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[Book Review of] *By No Extraordinary Means: The Choice to Forego Life-Sustaining Food and Water*, edited by Joanne Lynn

Robert Barry

BOOK REVIEW

By No Extraordinary Means: The Choice to Forego Life-Sustaining Food and Water

Joanne Lynn, M.D., Editor

(Bloomington, Ind: Indiana University Press, 1986). xxii + 272 pp. $25 hardback.

This book is composed of 27 papers delivered at a symposium on the ethical, medical and legal aspects of providing nutrition and fluids to patients. The symposium was sponsored by a number of medical, ethical and legal organizations in response to the New Jersey Supreme Court decision *In the Matter of Claire Conroy*. The papers are of uneven quality, and most of them leave something to be desired because of their extreme brevity. Hardly any of the papers touch, with any profundity, the major legal, ethical and medical issues involved in the provision of food and water to patients. Generally, the papers hold that assisted feeding is a medical treatment, that food and water can be withdrawn or rejected when they are judged to be too burdensome, and that the present trend among American state courts to permit their withdrawal from more and more classes of patients is unobjectionable.

The book contains a number of articles which consider the medical and clinical aspects of feeding. The emphasis of these articles is on the medical complications involved in the provision of assisted feeding. It is unfortunate that a wider range of viewpoints was not represented in the medical articles, viewpoints suggesting that virtually all patients can be sustained through either enteral or parenteral feeding because of remarkable recent advances.

Ronald Cranford admits that the removal of food and water certainly brings death. He cannot see how anyone who has lost consciousness has any interests whatsoever, and he therefore believes that removing food and water should not be problematic. He says this even though he admits that most patients who are permanently unconscious have healthy bodies and cannot be considered as terminally ill because of contemporary developments in medicine. These views show that many who are promoting the removal of food and water from the comatose suffer from a seriously flawed anthropology and are uncritical philosophically.

A number of articles consider the legal aspects of assisted feeding, and virtually all of them argue for the pure contentless patient autonomy model of medical decision-making. This viewpoint is dubious jurisprudentially because it undermines the responsibilities of the state and the medical profession to provide ordinary and customary care to patients.

This model is even more objectionable because it destroys the covenantal model of decision-making between patient and physician. The covenantal model holds that both the health care provider and patient have obligations to promote health. It requires both parties to have input into treatment decisions so that they can both fulfill their responsibilities. The health care provider has a professional obligation to advance the goals of healing as far as possible, and the patient has a duty to accept ordinary burdens to protect his or her life and to promote the good of health in general. The pure contentless patient autonomy model of decision-making ignores these obligations, and makes the physician the servant of the patient who is often the least well-informed and least capable of making medical decisions.

Most authors who comment on the law in this volume generally agree that the competent patient should be permitted to refuse all medical treatments, including food and water. Some, such as Lynn and Brock (p. 214) hold that people who are far from dying, such as Elizabeth Bouvia, should be allowed to reject feeding because they find their condition hopeless because there are no significant state interests which could warrant limiting freedom. That fails to see that giving legal permission for some classes to commit suicide educates other classes that suicide is permissible. Suicide is not a threat for those whose lives are happy, secure and mature. But for those who are not, legalized suicide presents a serious threat. A desperate, despairing and lonely individual is not going to make subtle legal distinctions about those who are permitted to commit suicide. He/she will simply see that profound suffering permits wilful self-killing, and will see their suffering as being far worse than anyone else's. Brock and Lynn fail to see that breaching the law against suicide will create a whirlpool before that breach which will exploit the weak, immature and despairing, and their challenges to the law against suicide should not be heeded.

Alan Weisbard and Mark Siegler demand caution in developing policies governing the provision of food and water. They point out that removal of food and water is becoming the "treatment of choice" for "biologically tenacious" patients who refuse to die at the expected time. They wonder how the supposed "burdens" of feeding can outweigh the benefits of sustaining life, particularly for comatose patients. They wonder how withdrawing food and water from a patient can truthfully be considered as "letting nature take its course". The lack of food and water becomes the direct cause of death of the patient, and it is an avoidable death for which moral responsibility cannot be avoided.

