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Withholding or Withdrawing Nutrition or Hydration

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(Scope Note 7, first published in November 1986, was last revised in 1988. Material published in the past few years has been added to this update.)

Current medical technologies allow more people than ever before to survive for long periods of time with extremely limited physical and mental capacities. For those patients who are irreversibly comatose or who are imminently going to die or who are in a persistent vegetative state (PVS), the question of withholding or withdrawing the nutrition and fluids that they have been receiving through feeding tubes, has become an ethical dilemma for those responsible for care. Families, physicians, nurses and other health personnel question what constitutes appropriate medical care, and whether such treatments any benefits to the patient or whether prolonged intrusive procedures become burdensome to the dying, deeply comatose, or PVS patient.

About 80% of those who die are in hospitals or a health care facility (I, President's Commission 1983), and, according to the American Hospital Association, 70% of these deaths are preceded by a decision stop or withhold some form of care. (V, Albert 1991). Using these figures, over half of all who die are involved in some way in an end of life health care decision. In most such cases the families of the patients, their physicians, and hospital or nursing home personnel are able to reach decisions based on the deteriorating health of the patient (V, Mishkin 1986) but in a few cases, solutions are found only through the courts.

In the past 15 years dozens of court cases concerned with the removal of tubes providing nutrition and from patients have been heard in local, state, and federal courts. In 1990 the U.S. Supreme Court handed down a decision in its first consideration of such a case, the removal of a gastrostomy tube from Nancy Cruzan, a patient who had been in a persistent vegetative state for seven years (III, Cruzan 1990).

The development of flexible plastic tubing, a technical advance of the past half century, has made it possible to supply nutrition and hydration to patients who are unable to chew or to swallow natural foods or liquids. Pre-prepared, chemically balanced, liquid diets have been developed which can provide the body with the various minerals, proteins, electrolytes and other substances needed to sustain life. Currently, such nutrition and hydration are given through: a) nasogastric tubes, b) intravenous tubes, and c) surgically implanted gastrostomy tubes which carry these substances to the patient. A fourth method, hyperalimentation, involves the permanent insertion of a large needle into a deep, large vein (tubes are attached to this access whenever needed). This provision of nutrition and fluids in the medical setting has been perceived by many persons as yet one more technological medical treatment—a treatment not unlike using a respirator to breathe for the patient. However, many others see tube feeding as simple health care that is basic and never to be denied to any patient: the giving of food and water.

Forty-eight states and the District of Columbia have natural death statutes, many specifically mentioning nutrition and hydration. Nebraska and Pennsylvania have no legislation concerned with living wills or health decisions. Among those states which prohibit withholding nutrition and hydration are Georgia, Kentucky, Missouri, and Wisconsin; North Dakota says it must be given if it can be physically assimilated.

One thing is certain, withdrawing or withholding nutrition and fluids from terminal or irreversibly comatose patients or those in a persistent vegetative state will end these lives in a brief period of time. Those who see such treatment as only prolonging a lingering death believe that a burden which offers no benefits has been removed. Those who believe that the removal of feeding tubes is the immediate cause of death, raise questions concerning euthanasia and professional ethics. To date there is no consensus of opinion that satisfies everyone, no court decision that answers in every situation, nor are there any guidelines that have been universally agreed upon. However, there is a large body of literature available, particularly as it

pertains to individual patients or situations, about the denial of tube feeding and hydration.

The literature about the withholding or withdrawal of nutrition and hydration in this Scope Note concerns patients who are near death or who exist in a permanent coma or a permanent vegetative state.

The documents cited have been divided into five areas: I. Federal and State Actions, II. Professional Groups, III. Court Cases, IV. Books, and V. Articles (includes journal articles, chapters, special sections, and news reports).

Throughout the literature and documents concerned with the topic of the denial of artificial food or fluids, there is agreement that the ethical and societal issues involved are complex.

I. Federal and State Actions

President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. **DECIDING TO FOREGO LIFE-SUSTAINING TREATMENTS: ETHICAL MEDICAL AND LEGAL ISSUES IN TREATMENT DECISIONS.** Washington: US Government Printing Office, 1983. 554 p. (Out of print at GPO; facsimiles are available from the National Technical Information Service, Springfield, VA 22161, document number PB 83-236836.)

The Commission notes that most persons now die in a hospital or a nursing home, and that “for almost any life-threatening condition, some intervention can now delay the moment of death. . . . Matters once the province of fate have now become a matter of human choice, a development that has profound legal and ethical implications” (p. 1). In the report the term “life-sustaining treatment” includes all health care interventions which lengthen the patient's life. One such treatment named is any special feeding procedure (p. 3). The Commission found no moral or legal distinction between withholding or withdrawing any treatment, and concluded “that neither law nor public policy should mark a difference in moral seriousness between stopping and not starting treatment” (p. 17). It also found that no particular treatments including such “ordinary” hospital interventions as parenteral nutrition or hydration, antibiotics, and transfusions to be universally warranted and thus obligatory for a patient to accept (p. 90).

