IV feeding for a dying or comatose person. Noting further that 27% of these doctors would order an amount of fluids which would be insufficient to sustain the person's life, Bayer suggests that their purpose in ordering the feeding regimes may not have been "medical, but symbolic and psychological: to satisfy the physician's sense of duty, and to prepare the patient's family for the worst."<sup>11</sup> He questions the moral validity of this kind of instinctive "sense of duty" on the part of the physician. It is precisely this which at times appears to be, in fact, a place of retreat from moral discernment at the expense of the patient.

Others also have spoken of what has come to be called the "symbolic" meaning of feeding.<sup>12</sup> Eating, drinking and feeding are among the most basic, even sacred, human activities, it is said. The issue of whether to feed or not to feed is such an emotional one for us, not only because it is about survival at its most primitive level, but also because the gesture of feeding another, especially infants and the disabled who are not able to feed themselves, is one of the most basic human ways to express caring and friendship. On the other hand, "artificial feeding reduces food intake to its barest essential—nourishment of the patient. It is introduced as a medical

treatment and excludes the sensory, social and cultural pleasures and traditions associated with eating."<sup>13</sup>

### Worries About Optional Feeding

Some are worried that if we admit that feeding is optional for some very ill people, we are implicitly admitting that some kinds of life are not worth sustaining. To declare feeding optional is to start down the slippery slope. For them, continuance of this fragile life, no matter how burdensome, is in itself a human good. To withhold or withdraw artificial feeding from a debilitated patient betrays our lack of regard for his or her life; it is to reduce *him* or *her* to a burden. Those who assume this moral posture are particularly resistant to making feeding, even artificial feeding with its attendant risks, optional, because in their view it is contradictory to obligate ourselves to care for another while denying him or her food, the most basic human need. For them, the provision of nourishment is such an elemental human response to one in need that refusing to provide it threatens the humanity of both the needy person and the one who refuses to respond to that need.

And even for those of us who see mostly technical processes more or less anonymously at work, there is a vestige of the traditional "natural" meaning present in those gestures. Those who are involved in managing the feeding systems know, after all, that they are providing sustenance for another human being. And they know that if they don't provide it, that human being will die. The situation is different from the one in which the patient whose respirator is removed just *may* begin to breathe on her own. And so we hesitate.

But can we honestly say that artificial feeding procedures *always* represent the most compassionate and respectful response to a patient? If we insist that we must *always* feed a patient, no matter what his condition or his desires, are we really acting in a way which is consistent with the Catholic tradition? Or is it not often the case, rather, that those who order and administer feeding regimes are doing so because they dare not discontinue them, and even that they dare not ask themselves whether these procedures are not from the patient's point of view, futile or excessively burdensome?

Enteral and parenteral nutrition systems which supplant the natural feeding activities rob the latter of virtually all of their human meaning.<sup>14</sup> The mechanisms themselves and many of the technical gestures employed to carry out the nutrition and hydration of the patient who is permanently comatose or very nearly dead, mask almost entirely a meaning we have learned to associate with the terms, "eating", "drinking", and even "feeding".

Consequently, there is a growing consensus among Catholic thinkers and others as well that there is no moral justification on the basis of the vestigial images of natural feeding barely present in nutrition/hydration systems, for invoking a moral principle which prohibits us categorically

from withdrawing an artificial feeding system.<sup>15</sup> Even though for us it is technically and psychologically convenient, "natural", to continue feeding, for *this* patient's good it may be time to withdraw. Mechanical, impersonal, invasive and risky feeding programs are experienced by some patients and their families as inhumane rather than as caring gestures. In some situations, for some patients, what is promoted by medical or nursing staff as the symbol of human compassion is totally emptied of its meaning. Some patients experience it as force feeding, a treatment they'd rather be spared. Situations where restraints or sedation or both are required in order to feed an incompetent elderly patient dramatically portray the difficulty of determining the moral limits of what we call care.

