

Withholding Nutrition

The primary goal of the Christian clinical ethic is to provide compassionate medical care to all human beings. We recognize that nutritional support is both a universal human biologic requirement and a fundamental demonstration of human caring. Because we believe there should be a basic covenant between all of us to care for those who are incapacitated, we are committed to the provision of food and water to those who cannot feed themselves.

In exceptional cases, tube feeding may actually result in increased patient suffering during the dying process. Although we have a basic covenant to offer food and water to patients, we recognize that the provision of enteral or parenteral nutrition may not be indicated in patients who are clearly and irreversibly deteriorating, who are beyond a reasonable hope of recovery, and in whom death appears imminent.

In such cases, it is ethically permissible to withhold or withdraw nutrition and hydration, in full consideration of patient and family wishes.

However, we believe that physicians, other health professionals, and health care facilities should initiate and continue nutritional support and hydration when their patients cannot feed themselves. We are concerned that demented, severely retarded, and comatose individuals are increasingly viewed as "useless mouths." We reject this dehumanizing phrase. Rather than encouraging physicians to withhold or withdraw such patients' food and water, we encourage physicians to respond to God's call for improved physical, social, financial, and spiritual support of all vulnerable human beings.

The issue of the treatment of patients in coma or in persistent vegetative state (PVS) is part of the ongoing deliberations of the Ethics Commission and CMDA.

*Approved by the House of Delegates
Passed unanimously
May 3, 1990. Toronto, Canada.*

Explanation

Next to abortion, few other ethical issues in the current practice of medicine have generated as much difference of opinion or as many court cases in the past 15 years as the questions surrounding the removal of feeding tubes. Perhaps it is best to clearly frame the question: is it permissible to withhold or withdraw artificially administered fluids and nutrition from a patient who is unable to take in sufficient oral fluids and nutrition to survive?

The elements of the question are important for analysis and resolution. We are talking here of artificially administered fluids and nutrition, i.e. intravenous fluids, total parenteral nutrition, feeding tubes (nasogastric, gastrostomy, jejunostomy). We are not talking about orally administered fluids and nutrition. We will start with the assumption that it is never morally permissible to withhold oral fluids and nutrition from a patient who is willing and able to swallow enough to survive. This assumption is rooted in the basic obligation we have to meet the needs of even the least person who is hungry or thirsty (Matt. 25:44-45; generalized in Gal. 6:10). (Parallel to but different from the question posed, is the issue of whether it is ever permissible to allow a patient to refuse oral fluids if he or she is able to swallow. This question is better addressed in conjunction with the questions of refusal of treatment and/or suicide.)

In addition, we are talking about a patient who is unable to take in oral fluids and nutrition. Most often this is because the patient is unconscious and unable to swallow, e.g. permanent unconsciousness from brain injury (traumatic, hypoxic, other) or brain deterioration (dementia, tumor, etc.). The question also arises when oral alimentation is impossible in patients with various levels of consciousness because of disorders of the gastrointestinal tract, such as problems with motility (e.g. danger of aspiration), integrity (e.g. obstruction), or absorption (e.g. short gut syndrome).

Early discussions of the issue in both secular and Christian literature tended to focus on the act of feeding and the morality of the different ways of administration of fluids and nutrition. Early opponents of withdrawal of feeding tubes argued that feeding is obligatory because it is supportive and symbolic of caring, thus different from treatments like ventilators or dialysis machines. There was also talk about the cruelty of starving patients to death and fears of abuse if it became acceptable to stop feeding tubes. As the argumentation developed, it became clear that patients from whom fluids and nutrition are withdrawn die of dehydration, not starvation. Studies in hospice patients showed that dehydration was not uncomfortable as long as the patient's mouth was kept moist.^(1,2) Slowly, a secular consensus has developed that artificially administered fluids and nutrition are different from eating and drinking, are modes of treatment, and are thus optional like any other treatment. This opinion is reflected in position statements from the AMA (3), the American Geriatrics Society (4), and the American Academy of Neurology⁽⁵⁾.