Similarly, Gilbert Meilaender wondered how one could say that feeding a comatose patient was "burdensome" for the patient. He argues that feeding the comatose is not useless, and I would add that food and fluids can accomplish their natural finalities for the comatose, which is to sustain their lives. We cannot realistically ask that they do much more than that for anyone. Meilaender sees that food and water are different from respirators because patients can often survive the definitive removal of respirators, but no one can survive the definitive and absolute removal of food and water. He notes that food and water simply give what is needed to live, that food and water treat no particular disease and that their cessation brings certian death.

Dan Brock argues that the ordinary-extraordinary and killing-letting die distinctions are not helpful or relevant. He suggests that there might not be any relevance to the issue of providing food and water to patients. What this critique fails to see is that the crucial issue is not whether the act or omission is the cause of death, but whether there is an obligation to take measures to prevent death and preserve life. Failing to provide food and water in some circumstances would not be morally culpable because there is no moral obligation, but in other situations, it would be morally required. An action is morally obligatory if ordinary efforts on the part of the patient or care giver can sustain life or prevent death. Brock holds that if the patient is "terminally ill", death resulting from omission would not be killing, for the patient would die from the underlying condition. But surely this is too lax, for it would be possible to kill a "terminally ill" patient by omission. If a terminal illness is one which would result in death imminently if the treatment was removed, as the Nevada living will law holds, then insulin could be removed from a diabetic without killing the patient according to Brock. Only if a patient is not only terminally ill, but also imminently and irreversibly dying, so that the removal of normal care or ordinary treatments would not be the fundamental cause of death, would omission of these treatments not be culpable killing.

Kenneth Micetich, David Thomasma and Patricia Steinecker conducted a survey of physicians to determine their attitudes on feeding. It is remarkable that it was even included in the book because it was so unscientific that it is virtually useless. They gave no information about the nature of their sample, what populations of physicians were chosen or what analytical techniques were employed. It is difficult to believe these statistical claims, for just as in the abortion movement, it seems that secure data is very difficult to obtain. As another example of this, Dr. Ronald Cranford commonly states that there are

between 5,000 and 10,000 comatose patients in the country, yet he frankly admits that there is no scientific basis for this figure. The fact is that there is little hard data about any of these issues, and much of the statistical information we have on issues of providing care and treatment are pure fabrications.

Among the more notable papers is that of Rev. Edward Bayer who presents what he understands to be the Roman Catholic view of providing food and water to patients. He holds that nutrition and fluids which can be taken "connaturally", or orally, must be provided and received as a matter of obligation. However, when they cannot be ingested in this manner, they become electable medical treatments. According to Bayer, assisted feeding only has to be given if life is basically conscious, if it relieves "useless" pain, whatever that might be, and if it does not add to the burdens of a patient. Assisted feeding can morally be withdrawn from a patient if the patient is unable to engage in human communication because of severe brain damage. This is permitted because it is the capacity for intercommunication which constitutes the person for Bayer. When this capacity is lost, Bayer implies that there is no ethical duty whatsoever to sustain life by even the provision of food and water. This is dubious ethically and theologically. It is ethically questionable because it would implicitly assert that there are weaker obligations to protect those with diminished capacities for human communication, such as the handicapped. And it is also weak theologically because it fails to see that the permanently comatose patient remains an *imago Dei*, is therefore still open to divine grace and has some moral rights. These patients still have rights to at least minimal care, and they cannot be directly killed by either omission or commission of morally required actions.

Bayer argues that removing food and water from nonterminal comatose patients would not be direct killing but would be an instance of rejecting a burdensome medical treatment and only foreseeing but not intending death. One must ask how this can be done when the definitive withdrawal of food and water sets into action a new and independent, certainly lethal, chain of events, no different in its outcome from suffocating a patient to death. How is it possible to take a course of action which certainly brings death without intending death but only foreseeing it?