Most patients who are permanently unconscious cannot be kept alive without “an array of increasingly artificial feeding interventions. . . . Since permanently unconscious patients will never be aware of nutrition, the only benefit to the patient of providing such increasingly burdensome interventions is sustaining the body to allow for a remote possibility of recovery. The sensitivities of the family and care-giving professionals ought to determine whether such interventions are made” (p. 190).

Appendix B of the Commission report discusses care of the dying patient and says that substantial lack of appetite is “almost the norm in the latter stages of terminal illness. . . . Only rarely should a dying patient be fed by tube or intravenously” (p. 288).

Baby Doe Case

Parents of a Down’s syndrome infant who was born in Indiana in 1982 decided not to permit surgery to repair the baby’s blocked esophagus. The infant, who was known as “Baby Doe,” starved to death in the hospital. In response, the Secretary of the US Department of Health and Human Services proposed federal regulations (under Section 504 of the Rehabilitation Act of 1973) to require that hospitals post notices stating that health care could not be withheld from infants on the basis of mental or physical impairments. This regulation took effect early in 1984, and the approved display notices said that “nourishment and medically beneficial treatment” should not be denied (45 CFR §84. 55(b) [3] and [4]).

Subsection (c) of this regulation said that state child protective agencies should be prepared to obtain “timely court order[s] to compel the provision of necessary nourishment and medical treatment” (45CFR §84. 55(c)(1)[iv]). These federal regulations concerning handicapped infants applied even if parental consent to treatment had been refused.

In cases testing the regulations, the American Medical Association, the American Hospital Association and other medical groups questioned their validity (United States v. University Hospital, 729 F. 2d. 144 [1984]; American Hospital Association v. Heckler, 585 F. Supp. 541, App. to

Pet. for Cert. 50a [1984]). The lower courts found the regulations were an invalid application of the 1973 act and this ruling was upheld by the U.S. Supreme Court on June 9, 1986 (Bowen v. American Hospital Association, et al., [No. 84-1529] 54 LW 4579, US Supreme Court, June 9, 1986).

Currently, under the final rule in the Child Abuse and Neglect Prevention and Treatment Program (implementing the Child Abuse Amendments of 1984 [Pub. L. 98-457]), treatment of infants with life-threatening conditions must include providing appropriate nutrition, hydration, and medication even when the infant is irreversibly comatose, imminently dying, or when such measures are futile in terms of survival (45 CFR 1340.15(b)(2)(i),(ii),and (iii), April 15, 1985).

Office of Technology Assessment

U.S. Congress, Office of Technology Assessment. **LIFE-SUSTAINING TECHNOLOGIES AND THE ELDERLY**. OTA-BA-306. Washington, DC: US Government Printing Office, 1987. Summary Report, OTA-BA-307.

The Office of Technology Assessment (OTA) report includes discussion about nutrition and hydration care. Levels and kinds of care are part of Chapter 4, “Ethical Issues,” with food and water discussed on pp. 147-148. Chapter 8, “Nutritional Support and Hydration”, pp. 275-329, describes kinds of artificial feeding available and includes different nutritional views as well as utilization and cost figures. This chapter ends with 234 references to the literature. Appendices include: “The Effect of Normal Aging on the Assessment of Nutritional Status” and a “Useful Glossary of Acronyms and Terms.”

State Actions

New York State Task Force on Life and the Law. **LIFE-SUSTAINING TREATMENT: MAKING DECISIONS AND APPOINTING A HEALTH CARE AGENT**. Albany: The Task Force, July 1987. 180 p.

The New York Task Force was convened in March 1985 to develop recommendations for public policy. This report discusses the right to refuse treatment under New York law and various ethical problems. Consideration of artificial nutrition and hydration treatments

were the “focus of the most lengthy and thorough deliberation” of all the treatments reviewed by the Task Force (p. 36). The Task Force states that competent adults have the right to have previous decisions concerning withholding or withdrawing of nutrition or hydration honored if health circumstances cause permanent unconsciousness or if the person is “at the end stage of the dying process” (p. 39). The Task Force concludes that there is a compelling need for legislation to ensure that a person’s preferences concerning treatment are honored after one has lost the capacity to make the preferences known (p. ii), and that a proxy be named to carry out health care decisions.

II. Professional Groups

American Academy of Neurology. **Position of the American Academy of Neurology on Certain Aspects of the Care and Management of the Persistent Vegetative State Patient.** Adopted April 21, 1988, Cincinnati, Ohio. 6 p.

The document says that PVS is a “form of eyes open permanent unconsciousness in which the patient has periods of wakefulness and physiological sleep/wake cycles, but at no time is the patient aware of himself or his environment.” The statement indicates that these patients are not terminally ill, do not experience pain or suffering nor can they swallow. It goes on to call the artificial provision of nutrition and hydration a medical treatment which may be discontinued after a careful evaluation of the patient’s diagnosis and prognosis, benefits and burdens, and the preferences of the patient and family. The statement describes why it is a medical treatment and says that it is good medical practice to initiate artificial feeding when prognosis is uncertain, but that it is also all right to terminate treatment when the patient’s condition becomes hopeless.

American Dietetic Association. **Position of the American Dietetic Association: Issues In Feeding the Terminally Ill Adult.** *Journal of the American Dietetic Association* 87(1): 78-85, January 1987.