Many Christians have been reluctant to join this secular consensus. They often refer to Jesus' mention of his disciples giving a cup of cold water in his name (Matt 10:42, Mark 9:41) and the pleading of the rich man in hell for the beggar Lazarus to dip his finger in water to cool his tongue and ease his agony (Luke 16:24). These passages assume that such actions would both sustain life and/or relieve suffering. Accordingly, some Christians can support withholding artificially administered fluids and nutrition in the exceptional cases where patients are imminently dying with or without fluid/nutrition support and for whom that support will add to the suffering of the dying process or will at least provide no significant benefit. The 1990 CMDS statement on **Withholding and Withdrawing Fluids and Nutrition** reflects this position. There continues to be disagreement among Christians, both among Protestants and among Catholics, about the use of artificially administered fluids and nutrition in patients who are not imminently dying, but could live for an extended period of time with a feeding tube or other means of alimentation. Some distinguish these cases from cases of imminent death on the grounds that to withhold even artificially administered fluids and nutrition when ongoing life requires them is unacceptably to pass judgment on a life as "unworthy to be lived." Differences in outlook on these matters are reflected in the abstracts and references offered for your further study.

Footnotes:

1. McCann RM, Hall WJ, Groth-Juncker A. Comfort care for terminally ill patients: the appropriate use of nutrition and hydration. *JAMA* 1994;272(16):1263-1266.

2. Printz LA. Terminal dehydration: a compassionate treatment. *Archives of Internal Medicine* 1992; 152(4):697-700.

3. AMA Council on Ethical and Judicial Affairs. *Current Opinions* 1986. Chicago: AMA, 1986:12-13.

4. AGS Clinical Practice Committee. Feeding tube placement in elderly patients in the long-term care setting. 1990

5. AAN. Position of the AAN on certain aspects of the care and management of the persistent vegetative state patient. 1988.

Abstracts

Souba WW. Nutritional support. *New England Journal of Medicine* 1997;336(1):41-48.

In this article on nutritional support by the enteral or intravenous route, the author discusses the identification of malnourished patients, the indications for nutritional support, and the optimal route of delivery and composition of nutritional formulas. It is also noted in this article that the benefits of

nutritional support is unproven and the author reviews studies done on patients using nutritional support in various illness. He concludes, "Although the dividends from nutritional support have been modest, this should not dampen our enthusiasm, because there are investigational areas that should be actively pursued. Carefully conducted clinical trials may identify additional groups of patients who will benefit from nutritional intervention."

Craig G. Palliative care from the perspective of a consultant geriatrician: The dangers of withholding hydration. *Ethics & Medicine* 1999;15(1):15-19.

"Dr. Craig reviews arguments she put forward in a paper in the *Journal of Medical Ethics* in 1994. This became the focus for wide debate of the ethical and legal dilemmas that arise when hydration is withheld in terminally ill patients. As a result national guidelines on the ethical use of artificial hydration were developed. Sedation without hydration is dangerous on medical, physiological, ethical and legal grounds, and can be disturbing for relatives. Doctors are legally responsible for their acts and their omissions and must not abuse their power. Attention to hydration is not merely optional, it should be a basic part of good medicine and good palliative care. Recommendations. There should be:

1. An obligatory second Consultant opinion when sedation without hydration is considered.
2. A confidential enquiry into the use of parenteral sedation in palliative care, and some effective monitoring system.
3. A forum for resolving clinical ethical disputes during life.
4. Research into thirst perception in the dying.
5. A life-oriented approach to palliative care, in keeping with the best traditions of the hospice movement."

Finucane TE., Christmas C, Travis K. Tube feeding in patients with advanced dementia. *JAMA* 1999;282(14):1365-70.

"Patients with advanced dementia frequently develop eating difficulties and weight loss. Enteral feeding tubes are often used in this situation, yet benefits and risks of this therapy are unclear. We searched MEDLINE, 1966 through March 1999, to identify data about whether tube feeding in patients with advanced dementia can prevent aspiration pneumonia, prolong survival, reduce the risk of pressure sores or infection, improve function, or provide palliation. We found no published randomized trials that compare tube feeding with oral feeding. We found no data to suggest that tube feeding improves any of these clinically important outcomes and some data to suggest that it does not. Further, risks are substantial. The widespread practice of tube feeding should be carefully reconsidered, and we believe that for severely demented patients the practice should be discouraged on clinical grounds."

Gillick MR. Rethinking the role of tube feeding in patients with advanced dementia. *New England Journal of Medicine* 2000;342(3):206-09.

