Perspectives on Directive 58

**John M. Travaline, M.D., and
Rev. Thomas V. Berg, Ph.D.**

Dr. Travaline is professor of medicine at Temple University School of Medicine, Philadelphia. Fr. Berg is adjunct professor of medical ethics at St. Joseph's Seminary in Yonkers, New York, a member of the New York State Task Force on Life and the Law, and a member of the Ethics Committee of the Empire State Stem Cell Board. He may be reached at tberg@westchesterinstitute.net.

Abstract

The United States Conference of Catholic Bishops recently revised directive 58, on the use of artificial nutrition and hydration, in its Ethical and Religious Directives for Catholic Health Care Services. Although the revision clarifies that the use of artificial nutrition and hydration is ordinary, proportionate, and therefore, in principle, morally obligatory, the ethical debate surrounding this issue continues. Furthermore, many clinicians remain confused about the implications of this directive, as well as its application to specific cases. This article seeks to clarify both the implications and the practical application of directive 58, pointing out that providing artificial nutrition and hydration is part of normal care giving, and there are few instances in which such care can be licitly withheld or withdrawn from a patient.

The latest edition of the *Ethical and Religious Directives for Catholic Health Care Services*, approved by the United States Conference of Catholic Bishops (USCCB) in November 2009, contains an important revision of directive 58, addressing the use of artificial nutrition and hydration for patients in states of minimal and permanent unconsciousness. The revised directive states:

In principle, there is an obligation to provide patients with food and water, including medically assisted nutrition and hydration for those who cannot take food orally. This obligation extends to patients in chronic and presumably irreversible conditions (e.g., the “persistent vegetative state”) who can reasonably be expected to live indefinitely if given such care. Medically assisted nutrition and hydration become morally optional when they cannot reasonably be expected to prolong life or when they would be “excessively burdensome for the patient or (would) cause significant physical discomfort, for example resulting from complications in the use of the means employed.” For instance, as a patient draws close to inevitable death from an underlying progressive and fatal condition, certain measures to provide nutrition and hydration may become excessively burdensome and therefore not obligatory in light of their very limited ability to prolong life or provide comfort.¹

While the revision of directive 58 provides a clearer articulation of the use of artificial nutrition and hydration, indicating that its use is ordinary, proportionate, and therefore, in principle,² morally obligatory, it has not diminished the intensity of debate among medical ethicists on the issue. Moreover, a lingering sense of confusion among physicians concerning the clinical implications of this directive remains. Herein we attempt to further clarify the meaning of this revision first, by summarizing the main implications of directive 58, and secondly, by addressing sources of confusion over the clinical application of this directive.

Implications of the Revised Directive 58³

1) Clinical protocols that would indiscriminately withhold or remove artificial nutrition and hydration without due regard for the moral guidelines articulated in directive 58 leave death by starvation or dehydration as a potential outcome. In the words of John Paul II, such an omission could constitute “true and proper euthanasia.” Catholic health-care facilities must assure that their policies and procedures are in line with directive 58—including their policy regarding patient requests to be deprived of artificial nutrition and hydration.

2) Provision of food and water are to be considered a part of normal care giving (not an “extraordinary means”), even when provided artificially, as with the assistance of a feeding tube.

3) Directive 58 extends beyond the specific case of persons in states of minimal or permanent unconsciousness to include any persons suffering a pathology that makes them unable to assimilate food and water without artificial assistance, such as advanced Alzheimer’s disease or acute dementia.

4) Directive 58 states that such provision of artificial nutrition and hydration is obligatory “in principle,” and the possible exceptions to this obligation are fairly narrow. The provision of artificial nutrition and hydration is not obligatory when it cannot be reasonably expected to

prolong life, when it is judged to constitute an “excessive burden” for the patient (as in the rare instance that it might cause “significant physical discomfort”), or when the patient can no longer assimilate food and water (as when death is imminent). Determining if and when artificial nutrition and hydration can be removed will normally require consultation between family and care-givers, attending physicians, and, if necessary, a priest or ethicist trained in the Church’s moral teaching on such matters.

5) Catholics considering end-of-life decisions should adhere to the moral truths affirmed in the revision of directive 58 and plan their health care accordingly. It would be immoral for them to indicate in their “living wills” or advance medical directives a desire to forgo or have withdrawn the provision of food and water if they should suffer severe cognitive impairment.

Toward the Application of Directive 58: Addressing Uncertainties

While the foregoing may sound simple, clinicians frequently find themselves struggling with the implications of the Church’s teaching on artificial nutrition and hydration, particularly when dealing with patients in states of permanent or minimal consciousness. From a clinical perspective, however, directive 58 is far more straightforward and less complicated than it may appear.

To more fully appreciate the directive, and avoid confusion about artificial nutrition and hydration, we must first understand that recourse to artificial nutrition and hydration from the perspective of Catholic moral teaching constitutes, in itself, a form of ordinary care giving, even when administered via medicalized means such as a percutaneous endoscopic gastrostomy (PEG) tube. Confusion on the issue of artificial nutrition and hydration arises when one places too much attention on this medicalized aspect of artificial nutrition and hydration.

Understandably, many medical professionals indeed consider artificial nutrition and hydration a medical intervention. However, in his March 2004 allocution to the participants in the international congress on “Life-Sustaining Treatments and the Vegetative State,” Pope John Paul II affirmed that recourse to artificial nutrition and hydration “always represents a natural means of preserving life, not a medical act.”⁴ In so doing, the Holy Father was making a philosophical distinction without which an embrace of the Church’s teaching on this matter would remain problematic.