The statement addresses some of the ethical, medical, legal and nutritional issues in feeding the dying. It concludes with specific considerations on whether to withhold nutritional sup-

port: the patient’s death will come in a few hours or days; feeding will worsen the patient’s condition, symptoms, or pain; a competent patient has expressed an informed preference to refuse such feeding; or the patient has an advance directive indicating preference if incompetence occurs.

American Medical Association, Council on Ethical and Judicial Affairs. **Persistent Vegetative State and the Decision to Withdraw or Withhold Life Support.** Chapter 19 in **REPORTS.** Chicago: American Medical Association, 1989. 19p.

The paper defines PVS and discusses the ethical and legal implications of decisions to withhold or withdraw life-prolonging medical treatment.

American Medical Association, Council on Ethical and Judicial Affairs. **CURRENT OPINIONS 1986.** Chicago: American Medical Association, 1986.

In March 1986 the AMA amended an earlier statement regarding the care of a patient whose death is imminent or whose coma is irreversible to include the following: “life-prolonging medical treatment includes medication and artificially or technologically supplied respiration, nutrition or hydration.” Section 2.18, Withholding or Withdrawing Life-Prolonging Medical Treatment, pp. 12-13.

American Nurses Association. **Dilemmas In Practice: Withdrawing or Withholding Food and Fluids.** Excerpts from the Guidelines of the American Nurses Association Committee on Ethics. *American Journal of Nursing* 88(6): 797-798, June 1988.

Stating that nurses should not usually be involved with the withholding or withdrawing of food or fluids, the guidelines then say there are a few cases when such a step is morally permissible: if the patient clearly would be harmed (damaged), or when patients competently refuse such treatment. However, in most cases it says the provision of food and fluid is in the patient’s best interest.

Committee on Biomedical Ethics of the Los Angeles County Medical Association and the Los Angeles County Bar Association. **Principles and Guidelines Concerning the Foregoing of**

Life-Sustaining Treatment for Adult Patients.
Adopted January 6, 1986.

The guidelines present general principles for decision making by adult patients or their surrogates, and define a terminal illness as an irreversible medical condition which will cause death in one year. The medical records of a comatose patient should have statements by at least two qualified physicians indicating that any meaningful recovery of the patient's cognitive functions is unlikely: "In such circumstances, all life-sustaining interventions, including nutrition and hydration, are legally equivalent. It is legally acceptable for the caregivers to withhold or withdraw any or all of them. It is recognized however, that nutrition and hydration have a powerful and symbolic significance to both the members of the general public and to many caregivers. Decisions concerning the care of an individual patient should be made jointly by members of the health care team and the patient's family and/or other appropriate persons."

Joint Subcommittee on the Care of the Terminally Ill and the Committee on Public Health and the Committee on Medicine and Society. **Statement.** Approved by the Council of the New York Academy of Medicine, April 22, 1987.

The committee states that "technologically supplied nutrition and hydration" should not be distinguished from other life-sustaining treatments, and supports the right of competent patients to decline such measures.

Massachusetts Medical Society. **Resolution.** Passed July 17, 1985.

"The Massachusetts Medical Society recognizes the autonomy rights of the terminally ill and/or vegetative individuals who have previously expressed their wishes to refuse treatment including the use of intravenous fluids and gastrointestinal feeding by tube and that the implementation of these wishes by a physician does not in itself constitute unethical medical behavior provided the appropriate medical and family consultation is obtained."

Pontifical Academy of Sciences. **Prolonging Life and Determining Death. Report.** *Health Progress* 66(10): 31-72, December 1985.

A short statement was released following a

three day meeting of the Pontifical Academy of Sciences in Rome in October 1985. Feeding is included as appropriate care for a person in an irreversible permanent coma. Medical interventions are not required if there is no benefit to the patient.

Society of Critical Care Medicine Ethics Task Force. **Consensus Report on the Ethics of Foregoing Life-Sustaining Treatments in the Critically Ill.** *Critical Care Medicine* 18(12): 1435- 1439, December 1990.

The consensus is a compilation of ideas from previous guidelines and statements, and includes: a decision to withdraw a treatment already initiated should not necessarily be ethically regarded as more problematic than a decision not to initiate a treatment; treatments derive medical justification from benefits and when these are achieved or no longer work, treatment loses justification and may be withheld; and provision of nutrition and hydration by artificial means is a category of treatment which is not intrinsically morally different from CPR, ventilators, etc.

III. Court Cases

Barber/Nejdl v. Superior Court of Los Angeles County, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983).

Clarence Herbert, a 55 year old man, became comatose following surgery, and his physicians, Doctors Barber and Nejdl, agreed that he would not recover from this coma. After meeting with Mr. Herbert's family, the doctors removed the patient's life-support systems, including his intravenous feeding tubes. A nurse complained about the decision, saying that it had been made hastily. The district attorney prosecuted the two physicians for murder; he said that their termination of treatment was to conceal malpractice in surgery and they had stopped treatment too quickly. The California Court of Appeals dismissed the charges and ruled that they were not required to treat if there were no hope of recovery; the court also said that a spouse could make such a decision if the patient were incompetent. It ruled that provision of artificial nourishment and hydration was no different from using other medical equipment (V, Mishkin 1986).

