Recent Revisions to the ERDs regarding Artificial Nutrition and Hydration (ANH)

John Paul Slosar, PhD
Senior Director, Ethics
Saint Louis, MO

Objectives

- Understand the substance of the revisions
- Understand the rationale for the revisions
- Understand the practical implications
The Fourth Edition on ANH: a quick review

Recent developments in Church teaching regarding ANH

The revisions

Practical Implications

Conclusion

From the Introduction to Part V
“Issues in Care for the Dying”

“The USCCB Committee on Pro-Life Activities’ report . . . points out the necessary distinctions between questions already resolved by the magisterium and those requiring further reflection, as, for example, the morality of withdrawing medically assisted hydration and nutrition from a person who is in the condition that is recognized by physicians as the ‘persistent vegetative state’ (PVS).”
ERD 58:

“There should be a presumption in favor of providing nutrition and hydration to all patients, including patients who require medically assisted nutrition and hydration, as long as this is of sufficient benefit to outweigh the burdens involved to the patient.”

ERD 58: Points of Interpretation

- Applies to all patients, not just those in a Persistent Vegetative State
- One should start from the assumption that nutrition and hydration, even when artificially delivered, always offer some benefit so long as they can be assimilated
- In the absence of explicit patient instructions, we ought to presume the person would want ANH
- Withdrawal may be based on patient or substituted judgment (by surrogate) of disproportionate means
Case #1

Would it be consistent with ERD no. 58 (4th ed.) to withdraw ANH in the following circumstance:

63 year old man, CHF, pneumonia, diabetes, in ICU as the result of a CVA, unconscious, mechanical vent., ejection fraction approximately 25%, phys. agree the Pt. won't regain consciousness and is immanently dying

**YES**, Directive 58 would allow for withdrawing ANH as well as the other life-sustaining interventions

**NO**, Directive 58 requires that ANH always be provided

---

Case #2

Would it be consistent with ERD no. 58 (4th ed.) to withdraw ANH in the following circumstance:

38 year old male, PVS due to diffuse anoxic brain injury, PEG Tube, no vent., advance directive refusing artificial life-support if ever permanently unconscious, family in agreement, saying “he wouldn’t have wanted to live like this.”

**YES**, Directive 58 allows us to respect the patient’s wishes

**NO**, Directive 58 requires that ANH be provided against the patient’s known wishes
Case #3

Would it be consistent with ERD no. 58 (4th ed.) to withdraw ANH in the following circumstance:

Unidentified male, mid 40’s, no known relatives or associates (“unbefriended”), undocumented, uninsured, head injury sustained in auto-ped. accident, no advance directive, phys. in agreement regarding “no hope of recovery of consciousness.”

**YES**, Directive 58 allows ANH to be stopped when the physicians determine that life sustaining treatment is no longer of sufficient benefit

**NO**, Directive 58 precludes stopping ANH solely on the basis of an external judgment of diminished quality of life

---

Church Teaching on ANH: Recent Developments

**2004 Papal Allocution on PVS**

- Background: response to “Utilitarian devaluation of human life”; legalization of PAS in Oregon and euthanasia in parts of Europe; Terri Schiavo
- PVS patients retain their inherent and inalienable human dignity
- Health care providers have obligations toward PVS patients from which they cannot exempt themselves
Church Teaching: Recent Developments

2004 Papal Allocution on PVS

- “Proper finality” of ANH is providing nutrition and hydration and the relief of suffering
- External judgment of diminished quality of life is not a sufficient reason to withdraw
- ANH is “in principle” a proportionate means and “as such” morally obligatory
  - Questions raised about the meaning of “in principle”

2007 CDF Responsum

- First Question: is ANH to PVS patient morally obligatory except when cannot be assimilated or causes significant physical discomfort? Answer: Yes, “so long as it is shown to accomplish its proper finality…”
- Second Question: may ANH be withdrawn from a PVS patient when a physician judges the patient will never recover? Answer: No, PVS Patient is “a person with fundamental human dignity…”
2007 CDF Responsum Commentary

- Clarifies that 2004 Allocution is consistent with previous papal teaching on obligation to use life-sustaining means
- Does not represent a change from previous teaching
- Primary purpose of allocution to reaffirm that the intrinsic value and personal dignity of every human being does not change . . . “A [person], even if seriously ill or disabled in the exercise of his [or her] highest functions, is and always will be a [person], and he will never become a ‘vegetable or an animal’.”

