Introduction

Over thousands of years Christians, and most physicians, have presumed that patients who are unable to feed themselves should receive assisted nutrition and hydration. Prior to the availability of current technology, this meant that patients who could not feed themselves received assistance via bottle-feeding, spoon-feeding or careful use of a cup or glass. This oral supplementation was voluntarily or reflexively swallowed and digested. We will begin with the assumption that if patients are willing and able, this type of nutrition and hydration should never be withheld from them.

In the last century, with the advent of plastic tubing, new ethical issues have been raised regarding nutrition and hydration. By performing fairly simple procedures, artificial nutrition and hydration (AN&H) may be provided to almost all patients, including those unable to swallow. Therefore, patients who would otherwise imminently die may sometimes be kept alive for months or years. Should AN&H be regarded as a benign extension of the concepts entailed in the spoon, bottle and cup, which should be embraced without exception, or as a medical intervention that is elective, not mandatory?

The Catholic Church has long maintained a distinction between ordinary and extraordinary (or proportionate and disproportionate) care and has stated that we have a moral obligation to use ordinary or proportionate means of preserving life. The church has defined extraordinary or disproportionate care as acts that in a physician's judgment "do not offer a reasonable hope of benefit, or entail an excessive burden, or impose excessive expense on the family or community." While many Protestant churches do not use this extraordinary/ordinary dichotomy, they often do employ the concepts of futility and the weighing of costs versus benefits (or benefits versus burdens) to assist in making these difficult choices regarding AN&H.

Arguments for Allowing the Withholding or Withdrawing of AN&H

In regard to patients who are imminently dying and for whom AN&H will provide absolutely no benefit, few would maintain that we have an ethical obligation to supplement. There are other patients, for whom the burdens clearly outweigh the benefits, for whom supplementation can be foregone with no debate. For instance, patients with complete digestive tract infarction will not benefit from and will in fact be caused pain by
continued AN&H. Again, few would suggest continued supplementation for these patients.

A more controversial area is that of patients who are in persistent vegetative state (PVS). In PVS, patients are not capable of voluntary action or behavior. They are not aware of their environment and do "not have the capacity to experience pain or suffering." Nevertheless, these patients are not terminally ill and may survive for years if AN&H are provided. In such cases, do physicians and families have an obligation to continue supplementation indefinitely?

While there is no compelling explicitly Christian argument that patients in PVS should necessarily have their AN&H discontinued, some important arguments have been put forth for regarding such termination as an elective decision:

1. Patients in PVS cannot experience pain. Withdrawal of AN&H will not cause pain.

2. Continued supplementation is costly and burdensome in many ways, and after a period of several months the likelihood that the patient will return to sentient functioning becomes vanishingly unlikely.

3. With so many other pressing material needs around the world, is it good stewardship to spend large sums of money on patients who will almost certainly never recover?

4. The American Medical Association, the American Academy of Neurology, health insurers, and most Christian ethicists agree that the provision of AN&H is a medical intervention and not simply a part of ordinary, routine care for patients.

5. Since the provision of AN&H is a medical treatment, "[W]ithholding them no more changes the basic medical cause of death than does withholding a respirator." Patients die not from starvation or dehydration, but from their underlying disease processes.

6. Withholding AN&H is not a painful process as long as the patient's lips, eyes, and mouth are kept moist.

Arguments for Not Allowing the Withholding or Withdrawing of AN&H

Some godly believers feel that since all humankind is made in the image of God, and since even the PVS patient remains in that image, we never have the right to terminate nutritional support. One of their concerns is that since God continues to perform miracles, and since we cannot know the future, we thus cannot know when a situation is truly futile. For these believers, there would never be a time when nutrition should be discontinued. In addition, they state that food and water have such symbolic value that they cannot be considered merely medical treatment. These believers must act in accord with their convictions, and fellow Christians who disagree should show respect for such convictions.
Many other Christians would allow for discontinuation in the cases of absolute futility. Of these Christians, very few would find AN&H ethically mandated when providing it would cause the patient increased pain and suffering with no chance of improvement (as in the example of complete digestive tract infarction). Thus, while some would debate the exact definition of futility or the valuation of costs versus benefits, many controversies revolve around the issue of PVS.