Although the line between a medical intervention with curative intent and comfort care cannot be cleanly drawn in abstraction from the decisions which have to be made about people's lives, guidelines can be formulated for morally responsible decision-making which are well founded in the Catholic tradition regarding the care of the terminally ill. A fundamental principle, to which we have already referred, is that a competent adult may refuse any treatment, including feeding, which he finds to be excessively burdensome or futile. A physician who judges that the patient's decision to refuse treatment violates his sense of what is right, can withdraw from the case. When the adult patient is not competent, the first order of business is to establish as accurately as possible the patient's wishes from advance directives (e.g., "living wills, "Christian Affirmation of Life") relatives and close friends. Then a determination about what to do must be made in light of the patient's present circumstances: how sick he is, how near death, how much pain he is in, is he "ready" to die, is his conscious life at such a low ebb that he has slipped into a "persistent vegetative state"?

### **Additional Guidelines Suggested**

Such questions suggest further guidelines implied by the Catholic emphasis on the value of the individual patient's life and specified by the individual patient's condition and degree of awareness. One kind of patient, of course, who falls outside of the morally problematic, is the one who has been confirmed as dead, i.e., whose spontaneous respiratory and cardiac functions have irreversibly ceased or whose total brain, including the brain stem, has irreversibly ceased to function.

Those who have been declared irreversibly comatose or in a "persistent vegetative state" (PVS), but not dead, represent one kind of patient about whom we do have to deliberate. Such patients have elicited serious moral and legal discussion, particularly since many of them survive for months or even years if they are fed. It is because we can, with technological assists, put them in a situation of long hopeless survival, that we have to ask the two fundamental questions which mark off the area of extraordinary or disproportionate means as articulated within the Catholic moral community. First, we have to ask if, by sustaining the patient



technologically, we are not imposing upon him a kind of survival which is burdensome to him, to his family and to all those who bear the cost of such a decision. If, like the judge who ruled in the case of Paul Brophy, we are reluctant to remove a feeding tube from a man who will never recover consciousness because to do so would require us to make a judgment about the quality of his life, we still have to weigh the second question.<sup>16</sup> We still have to ask, even if he is not in pain, whether it is not futile to feed him insofar as he has no hope of emerging from his vegetative state. To answer that it is not futile because it keeps him alive, of course, begs the question as to whether we *ought* to keep him alive. To refrain from seriously entertaining this question is to neglect to consider the individual human being, Paul Brophy, adequately. And to neglect to consider him in all of his concrete circumstances is to misunderstand the traditional Catholic emphasis on the patient as the measure of what should be taken as extraordinary or disproportionate.

In the Barber case, the court held that the question of withdrawal of feeding should be assessed in terms of the proportionate benefit to the patient:

Even if a proposed course of treatment might be extremely painful or intrusive, it would still be proportionate treatment if the prognosis was for complete cure or significant improvement in the patient's condition. On the other hand, a treatment course which is only minimally painful or intrusive may nonetheless be considered disproportionate to the potential benefits if the prognosis is virtually hopeless for any significant improvement in condition.<sup>17</sup>

This particular passage from the ruling reflects faithfully the way in which proportionate and disproportionate means of sustaining life are usually understood by Catholic moralists.

A number of Catholic authors find justification in the removal of life support, including feeding systems, in the appropriate subordination of the ends of human life to its ultimate end, which transcends the temporal. For them to continue to feed a patient in a persistent vegetative state is to assign absolute value to a certain very limited form of life and in so doing, to diminish the ultimately more valuable spiritual life of a person.<sup>18</sup>

Another group of patients we need to consider carefully are those in the last stages of terminal illness. After clearly stating that we can neither directly take the life of another nor ask another to assist in our suicide, the *Declaration on Euthanasia* also says that the patient (or, in the case of incompetence, others on his or her behalf) can "judge that the techniques applied impose on the patient strain or suffering out of proportion to the benefits which he or she may gain from such techniques." And again,

When inevitable death is imminent in spite of the means used, it is permitted in conscience to take the decision to refuse forms of treatment that would only secure a precarious and burdensome prolongation of life, so long as the normal care due to the sick person in similar cases is not interrupted.