Brophy v. New England Sinai Hospital, Inc., 398 Mass. 417, 497 N.E. 2d 626 (1986).

In March 1983 Paul Brophy, a 45 year old fireman, suffered a cerebral aneurysm, and was totally comatose following surgery to try to repair his brain. A gastrostomy tube was placed in his stomach in December 1983 to supply nutrition and hydration, and a little over a year later, in January 1985, his family requested that the hospital discontinue all treatment including artificial nourishment. When the hospital refused, Mrs. Brophy requested a court order. Paul Brophy, when he was healthy, had often said that he would never want to be kept alive in a vegetative coma. A Massachusetts lower court in October 1985 said the hospital could forego all interventions except the removal of the feeding tube which the judge said was not painful, burdensome, unusual or intrusive. The judge also included other hospitals in his order in the event Mrs. Brophy or the family moved the patient (Brophy v. New England Sinai Hospital, Docket No. 85E0009-G1, Massachusetts Probate and Family Ct., Norfolk, MA, October 21, 1985) (V, Mishkin 1986). The Massachusetts Supreme Judicial Court, the state's highest court, ruled September 11, 1986 that Mr. Brophy's family could have the feeding tube disconnected so that he could die. The decision also pointed out that Brophy was not considered terminally ill, and that another patient who was irreversibly comatose had been maintained on a feeding tube for 37 years. The court said that such an extended period of tube feeding is "not only intrusive, but extraordinary." Mr. Brophy died on October 23, 1986 at Emerson Hospital in Concord, MA, eight days after his feeding tubes were removed. (*New York Times*, October 24, 1986, p. B9.)

In the Matter of Claire C. Conroy, 98 N.J. 321, 486 A.2d 1209 (1985).

Claire Conroy was an 84 year old nursing home resident whose nutrients were supplied by a nasogastric tube. Her nephew requested that the tube be removed since his aunt was very debilitated and in a near vegetative state; he said that she would not have wished to have such a tube if she were competent. The trial court permitted removal of the tube (In re Conroy, 188 N.J. Super 523 [Chancery Div. 1983]). The New Jersey Appellate Court reversed this

opinion (190 N.J. Super. 435, 464 A.2d 303 App. Div. 1983), and held that Ms. Conroy's nasogastric tube could not be removed. The New Jersey Supreme Court reversed the appellate court decision on January 17, 1985, and said that any life-sustaining treatment, including artificial feeding, may be withheld from incompetent nursing home residents in certain circumstances: when there is evidence that the particular patient would have refused treatment, or when the decision maker feels that tubes prolong suffering, or when the burdens of continued life with the treatment clearly outweigh any benefits. The court also required that a New Jersey state ombudsman be notified whenever any decision to remove life support systems was under consideration (V, Mishkin 1986).

Corbett v. D'Allesandro, 487 So.2d 368 (Florida Dist. Ct. App.), review denied, 492 So.2d 1331 (1986).

The husband of 75 year old Helen Corbett asked a Florida Court in December 1984 to stop the artificial feeding of his wife through a nasogastric tube after her persistent vegetative state had existed for two years. She died before the court ruled that Florida state law prohibited withholding or withdrawing artificial sustenance. In April 1986, the Court of Appeal reversed this decision, holding that the feeding could have ended because the right to privacy includes treatment refusal (V, Mishkin 1986).

Cruzan v. Director, Missouri Department of Health, et al., 110 S. Ct. 2841 (1990); Cruzan v. Harmon, 760 S.W. 2d 410, Mo. banc, (1988).

Nancy Cruzan had been in a persistent vegetative state since an automobile accident in 1983 when she was 26 years old. In 1987 her parents requested that the hospital withdraw feeding tubes; the hospital refused, and went to court. Upon hearing the case the Missouri Circuit Court for Jasper County ruled that the tubes could be removed. The Missouri Attorney General appealed and in November 1988 the Supreme Court of Missouri ruled that the parents could not remove Nancy's feeding tubes. The case became the first concerning the withdrawal of feeding tubes from a PVS patient to be considered by the U.S. Supreme Court. On June 25, 1990, the Court ruled in a 5-4 decision

that federal constitutional rights would grant a competent person's right to refuse nutrition and hydration based on the 14th Amendment, but that a state could require clear evidence that an incompetent person had expressed desires that surrogates used in decision making. The Cruzan case returned to the Jasper County court where the Missouri attorney general asked that the state be dismissed as a party; no appeals followed the lower court's decision that the tubes could be removed. Ms. Cruzan died December 26, 1990. (V, Fairman 1992).

In re Hier, 18 Mass. App. 200, 464 N.E. 2d 959 (Ct. App.), review denied, 393 Mass. 1102, 465 N.E. 2d 261(1984).

An extremely weak 92 year old nursing home resident needed surgery to replace a gastrostomy tube in her stomach. She had been fed in this manner from 1978 to 1984 and had often pulled it out. In 1984 she refused permission for the surgery and the home requested a court appointed guardian to act for her. Prior to her moving to the nursing home, the patient, Mary Hier, had been a patient in a mental hospital for 50 years. The Massachusetts Probate Court and the Massachusetts Court of Appeals both agreed that her wishes should be followed—that although incompetent, if she were competent, she would have refused surgery for the feeding tube. Such treatment was seen as only an extension of her suffering (V, Mishkin 1986).