Ethicists who stand opposed to withdrawal of AN&H frequently believe:

1. AN&H are necessary to preserve patient dignity.

2. Nutrition and hydration is ordinary humane treatment and should be provided to every patient. The argument between artificial versus ordinary is pointless since such supplementation can be provided at small cost and with little difficulty.

3. Withdrawal of AN&H amounts to starving the patient to death. Dehydration and starvation would be the proximate cause of death, not the underlying illness.

4. Food and water symbolize basic human care for the dying. If we begin withholding such care from the dying, we are denying their humanity. This may represent the beginning of the slippery slope toward active euthanasia.

5. Food and nutrition represent "...the minimum nurturing support that every member of a human community is due until death." 

Resolution

Thus, the first point of debate would be whether there is ever a time that AN&H can ethically be withdrawn. For those that emphasize God's miraculous interventions and our inability to foresee the future, perhaps the answer would be "No." We should remain true to our godly convictions and act accordingly. Fellow believers who disagree with such convictions should remain respectful and supportive of them.

Most people on both sides of the debate generally agree that AN&H may be withheld or withdrawn when the administration of such would be absolutely futile (although they may debate when that point has been reached). Similarly, few will argue regarding situations where there is much greater burden than benefit for the patient (they may, however, debate when this is true). More frequently, Godly, thoughtful people may disagree on whether AN&H should be provided to patients in PVS. How, then, should Christians grapple with this thorny issue when it confronts their family or close friends?

I would suggest the following, based on thoughts from Rae, Kilner, the state of American law, and John Wesley:

1.
If you decide that AN&H should never be withdrawn, then stick with your convictions before God and act accordingly. This is your answer. If, on the other hand, you believe that there might be situations where discontinuation of AN&H would be ethical, then continue with the following items.

2. Decide if the patient can absorb AN&H. If not, the discussion is moot, as such supplementation should certainly be withheld or withdrawn.

3. If the patient is capable of sound decision-making and can absorb AN&H, ask the patient first about his or her wishes.

4. If the patient is incapable of deciding, has he or she indicated his or her wishes concerning AN&H prior to this time?

5. If a living will, power-of-attorney document, or surrogate principle applies, then this must be respected.

6. The proxy decision-makers should make their decisions based on the question "What would he or she have wanted done?" If they cannot answer this clearly, then the next question should be "What actions would serve the best interests of this patient?"

7. In deciding complex issues, one should always ask if the proposed solution is God-centered, bounded by present and ultimate reality, and impelled by a spirit of love.

8. After reviewing Scripture for appropriate guidance, seeking godly counsel of fellow believers, friends, and family, reviewing all the facts carefully, referring to church tradition (or the type of articles referenced here), and praying for the Holy Spirit's guidance, one should proceed with making a decision. God has promised to provide wisdom to those who pray in faith (James 1:5-8).

Conclusion

Godly people may end up on different sides of the complex decisions regarding AN&H. We can use the framework discussed above to find solutions that will honor and glorify God. We should carefully seek God's will in making the decisions that will confront us, be loving, prayerful and supportive of our friends and fellow believers who struggle with these choices, and realize that for the Christian, ultimate reality is eternal life with God.


3 National Conference of Catholic Bishops, "Ethical and Religious Directives for Catholic Health Care

Ibid.

5 “Certain Aspects of the Care and Management of the Persistent Vegetative State Patient" in American Academy of Neurology Practice Handbook (Minneapolis, MN: Member Service Center, 1988).

Ibid.


10 Scott B. Rae, Moral Choices: An Introduction to Ethics (Grand Rapids, MI: Zondervan Publishing, 1995).


12 Rae, Moral Choices


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