There continues to be much discussion over an acceptable definition of

"imminent." To say that a person's death is imminent should probably mean that he or she has less than a year to live. Some would want to de-limit the time frame more narrowly. In any case, a decision to withhold nourishment from a terminally ill person should not come before he is "ready to die." This moment is, of course, discerned only with difficulty and by weighing together all of the factors in the patient's condition and subjective attitude.

Some patients are in so much pain that they cannot bear the prospect of lingering for a long time. There are times when those who are competent can legitimately refuse to be sustained by artificial feeding systems. Those who make decisions on behalf of incompetent patients have the difficult task of trying to discern whether they are in pain and their degree of tolerance. For these patients, too, pain can constitute a burden which would morally justify the request to withdraw feeding in the last stages of their illness.

One of the most difficult groups of people about whom to make nutritional support decisions is the elderly who are severely debilitated by age and sickness, but not on the brink of death. Like Claire Conroy, most of them have no one fatal disease, nor have they slipped into a persistent vegetative state.<sup>19</sup> But they are sick enough that they could die at any time and often they are chronically confused, severely or "pleasantly" senile. Not only do they have physiological disabilities which severely limit their capacity to swallow, digest and absorb food, but they have lost their interest in eating. Some actively resist attempts to feed them orally and with artificial systems.

Decisions not to offer nutritional support to such elderly people should rarely be made and only after much consultation and deliberation. They should also be constrained by procedural safeguards both within the institution and in the law. The Committee for Pro-Life Activities of the National Conference of Catholic Bishops has recently issued two moral commentaries on legislation regarding decisions about life-sustaining treatment. The tone and content of both the *Guidelines for Legislation on Life-Sustaining Treatment* (November, 1984) and their *Statement on Uniform Rights of the Terminally Ill Act* (June, 1986)<sup>20</sup> urge caution in the enactment of laws designed to facilitate termination of treatment decisions. And as Callahan and others have pointed out, current pressures to reduce health care costs create incentives to withhold treatment from the elderly and other vulnerable members of our society which can quickly lead to abuse of them.<sup>21</sup> The consultation and deliberation surrounding the case of an elderly person again should focus on what will promote the dignity of the person himself.

The New Jersey Supreme Court decision *In re Conroy* is instructive not only because it offered some clearly delineated tests of the incompetent patient's best interests, but also because it applied them to Claire Conroy's situation very conservatively. In the absence of any reliable indication of the patient's wishes, the Court said, a guardian's request to terminate

feeding could be honored if "the recurring, unavoidable and severe pain of the patient's life with the treatment should be such that the effect of administering life-sustaining treatment would be inhumane."<sup>22</sup> Having weighed testimony about Conroy's condition, the Court ruled that there was insufficient evidence of pain to warrant the removal of the feeding tube.

Among their criteria for the withdrawal of nutritional support from dying patients, Dresser and Boisauvin include that "if medical evidence suggests that discontinuing nutrition would produce increased pain or discomfort, the patient should be fed."<sup>23</sup> At the same time, these authors acknowledge a need for more clinical information on the degree to which specific feeding regimes do, in fact, alleviate a given patient's distress and in general enhance his/her sense of well-being. They cite some evidence which suggests that some hydration regimes may even cause certain patients complications and discomfort which they would rather be spared. In spite of what we intuitively feel about alleviating a patient's thirst, some are easily satisfied with ice chips or a glycerine swab. There are reports from caregivers indicating that "death from water deficiency appears painless and peaceful."<sup>24</sup> Others claim on the contrary that dehydration brings on a set of conditions which are anything but painless. Again, clinical observations such as these need to be carefully interpreted always through the filter of compassionate support for the individual patient.

The Catholic moral tradition has made an important contribution to the current discussion about providing nutrition and hydration to the very sick. The Catholic posture is framed by a strong bias in favor of supporting life that is in constant tension with our need to accept finally the limitation of sickness and death. This pro-life attitude is the expression of our belief that by His death and resurrection, Jesus Christ has transformed sickness and death into the fullness of life. Our faith gives us the freedom not to feel bound to use every available means to prolong temporal life, but to discern what is best for each patient, including in that discernment our hope for "eternal life", a life fully transformed in Jesus Christ.