In re Jane Doe, Georgia Superior Court, Fulton County, No. D-93064, October 17, 1991.

A 13 year old girl was admitted to the hospital May 18, 1991; within two weeks her care required feeding tubes and a respirator and she was diagnosed as having an irreversible, degenerative neurological disease and was in a comatose state. The hospital and health care personnel said that care could become so painful as to be abusive. The parents disagreed about whether to stop treatment; the father said that he had faith in a religious miracle, and the mother, although initially for ceasing treatments, later could not make up her mind. The court ruled that either parent could decide how long to continue treatment “and at what cost to their child to extend her life and the manner of her death, even if it may be

prolonged as a result. . . .” (V, Smothers 1991).

In re Jobes, 108 N.J. 394, 529 A.2d 419 (1987).

Nancy Jobes had been unconscious since a 1980 automobile accident when her family asked court approval to remove her gastrostomy tube in March 1985. The New Jersey Superior Court concluded that she was irreversibly comatose and that her care required constant handling of her body and that “pervasive bodily intrusions even for the best motives will arouse feeling akin to humiliation and mortification for the helpless patient. . . we should be ready to say: enough.” The New Jersey Supreme Court upheld this decision June 24, 1987, and Mrs. Jobes died shortly thereafter (V, Mishkin 1986).

In re Lawrance, Indiana Supreme Court, No. 29504-9106-CV-00460, September 16, 1991.

Sue Ann Lawrance, 42, had had a brain tumor since 1958 and had been unconscious since a fall in 1987. Her parents had received permission in May 1991 from Hamilton County Superior Court to withdraw her feeding tubes and she went without nourishment for two weeks. The National Legal Center for the Medically Dependent and Disabled said the ruling was discrimination against the handicapped and requested that a judge appoint a temporary guardian to pursue an appeal. The family agreed to continue feedings until the Indiana Supreme Court ruled on the case. Ms. Lawrance died July 18, 1991, before the court case was argued, but the family asked that the case be examined. The court ruled that the family had the authority, without judicial intervention, to halt artificial feedings. (V, Anonymous 1991).

In the Matter of Hilda M. Peter, by her Guardian, Eberhard Johanning, 108 N.J. 365, 529 A.2d 419 (1987).

Ms. Peter had a stroke and had been comatose in a nursing home for a year when her friend requested that her feeding tube be removed. While competent, Ms. Peter had said that she would not wish to live in a coma. The New Jersey State Ombudsman for the Institutionalized Elderly denied the request saying that one provision of the Conroy decision was that a patient must have a life expectancy of less than a year and that her

physicians had indicated that she could live for years with the tube in place. The state Supreme Court permitted removal of her tube and Mrs. Peter died in 1987.

Other court decisions which have given permission to remove feeding tubes from comatose patients or those in a persistently vegetative state include:

Delio v. Westchester County Medical Center, 129 A.D.2d 1, 516 N.Y.S. 2d 677 (1987).

Rasmussen v. Fleming, 741 P.2d 674, (Ariz. 1987).

Rekstad v. Florida Life Care Inc. Sarasota Co., No. 87-4285-CA-01.

In the following cases, the court refused permission to remove artificial nutrition from incompetent patients:

In re application of Kerr, 517 N.Y.S. 2d 346 (Sup. 1986) (Monsignor Thomas O'Brien was the patient.)

In re Vogel, 521 N.Y.S. 2d 622 (Sup. 1986).

IV. Books

Center for Health Ethics and Policy. **WITHHOLDING AND WITHDRAWING LIFE- SUSTAINING TREATMENT: A SURVEY OF OPINIONS AND EXPERIENCES OF COLORADO PHYSICIANS.** Denver: Center for Health Ethics and Policy, May 1988. 41 p. (The Center is located at the Graduate School of Public Affairs, University of Colorado, Denver, CO 20804.)

Questionnaires were sent to all physicians in Colorado asking about their familiarity with advance directives, decisions to withhold or withdraw life-sustaining treatment (particularly nourishment questions), and about active euthanasia and assisted suicide. Of the 7,095 physician queried, 2,218 responded. Most of them thought orders could be written to remove various types of tubes: gastrostomy 79.9%, intravenous feeding 76.9%, and nasogastric tubes 75.5%.

Flynn, Eileen. **HARD DECISIONS; FORGOING AND WITHDRAWING ARTIFICIAL NUTRITION AND HYDRATION.** Kansas City, MO: Sheed and Ward, 1990. 106 p.

Ms. Flynn, a Catholic College moral theology professor, provides factual information about tube feeding, describes the legal aspects and moral considerations in decision making, and concludes with a section on making decisions.

The Hastings Center. **GUIDELINES ON THE TERMINATION OF LIFE-SUSTAINING TREATMENT AND THE CARE OF THE DYING.** Briarcliff Manor, NY: The Hastings Center, 1987. 159 p.