The "graying of America" and elsewhere has brought with it a sharp increase in the rate of Alzheimer's disease and other types of dementia. As dementia progresses and patients cease to be able to feed themselves, caretakers are faced with the difficult decision of whether to use a feeding tube. The author discusses pragmatic aspects of using feeding tubes in patients with advanced dementia such as efficacy and promotion of comfort. Because "feeding tubes are generally ineffective in prolonging life [and] preventing aspiration", he concludes that a new standard of care should be adopted, one in which advanced dementia is viewed as a terminal illness and treated as such by physicians.

Orr RD, Harris CE. The PVS Debate. *Today's Christian Doctor* 1999;XXX(1):8-13.

In this article, 2 members of the CMDA Ethics Commission take opposing viewpoints about the moral requirement for continued use of tube feedings in a case study involving a family whose son has been in a persistent vegetative state with no improvement for 7 years.

Siegler M, Weisbard AJ. Against the emerging stream: should fluids and nutritional support be discontinued? *Archives of Internal Medicine* 1985;145(1):129-131

In a narrowly focused paper on patients possessing the capacity for consciousness who have not completely rejected nutritional support, this physician/ethicist and attorney criticize the rapidly developing consensus that it is permissible to withdraw fluids and nutrition in a wide variety of patients. They contend that those making such decisions have concluded that the burdens of continued nutritional support outweigh the benefits of sustaining life, and this conclusion is often reached in too cavalier a manner.

They seek to reverse the flow of opinion in order to protect vulnerable patients, to relieve physicians from these troubling decisions, to continue the image of the medical profession as being driven by compassion rather than cost consciousness, and to preserve society's larger interest by supporting the value of life.

Connery JR. The ethical standards for withholding/withdrawing nutrition and hydration. *Issues in Law and Medicine* 1986; 2(2):87-97

This Jesuit professor concludes that "... even if one does not place some positive act of violence but simply omits something necessary to preserve life, he can be guilty of euthanasia. It all depends on his intention. If his intention is to spare the patient a burdensome treatment, or one that is useless to preserve life, the omission can be justified. But if his intention is to bring on death, it is euthanasia. Since the latter intention is present when nutrition and hydration are omitted for quality of life reasons, the failure to provide them has to be condemned as intentional euthanasia by omission."

Steinbrook R, Lo B. Artificial feeding---solid ground, not a slippery slope. *New England Journal of Medicine* 1988;318(5):286-290

The authors state that a 1986 Supreme Judicial Court of Massachusetts decision (Brophy) "is part of an emerging medical and legal consensus on the withholding of artificial feeding from adult patients. The view is growing that tube and intravenous feeding should be likened to other medical interventions and not to the routine provision of nursing care or comfort. Competent patients have the right to refuse such feeding. Feeding can also be stopped in incompetent patients who have earlier stated such a wish."

Shannon TA, Walter JJ. The PVS patient and the forgoing/withdrawing of medical nutrition and hydration. *Theological Studies* 1988;49:623-647

These Roman Catholic authors argue that "... the moral intention to forgo or withdraw medical nutrition and hydration is not identical with the intention in euthanasia....The clear intent is to end a procedure that is not proportionately benefiting the person or to release the person from entrapment in technology." They go on to say that "... forgoing or withdrawing this technology is argued as a moral option, not a mandatory practice" and is thus "... within the range of moral activities."

Harvey, Nancy. "Dying Like a Dog." *First Things* 52: 28-31 April 1995.

The author, often a patient herself due to chronic illnesses, defends the position that artificial nutrition and hydration should generally be administered and may only be withheld or withdrawn in exceptional cases in which the provision of such would increase the suffering of a patient who is imminently and irreversibly in the process of dying. She rejects appeals to the "unnaturalness" of artificial nutrition and hydration as a basis for the rejection of such treatment and also counters the notion that policies which call for the administration of artificial nutrition and hydration result in an increased desire for and acceptance of euthanasia by those who fear the receipt of such treatment. She calls for persons to speak out against "... the idea, so popular with those who would remove food and fluid, that taking away a helpless person's food and water is morally superior to giving him a lethal injection. "

Harris, Curtis and Hollman, Jay. "Withdrawal of Treatment: Feeding, Hydration and the Persistent Vegetative State" . Chapter 13 in *New Issues in Medical Ethics*, Hollman J ed. Bristol, TN: CMDS; 1995, pp 189-198

After setting the stage by briefly reviewing major court decisions about limitation of treatment in patients in the persistent vegetative state (PVS), the authors present a clinical perspective of the PVS and other non-sentient conditions. They go on to point out that Christians are not unanimous on the issue of withdrawal of artificially administered fluids and nutrition in PVS patients. They discuss the moral and legal issues and conclude that there is room for differences of opinion in such difficult decisions.