Hasty decisions to withdraw nutritional support should be avoided. Such decisions should be made with sufficient consultation and deliberation, especially to check our tendency to make them for cost-saving reasons. The Catholic moral tradition, as it has developed in response to the evolution of medical practice, supports the view that the best interests of the patient are protected if we defer to the patient himself or herself, and if we employ only those measures including nutrition and hydration which will help to sustain him without imposing on him excessive burdens or futile treatments. When feeding or other life-support treatments constitute a grave burden to the patient or provide no therapeutic benefit, there is no obligation—or even justification—for continuing them. Compassion and respect for the person, of course, require that we continue to offer him or her moral and spiritual support as long as he or she lingers.

## References

1. *Declaration on Euthanasia*. The Sacred Congregation for the Faith, Vatican City, May 5, 1980, in *Deciding to Forego Life-Sustaining Treatment*, President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, (Washington, DC: U.S. Government Printing Office, 1983), pp. 300-307.

2. See Gerald Kelly, S.J., "The Duty to Preserve Life," *Theological Studies*, XI, 1950, p. 554, on the "good Catholic" attitude, where he says about "many religious and . . . devout lay Catholics" that "they believe that the important thing is to die holily, and they frankly say that there are limits to what must or should be done in order to prolong temporal life."

3. James J. McCartney, O.S.A., M.S., M.A., "The Development of the Doctrine of Ordinary and Extraordinary Means of Preserving Life in Catholic Moral Theology Before the Karen Quinlan Case," *Linacre Quarterly*, August, 1980, pp. 215-224, has a brief history of these terms.

4. Kelly, *op. cit.*, p. 550.

5. Cronin, Daniel A., "The Moral Law in Regard to the Ordinary and Extraordinary Means of Conserving Life", Rome: Typis Pontificae Universitatis Gregorianae, 1958, quoted in McCartney, p. 219.

6. Pius XII, Allocution "Le Dr. Bruno Haid," [to an international congress of physicians and anesthesiologists], *Acta Apostolicae Sedes*, 49, 1957, pp. 1031-1032.

7. Kelly, *op. cit.*, p. 553.

8. The *Ethical and Religious Directives for Catholic Health Facilities* were promulgated by the National Council of Catholic Bishops in 1971 and amended slightly in 1975. This document is a code intended for Catholic health care institutional providers which is subject to the interpretation of each bishop within his diocese. A short history of the *Directives* can be found in *Ethics Committees*, by Robert P. Craig, Carl L. Middleton and Laurence J. O'Connell (St. Louis: Catholic Health Association, 1986), pp. 21-29.

9. The available modes of artificial nutrition and hydration are (1) peripheral IV, which cannot provide sufficient nutrition to sustain life over a long period of time; (2) superior vena cava IV, which allows for adequate nutrients, but because it is more invasive, carries the risks of thrombosis, lung puncture and infection; (3) nasogastric tube, which allows feeding via the gastrointestinal system, but is uncomfortable for the patient, especially when it has been in for some time; and (4) gastrostomy, a tube inserted surgically into the stomach. This last procedure is less uncomfortable for the patient, but is initially the most invasive of all of the available methods. See David T. Watts, M.D. and Christine K. Cassel, M.D., "Extraordinary Nutritional Support", *Journal of American Geriatrics Society*, Vol. 32, No. 3 (March, 1984), pp. 237-242.

10. Fifty-six of the 84 patients at New England Sinai Hospital where Paul Brophy is being fed by means of a gastrostomy, were on artificial feeding regimes of various kinds at the time of the Brophy hearing in 1985. *Brophy*, at sec. 56. Cf. also Rebecca S. Dresser, J.D. and Eugene V. Boisaubin, Jr., M.D., "Ethics Law and Nutritional Support," *Archives of Internal Medicine*, Vol. 145, January, 1985, p. 122.

11. Bayer, Edward J., S.T.D., "Intravenous Food and Fluids for the Dying," *Ethics and Medics*, Vol. 9, No. 6, June, 1984, p. 1, commenting on Kenneth C. Micetich, M.D., Patricia H. Steinecker, M.D. and David C. Thomasma, Ph.D., "Are Intravenous Fluids Morally Required for a Dying Patient?" *Archives of Internal Medicine*, Vol. 143, May, 1983, pp. 975-978.