This comprehensive report is divided into six main parts: Making Treatment Decisions, Specific Treatment Modalities, Prospective Planning, Declaring Death, Policy Considerations, and Special Problems. There is a glossary of terms as they are used in the work, a 10-page bibliography, and a list of selected legal citations. The guidelines concerning medical procedures for supplying nutrition and hydration provide specific steps each having from two to six different parts for consideration in decisions concerning artificial nourishment. Users are referred back to Part 1, treatment decision making, as part of the process to be followed.

Lynn, Joanne, ed. **BY NO EXTRAORDINARY MEANS: THE CHOICE TO FORGO LIFE-SUSTAINING FOOD AND WATER.** Bloomington: Indiana University Press, 1986. 272 p.

Physician Lynn divides the book into five parts: The Issues, Consideration in Forming a Moral Response, Perspectives on the Law, Special Considerations for Particular Populations, and *In re Claire C. Conroy: A Case Study*. Each of the 27 chapters is by a different author.

V. Articles

Albert, Lee A. **Cruzan v. Director, Missouri Department of Health: Too Much Ado.** *Journal of Legal Medicine* 12(3): 331-358, September 1991.

Attorney Albert provides background to the Cruzan case and says that the Supreme Court had declined such cases because it wanted to

leave “seemingly intractable ethical and legal questions to state law-making institutions.” He thinks that the court’s message is that the Constitution is not a source of principles for medical interventions. He concludes that the Cruzan decision is not a far-reaching event that will affect difficult medical decisions, but goes on to predict that concern over public health care budgets will create future court tests.

Annas, George J. **The Case of Mary Hier: When Substituted Judgment Becomes Sleight of Hand.** *Hastings Center Report* 14(4): 23-25, August 1984.

The judgment made by the court in the case of the mentally ill Mrs. Hier should be the same as in “best interest” tests. The court describes her as incompetent, and yet it says her actions indicated she does not want treatment. Annas calls this “sleight of hand.”

Anonymous. **Indiana Court Backs Family in Allowing Daughter to Die.** *New York Times*, September 17, 1991, p. A12.

News report tells of the Sue Ann Lawrance case in Indiana (see III, In re Lawrance.)

Archdiocese of Chicago. Medical Ethics Commission. **Chicago Commission Speaks Out on Nutrition and Hydration.** *Health Progress* (68)10: 35-36, December 1987.

The commission says that legal cases concerned with artificial nutrition and hydration have “pointed out some differences of perspective among Roman Catholic moral theologians,” and that the commission saw a need to assist health care personnel make ethical decisions. In its statement, the commission takes a position that artificial nutrition and hydration could be omitted or not be obligatory under circumstances that are useless or burdensome.

Aronheim, Judith C. and Mulvihill, Michael. **Refusal of Tube Feeding as Seen from a Patient Advocacy Organization: A Comparison with Landmark Court Cases.** *Journal of the American Geriatrics Society* 39(11): 1124-1127, November 1991.

The authors studied 116 inquiries to the Society for the Right to Die from patients or their representatives concerning the withholding or withdrawal of life-sustaining treatment and

compared these records with 20 tube feeding court cases. They concluded that the elderly are underrepresented in court decisions.

Baron, Charles H. **Why Withdrawal of Life-Support for PVS Patients Is Not a Family Decision.** *Law, Medicine & Health Care* 19(1-2): 73-75, Summer 1991.

The author thinks that society is coming to the presumption that the PVS patient fits a definition of death. He says that evidence of competent statements by the patient or the family’s substitute judgment are “covers” or backstops about a decision that has already been made on the ground that “no one would want to go on like this.”

Barry, Robert L. **The Ethics of Providing Life-Sustaining Nutrition and Fluids to Incompetent Patients.** *Journal of Family and Culture* 1(2): 23-37, Summer 1985.

Father Barry writes that the precedent established in the Herbert case is dangerous because it gives excessive power over incompetent patients to physicians and family. He thinks that nutrition and fluids are not medical treatments since they are not supplied to remedy a pathological condition, but to support the body’s basic needs. He says withdrawal of nutrition and fluids will never improve the clinical condition, and that such feeding benefits the patient by sustaining life. He concludes that there is no obligation to provide such nutrition if it is impossible or if it causes extreme pain.

Billings, J.A. **Comfort Measures for the Terminally Ill: Is Dehydration Painful?** Editorial. *Journal of the American Geriatrics Society* 33(11): 808-810, November 1985.

The author says the decision to administer fluids should be based on clinical concerns about water and electrolyte disorders combined with potential treatment benefits. A discussion of dehydration is included and Billings says fluid depletion in a dying patient is a disorder with relatively benign symptoms.

Callahan, Daniel. **Care of the Elderly Dying,** in Chapter 6 in his **SETTING LIMITS: MEDICAL GOALS IN AN AGING SOCIETY.** New York: Simon and Schuster, 1987, pp. 187-193.

Callahan says that a “conflict” exists between the moral duty to feed the hungry and give water to the thirsty, and the medical traditions that food and water are part of treatment which may stop if not improving a condition. He states that in the imminently dying and the irreversibly comatose “neither provides any genuine benefit to the patient.” For the demented or the totally vegetative, he sees no justification for withholding food or water since what is going on in the mind of such a patient is totally unknown. Callahan thinks that age alone should never be sufficient reason to terminate artificial feeding.