Bayer argues that only the patient himself can make the judgment whether food and water should be provided. Does this mean that the autonomous individual is above the teachings of the Church? What is the extent of the autonomy Bayer gives to the patient? He believes that individuals such as Elizabeth Bouvia have the right to reject assisted feeding in all cases except where their refusal would cause grave harm to another individual or to society as a whole. This would seem to mean that feeding would be rejected with suicidal motives if society or no other individual would be harmed by such a choice. He does admit that society has a duty to prevent suicide, but it has no obligation to force feeding on a competent patient who wishes to commit suicide. In his view, society has no right to take on the responsibilities of a competent patient to sustain life because the responsibility one has over one's body is the most intimate of all personal rights.

Bayer may claim to be representing Catholic teaching on this issue, but his views seem to be far from what the Church is actually teaching today. Bayer would permit feeding to be removed from the persistently comatose, as did the AMA's Judicial Council, but this opinion was clearly and sharply condemned by Archbishop Philip Hannan of New Orleans as being contrary to Catholic teaching. Bayer would permit Elizabeth Bouvia to starve herself to death, but Archbishop Roger Mahoney of Los Angeles condemned as irrational a decision permitting that choice. Bayer would allow those like Paul Brophy or Nancy Ellen Jobes who lost the ability to communicate because of severe brain damage to be starved or dehydrated to death, but both Cardinal Law and Cardinal O'Connor demanded that they be fed. Bayer calls artificial feeding a medical treatment, but a report from the Pontifical Academy for Sciences called it normal care which was to be given to all patients, even the comatose, and even when all other medical treatments had been withdrawn. It would seem Gilbert Meilaender and Russell McIntyre are closer to Catholic teaching on this issue than is Bayer.

Bayer fails to see that food and water are extrinsic natural resources of the body which directly, immediately and proximately support the natural functions of the body and sustain its natural defenses against disease. They are used universally in the body for this purpose. Nutrition and fluids might be of indirect and remote clinical, curative, or palliative value, but they are not directly so. Food and water are aspects of care and are not medical treatments because they do not cure, but meet the need of the entire body for basic resources. No matter what the clinical condition of a patient might be, a person needs food and water and to deny them is to cause death. The mode of provision of food and water does not change their finalities and make them medical treatments, for if that was the case, then poison would be a medical treatment if it was given by hypodermic injection and not orally. Medical treatments, on the other hand, directly, immediately and proximately cure, remedy and palliate clinically diagnosable conditions.

Food and water are elements of basic patient maintenance, just like sanitary care, protection from exposure and psychological support. *Because of this, they should be provided through routine nursing procedures when their mere provision will significantly sustain life and when it is medically possible to provide them through these means.* The aim of providing food and water is to prevent the person from succumbing to a lack of basic natural resources of the body, and to permit the person to succumb to the underlying pathological condition, and when this can be prevented by providing food and water through ordinary nursing measures, they should be given. When food and water can only be given through procedures which require the skill of a physician, such as total parenteral feeding, then they become a medical treatment, and they should be given according to the ordinary-extraordinary criteria.

It is disturbing to see that many authors in this work seem to be ignorant that the mercy killing movement is seeking to import active euthanasia into our law and society by gaining social and legal endorsement for voluntary suicide by rejection of assisted food and water. It is also disturbing to see so many leading American academics confidently reject appeals for caution on this issue. This study has failed to consider the deeper philosophical issues involved in feeding, and it generally just repeats the same themes that have been heard for the past four years on the issue of providing assisted feeding. This issue is complex, and it requires detailed and careful studies. This study, in large part is neither, and it is not clear if it will actually further our understanding of these complex issues.

— Rev. Robert Barry, O.P.
Assistant Professor of Religious Studies
University of Illinois, Champaign-Urbana