12. Callahan, Daniel, "On Feeding the Dying," *Hastings Center Report*, 13, 1983, p. 22 and Alexander Morgan Capron, "Care of the Dying: Withholding Nutrition," *Hastings Center Report*, October, 1984, pp. 32-35.

13. Geraldine V. Padilla, Ph.D. and Marcia M. Grant, R.N., M.S.N., "Psychosocial Aspects of Artificial Feeding," *Cancer*, Vol. 55, No. 1, January supplement, 1985, p. 301.

14. Enteral systems are tube feeding systems. Parenteral ones provide nutrients and fluid intravenously.

15. David W. Meyers, J.D., L.L.M., lists the arguments usually brought forward to

justify providing nourishment in all cases and shows that each of these arguments fails in certain cases because of the circumstances and desires of the individual patient. See "Legal Aspects of Withdrawing Nourishment from an Incurably Ill Patient," *Archives of Internal Medicine*, Vol. 145, January, 1985, pp. 125-128. See also Bayer, p. 2.

16. Paul Brophy is a patient in New England Sinai Hospital in a "persistent vegetative state." Judge Kopelman refused to authorize his wife to withdraw a feeding tube. According to the judge, "It is ethically inappropriate to cause the preventable death of Brophy by the deliberate denial of food and water which can be provided to him in a non-invasive non-intrusive manner which causes no pain and suffering, irrespective of the substituted judgment of the patient. The proper focus should be on the quality of treatment furnished to Brophy and not on the quality of Brophy's life. Otherwise the Court is pronouncing judgment that Brophy's life is not worth preserving. The quality of life is an incorrect focus because there are no manageable criteria for making such a judgment." *Brophy v. New England Sinai Hospital*, No. 85E0009-G1 (Mass. Prob. Ct., Norfolk Div., Oct. 21, 1985).

17. Quoted in Dresser and Boisaubin, *loc. cit.*, p. 123.

18. See e.g., Dennis Brodeur, "Feeding Policy Protects Patients' Rights, Decisions," *Health Progress*, June, 1985, pp. 38-43; Kevin O'Rourke, O.P., "The AMA Statement on Tube Feeding: Ethical Analysis," *Ethical Issues in Health Care*, VII/8, April, 1986; Pope Pius XII's Allocution cited above, while not mentioning feeding, does say that no one is obliged to take on a "grave burden" because to do so would "render the attainment of a higher good too difficult." The Pope seems to assume that the patient is still vital enough to struggle for his good.

19. Claire Conroy was an 84-year-old woman suffering from a number of serious and progressively debilitating conditions. She was minimally responsive to the gestures of care givers and to other stimuli in her environment. The Supreme Court of New Jersey ruled that life-sustaining treatment, including nutrition and hydration, could be withheld from a patient such as Conroy if (1) the person deciding on her behalf had clear evidence that she would have refused such treatment, if (2) there was *some* indication she would have refused and the surrogate decision-maker determined that the "burdens of the patient's continued life with the treatment outweigh the benefits of that life", or if in the absence of any indications as to her wishes (3) the patient's burdens "clearly and markedly" outweighed the benefits of continuing to treat her. The court determined that there was not sufficient evidence presented by the case to have justified the withdrawal of a feeding tube from Conroy.

20. Office for Pro-Life Activities, National Conference of Catholic Bishops, 1312 Massachusetts Ave., N.W., Washington, DC 20005.

21. Mark Siegler, M.D. and Alan J. Weisbard, J.D., "Against the Emerging Stream," *Archives of Internal Medicine*, Vol. 145, January, 1985, pp. 129-131.

22. *In re Conroy*, 486 A. 2nd 1209 (NJ, 1985).

23. Dresser and Boisaubin, *loc. cit.*, p. 123.

24. David T. Watts, M.D. and Christine K. Cassell, M.D., *loc. cit.*, p. 241.