Callahan, Daniel. **On Feeding the Dying.** *Hastings Center Report* (13)5: 22, October 1983.

The author points out that no one has argued that feeding must be continued, only that it may be discontinued, but he says that there is an emotional repugnance against stopping nutrition which is a necessary social instinct.

Capron, Alexander M. **Ironies and Tensions in Feeding the Dying.** *Hastings Center Report* 14(5): 32-35, October 1984.

Capron writes that policy makers in the area of nutrition and hydration face the task of balancing autonomy (which might oppose feeding) with paternalism (which might feed resisting persons). In the cases concerning Conroy, Herbert, and Hier, the courts did not acknowledge the symbolic nature of offering food and water. The author says a decision maker must have clear goals: in a patient whose problems are irreversible and whose death is likely in the near future, arduous efforts to feed are not mandatory.

Cassell, E.J. **Life as a Work of Art.** *Hastings Center Report* 14(5): 35-37, October 1984.

Emphasizing that there is no theoretical difference between refusal to eat and refusal of any other medical treatment, Cassell suggests that to interpret all such decisions as only legal or medical can create “ugliness” when life should unroll as an aesthetic art. Persons are in a flow process from beginning to end he says and the process can include illness or infirmity, but choices should reflect previous patterns and purposes in the patient’s life.

Chang, Rene W.S.; Lee, Bernie; and Jacobs, Sydney. **Identifying ICI Patients Who Would Not Benefit from Total Parenteral Nutrition.** *Journal of Parenteral and Enteral Nutrition* 13(5): 535-538, September/October 1988.

A study was conducted to try to identify patients whose prognoses were so hopeless that they would not benefit from total parenteral nutrition (TPN). Of 278 patients treated with TPN, 64% died, which was twice the overall ICU death rate. The authors suggest that using a predictive model would be best for the patient to avoid unnecessary care with useless therapy.

Chrisman, J.P. **IV Withdrawal: The Severance of Medicine’s or Society’s Umbilical Cord? Barber v. Superior Court of Los Angeles County, 137 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983).** *Nebraska Law Review* 63(4): 942-972, 1984.

The author offers a substantive discussion of the propriety of the Barber decision (concerning Clarence Herbert), presenting arguments that such intravenous feeding and hydration are not medical treatments but sustenance which cannot be discontinued, and recommends the adoption of the Uniform Determination of Death Act as the best solution. A patient still alive under the specifications presented in the Act would be fed, and one that fitted the Act as legally dead would be withdrawn from tubes unless fluids or organs were to be donated.

Cranford Ronald E. **The Case of Mr. Stevens.** *Issues in Law & Medicine* 7(2): 199-211, Fall 1991.

(See V, Different Viewpoints). Cranford says that PVS patients usually live five to ten years, although some may live longer. He goes onto say that when the tubes are withdrawn such patients do not die of starvation, which usually takes six to ten weeks, but they die of acute dehydration without pain, suffering, or significant physical indication, in from three to thirty days. He writes that there are no benefits or burdens to the PVS patient, but there may be great benefits or burdens for family and others.

Cranford, Ronald E. **Neurologic Syndromes and Prolonged Survival: When Can Artificial Nutrition and Hydration Be Forgone?** *Law, Medicine & Health Care* 19(1-2): 13-22, Summer

1991.

Saying that the use of artificial nutrition and hydration in the imminently dying is not a major ethical dilemma for the most part, Dr. Cranford discusses three neurologic syndromes: PVS, dementia, and severe and permanent paralysis, which he says comprise the patients in most of the right to die court cases. He describes the PVS patient as completely and permanently unconscious, often with severe contractures of the extremities; their swallowing reflex is usually abnormal and spoon feeding of liquid or pureed food risks aspiration to the lungs. Various patients in different court cases are discussed as well as descriptions of their physical state after nutrition and hydration ceased. He says that there are 5,000 to 10,000 PVS patients in this country (four million patients in various states of dementia: ultimate dementia is amentia or the persistent vegetative state).

Davis, John Jefferson. **Concerning the Case of "Mr. Stevens"**. *Issues in Law & Medicine* 7(2): 227-241. Fall 1991.

(See V, Different Viewpoints.) Davis provides various religious views by theologians and concludes that tube feeding is a form of medical treatment. He says that both law and morality should distinguish between impaired consciousness (Alzheimer's disease or retardation) and non-existent potential for present or future consciousness (anencephaly or irreversible PVS).

Derr, Patrick G. **Why Food and Fluids Can Never Be Denied**. *Hastings Center Report* 16(1): 28-30, February 1986.

Derr says all patients who can receive food and water by any means should be given them. The methods involved are not fundamental, but the giving of sustenance is a basic human need; denial of food and fluids is "final" in a way that the denial of medical or surgical therapy is not. He writes that potential abuses easily arise when food and fluids can be denied.

Different Viewpoints: A Case for Consideration. Special Issue. *Issues in Law & Medicine* 7(2): 169-241, Fall 1991.