Bibliography

Meilander G. On removing food and water: against the stream. *Hastings Center Report* 1984; 14(6):11-13

The author maintains that feeding the permanently unconscious is neither useless nor excessively burdensome, even though it cannot restore cognitive function. Withdrawing a feeding tube from a patient who is comatose, but not dying, can only result in death.

Dresser RS, Boisaubin EV. Ethics, law, and nutritional support. Archives of Internal Medicine 1985;145(1):122-124

The authors point out that advanced techniques of nutritional support raise questions about the propriety of their use for certain patients. They view artificially administered fluids and nutrition as a medical intervention, and it should be used with the same guidelines applied to other interventions based on its benefits. They conclude that tube feedings and total parenteral nutrition can no longer be dismissed as simple nor should they automatically be provided.

Lynn J, ed. By No Extraordinary Means: The Choice to Forge Life-Sustaining Food and Water. Bloomington, IN: Indiana University Press, 1986

Dr. Lynn, a geriatrician and ethicist, has collected new and previously published pieces by an exceptional spectrum of scholars from ethical, legal, religious, public policy, and health care fields. The book is authoritative and comprehensive and was written during the thick of the secular debate about the issue of stopping tube feedings.

Derr PG. Why food and fluids can never be denied. Hastings Center Report 1986; 16(1):28-30

A philosopher concludes that A social decision to permit physicians or health-care facilities to deny food and fluids to patients who are capable of receiving and utilizing them, directly attacks the very foundation of medicine as an ethical profession.

Wennberg RN. Terminal Choices. Grand Rapids, MI: Eerdmans, 1989; pp 130-136

This Presbyterian professor of philosophy states that providing food and water for a dying patient is an expression of care and compassion. He goes on to take the position, however, that sick people are not always obligated to accept artificial fluids and nutrition.

Bouma H, Diekema D, Langerak E, Rottman T, Verhey A. Christian Faith, Health, & Medical Practice. Grand Rapids, MI: Eerdmans, 1989; pp 290-297

The five scholars from the Reformed tradition (and from several disciplines) conclude that withdrawal of artificial fluids and nutrition is sometimes acceptable if there are adequate safeguards to protect the welfare of the terminally ill or permanently unconscious, and if appropriate means are used to minimize the negative psychological side effects. The possibility of abuse and the powerful symbolic nature of sustenance cause them to respect the stand of those who find it morally impermissible.

Scofield G. Getting down to cases. Issues in Law & Medicine 1991;7(2):213-226

Commenting on a hypothetical case, this attorney states that to equate tube feeding with eating demeans any symbolic offering of food and water, or human communal activity.

Davis JJ. Concerning the case of 'Mr. Stevens' . Issues in Law & Medicine 1991;7(2):227-241

This evangelical professor of theology and Christian ethics states "From the biblical perspective man is created for the purpose of praising the Creator and experiencing a conscious personal relationship with God. When this possibility no longer exists, then man has passed---at the personal level---from life into death, even though bodily organs may still function." He concludes that it would be permissible to withdraw the feeding tube from the hypothetical Mr. Stevens.

Bernat JL, Gert B. Patient refusal of hydration and nutrition: an alternative to physician-assisted suicide or voluntary active euthanasia. Archives of Internal Medicine 1993;153:2723-2727

This neurologist/ethicist and philosopher who have maintained a strong stance against physician-assisted suicide and euthanasia propose that the rational refusal of fluids and nutrition by competent patients who are terminally ill could offer them the control over their destiny which seems to undergird the movement to allow physician-assisted death.

Nelson LJ, Rushton CH, Cranford RE, Nelson RM, Glover JJ, Truog RD. Forgoing medically provided nutrition and hydration in pediatric patients. Journal of Law, Medicine & Ethics 1995; 23:33-46

Although the issue of artificially administered fluids and nutrition is fairly well settled in adults, the authors raise the more unsettling question regarding children. They conclude that Clinicians and parents should be guided by the presumption---well warranted in most cases---that minor patients should receive nutrition and hydration as part of conferring benefit and longer life...Nevertheless, it is not ethically acceptable to prohibit categorically the forgoing of medically provided nutrition when the patient is a child. They specifically discuss cases of neurologic devastation, irreversible total intestinal failure, and proximate death.