2007 CDF Responsum Commentary

- Clarifies that “in principle” does NOT exclude the possibility that . . . the artificial provision of food and water may be physically impossible due to:
  - Remote geographic location or extreme poverty
  - Emerging complications
  - Inability to assimilate food and liquids
  - Excessive burdens or physical discomfort arising from complications of the means employed
The Revisions


• Title: “Issues in Care for the Dying”
• Guided by Church’s teaching on Euthanasia re: ANH
• ANH not obligatory when do not provide comfort or can’t be assimilated
• Discusses ANH for PVS as “open question”

5th Edition, Part V

• Title: “Issues in Care for the Seriously Ill and Dying”
• Reaffirms guided by teaching on Euthanasia re: ANH
• While not obligatory in all cases, ANH is “basic care” that “in principle” should be provided to those in PVS
• Those in PVS retain full human dignity and must receive proportionate care

The Revisions

40. See Pope John Paul II, Address to the Participants…
ERD no. 58 (cont.)

“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.’”

41. Congregation for the Doctrine of the Faith, Commentary on…

ERD no. 58 (cont.)

“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.”
Practical Implications

Revisions must be interpreted in light of prior teaching

- “In principle proportionate” and “as such obligatory” means that ANH cannot be considered automatically disproportionate (optional) for this class of patients
- Withdrawal of ANH from PVS patient may not be based on “external assessment of diminished quality of life” (i.e., unilateral judgments of qualitative futility)
- Could still be withdrawn if causes complications or harm, cannot be assimilated or patient is imminently dying from an underlying pathological condition (other than PVS).

Practical Implications

Question remains about Advance Directives

- Could a Catholic health care institution respect an Advance Directive instructing the withdrawal of ANH in case of PVS in which the patient is not imminently dying from another underlying, progressive pathology and there are no other complications?
  - Church Teaching and the ERD revisions do not address this question explicitly
  - Individual bishops may hold diverging views or interpretations regarding this question.
Practical Implications

There are both arguments for:

- What is not explicitly forbidden is implicitly permitted
- Intent is to respect patient legal right to refuse ANH
- “Disproportionate means” remain those that “in the judgment of the patient” either do not offer a reasonable hope of benefit or entail excessive burdens.
- Analogy of Jehovah’s Witness and blood transfusion.

And against:

- Refusal in such circumstances would be suicide
- Respecting such an advance directive would be formal or implicit formal cooperation in suicide
- ERD no. 28 states that: “The free and informed health care decision of the person or the person’s agent is to be followed so long as it does not contradict Catholic principles.”
Practical Implications

Key Points of New ERD 58

- Generally\(^1\), there is a moral obligation to provide patients with food and water, including ANH.
- This obligation generally pertains to patients in a PVS (because they retain their full human dignity).
- This obligation precludes withdrawing ANH solely on the basis of “no hope of recovery”
- This obligation ceases in particular cases when ANH cannot be expected to prolong a patient’s life or the means used become excessively burdensome.

\(^1\)“In disregard of particular instances and details,”

The American Heritage Dictionary

Case #1

Would it be consistent with ERD no. 58 (5\(^{th}\) ed.) to withdraw ANH in the following circumstance:

63 year old man, CHF, pneumonia, diabetes, in ICU as the result of a CVA, unconscious, mechanical vent., ejection fraction approximately 25%, phys. agree the Pt. won’t regain consciousness and is immanently dying

**YES**, Directive 58 would allow for withdrawing ANH as well as the other life-sustaining interventions

**NO**, Directive 58 requires that ANH always be provided
Case #2

Would it be consistent with ERD no. 58 (5th ed.) to withdraw ANH in the following circumstance:

38 year old male, PVS due to diffuse anoxic brain injury, PEG Tube, no vent., advance directive refusing artificial life-support if ever permanently unconscious, family in agreement, saying “he wouldn’t have wanted to live like this.”

**YES**, Directive 58 allows us to respect the patient’s wishes

**NO**, Directive 58 requires that ANH be provided against the patient’s known wishes

Case #3

Would it be consistent with ERD no. 58 (5th ed.) to withdraw ANH in the following circumstance:

Unidentified male, mid 40’s, no known relatives or associates (“unbefriended”), undocumented, uninsured, head injury sustained in auto-ped. accident, no advance directive, phys. in agreement regarding “no hope of recovery of consciousness.”

**YES**, Directive 58 allows ANH to be stopped when the physicians determine that life sustaining treatment is no longer of sufficient benefit

**NO**, Directive 58 precludes stopping ANH solely on the basis of an external judgment of diminished quality of life
Final Thoughts

- The new ERD 58 does not reflect a change in Church teaching, but is intended to clarify what was previously referred to as the “presumption in favor” of ANH.
- Assuming a Health Ministry’s *current practices* are consistent with the previous directive 58, they should not require any kind of substantive revision.

Questions?/Discussion.