The distinction, namely, is that which holds between normal care giving on the one hand, and a medical act, i.e., the application of medical treatment for the restoration of personal well-being, on the other. While recognizing that the difference between care giving on the one hand, and medical treatment on the other, is often not black and white,

but rather a matter of degree, the Church nonetheless affirms that the provision of nutrition and hydration, albeit by medically assisted means, when considered in itself, falls into the former category, not the latter.

Granted, the provision of artificial nutrition and hydration often requires a surgical procedure (e.g., percutaneous endoscopic gastrostomy (PEG) for tube placement), and like any surgical procedure it is done in a medical facility, by physicians, and is associated with potential complications. However, in essence, the act of nourishment and hydration, even if achieved through medical interventions, remains first and foremost a matter of ordinary care giving. It is not an intervention carried out in the context of illness and aimed at restoration of one's well-being. Certainly artificial nutrition and hydration is necessary for one to recover from illness, or to avoid getting worse, and in fact it may contribute to one's restoration of well-being; however, it is no more considered a medical treatment than changing a patient's bed clothes, bathing a patient, or turning him, all of which are simply instances of care giving in the health-care setting. Nor, for example, is the provision of artificial nutrition and hydration any more a medical treatment than delivering a baby, though this, too, often involves medical procedures, occurs at hospital facilities, and can be subject to certain complications.⁵

Considered, then, as a form of ordinary care giving, artificial nutrition and hydration is "obligatory in principle," and there will be a relatively narrow margin of circumstances under which it could be considered burdensome to the patient and consequently morally optional.

A second reason for confusion concerning artificial nutrition and hydration has to do with the use of the term "artificial." Artificial nutrition and hydration, so the argument may go, is "artificial" (which is to say "not natural"), and therefore optional. The assertion rides on the false premise that clinical practices are never in principle obligatory to the extent they depart from "naturalness." From a clinical perspective, however, almost everything in clinical practice is unnatural. In fact, in dealing with disease, we speak of altering the "natural history" of the disease by medical interventions. We infuse synthetic chemicals into patients to fight off infection, place mechanical valves in patients' hearts, and the list goes on. Also, in the clinical context, apart from dealing with disease, caregivers help maintain the patient's hygiene, for example, by using various hygiene products to assist in bathing a patient. Can we similarly argue that such products are not natural and thus not obligatory? To assert that artificial nutrition and hydration is unnatural and therefore morally optional in itself is specious.

A third reason for the confusion surrounding artificial nutrition and hydration from a clinical perspective owes itself to an at times not so subtle bias in favor of allowing patients in states of minimal consciousness or permanent unconsciousness to expire. An underlying tendency to almost equate cognition with personhood needs to be recognized and avoided in order to appreciate the ordinary use of artificial

nutrition and hydration. The notion that if someone who is not cognate or is suffering severe dementia should receive minimal care, and just be allowed to die, is unquestionably prevalent within our contemporary health-care system.⁶ This approach to such patients, though not necessarily always explicit, contributes to minimizing patient care, and in such cases, the recourse to artificial nutrition and hydration is too easily deemed inappropriate. Why does this occur? Often, the “too burdensome” argument is made, and on those grounds, coupled with some of the other misconceptions (artificial nutrition and hydration is a medical treatment, and is unnatural), artificial nutrition and hydration is not provided, contrary to Church teaching as articulated in directive 58.

These three areas of misunderstanding artificial nutrition and hydration—as extraordinary care, as not natural, and as not necessary for the minimally conscious or unconsciousness—perpetuate confusion about directive 58, and potentially scandalize clinicians trying to provide authentic charitable care for their patients. It seems that unless we become clear about these few key issues, practices involving artificial nutrition and hydration will be potentially misguided. For additional information on this subject, the Catholic Medical Association has outlined a number of points concerning the use of artificial nutrition and hydration for patients in states of minimal or permanent unconsciousness.⁷

Notes

¹ United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 5th ed. (Washington, D.C.: USCCB, 2009), dir. 58, quoting Congregation for the Doctrine of the Faith, commentary on “Responses to Certain Questions of the United States Conference of Catholic Bishops Concerning Artificial Nutrition and Hydration.”

² The phrase “in principle” as used by the USCCB means that there are exceptional instances in which the provision of artificial nutrition and hydration is not morally obligatory. We make reference to such instances later in the article.

³ These five points were published previously: T. Berg, “The Terri Schiavo Effect,” *Legatus Magazine* (February 1, 2010), <http://www.legatusmagazine.org/?p=2160>.

⁴ John Paul II, address to the participants in the international congress on “Life-Sustaining Treatments and the Vegetative State: Scientific Advances and Ethical Dilemmas,” March 20, 2004, http://www.vatican.va/holy_father/john_paul_ii/speeches/2004/march/documents/hf_jp-ii_spe_20040320_congress-fiamc_en.html.

⁵ Catholic Medical Association, “Response to the Consortium of Jesuit Bioethics Programs Statement ‘Undue Burden?’” *Linacre Quarterly* 76 (2009): 296–303.

⁶ See discussion about the worth of human lives in President’s Council on Bioethics, *Taking Care: Ethical Caregiving in Our Aging Society* (Washington, D.C.: President’s Council on Bioethics, 2005), 103–107.

⁷ The Catholic Medical Association, “Response to the Consortium,” 296–303.