At a symposium held in April 1990 in Washington, DC, various speakers discussed a

hypothetical case about a 49 year old man in a persistent vegetative state (see V, Cranford, Davis, Dolan, and Scofield 1991).

Dolan John M. **Death by Deliberate Dehydration and Starvation: Silent Echoes of the Hungerhausen**. *Issues in Law & Medicine* 7(2): 173-197, Fall 1991.

(See V, Different Viewpoints). Dolan writes that it is necessary to provide the PVS patient with cleanliness, warmth, and nourishment. Quoting Dr. Peter Admiraal, (the Dutch physician who will perform active euthanasia if a competent patient requests it), he says that Admiraal does not advocate withholding food or water from a PVS patient. Dolan says that the euphemized vocabulary uses hydration and nutrition, not water and food.

Dresser, Rebecca S. and Boisubain, E.V. **Ethics, Law, and Nutritional Support**. *Archives of Internal Medicine* 145(1): 122-124, January 1985.

The authors point out that advanced techniques of nutritional support raise questions about the propriety of their use for certain patients. They view nutrition as a medical intervention which should be administered by physicians with the same guidelines as other forms of treatment, depending on the actual benefits delivered. They describe tube feeding (enteral alimentation and total parenteral nutrition) and say these methods can no longer be dismissed as simple nor should they automatically be provided.

England, Randall M. **Withdrawal of Nutrition and Hydration from Incompetent Patients in Missouri**. *Missouri Law Review* 54(3): 713-731, Summer 1989.

England addresses the legal issues raised after the Missouri Supreme Court refused to allow the hospital to withhold nutrition and hydration from an incompetent person (Nancy Cruzan) in a persistent vegetative state. He includes the right to refuse treatment, the right to privacy, the state's interest, whether nutrition and hydration are different, questions of guardianship, and third party consent.

Ethics Issue, *Issues in Law & Medicine* 2(2), September 1986.

This special issue focuses on analysis for health care professionals of withdrawal of nutrition

and hydration from incompetent patients. In the lead article, John P. Connery's **The Ethical Standards for Withholding/Withdrawing Nutrition and Hydration** (pp. 87-97), he concludes that except in very rare instances, such withdrawal is not justified. Father Robert Barry presents three hypothetical cases from a Catholic perspective; Rabbi J.D. Bleich discusses these cases from a Jewish perspective, Prof. Gilbert Meilaender offers a Protestant view, and Dennis J. Horan, provides a legal perspective.

Fairman, R. Paul. **Withdrawing Life-Sustaining Treatment: Lessons from Nancy Cruzan.** *Archives of Internal Medicine* 152(1): 25-27, January 1992.

The author describes the Nancy Cruzan case and says that eight "lessons" are there for physicians to draw upon in withdrawing/withholding decisions. He says that competent patients may refuse treatment; there are no distinctions among forms of treatment; there is no distinction between withholding and withdrawing treatment; advance directives are important; the Supreme Court's Cruzan decision does not change the law in any state; physicians should plan future care with their patients (he thinks 75% of patients and their doctors know the disease that will kill them a year before dying); when treating an incompetent patient, the physician should know what the patient would have wanted; and finally, families are best suited to determine the needs of an incompetent patient in most cases.

Fry, Sara T. **Withdrawing or Withholding Food and Fluids from Patients: New Guidelines from the American Nurses Association Committee on Ethics.** *Virginia Nurse* 56(2): 18-22, Spring 1988.

Discussing the language in the American Nurses Association guidelines on withdrawing or withholding food or fluids, she notes that terms are not defined in the document. She looks at the words feeding, nourishment, hydration, food, fluid, competency and incompetency, and compares the ANA usage to other published guidelines.

Green, W. **Setting Boundaries for Artificial**

Feeding. *Hastings Center Report* 14(6): 8-10, December 1984.

Green says that hydration and nutrition as medical therapies are different from ordinary feeding, since a patient may feel hunger and thirst even though tube feeding is adequate, or conversely, may feel no hunger or thirst when in fact, the patient is malnourished. He suggests that this issue should be considered in terms of benefit or burden to the patient.

Grisez, Germain. **Should Nutrition and Hydration Be Provided to Permanently Unconscious and Other Mentally Disabled Persons?** *Linacre Quarterly* 57(2): 30-43, May 1990.

Grisez writes that he has changed his mind since 1986 and now thinks that food by any means of delivery is only one aspect of care to the comatose. It has a minimal cost and should be provided in an affluent society. He says fairness does not require this if the formerly competent patient, now comatose, rejected such treatment, but that surrogates may not make such decisions. He states that to decide not to feed a comatose person is to choose to kill that person; Grisez says that the body is an intrinsic part of a personal reality and caring for it affirms human dignity.

Hirsh, H.L. **Who May Eat and Who May Starve?** *Legal Briefs. Nursing Homes* 34(4): 9-10, July/August 1985.

Physician-lawyer Hirsh writes that all nursing home administrators and physicians should encourage patients (or those responsible for them) to receive nourishment. If this fails, he recommends going to court.

Koshuta, Monica A.; Schmitz, Phyllis J.; and Lynn, Joanne. **Development of an Institutional Policy on Artificial Hydration and Nutrition.** *Kennedy Institute of Ethics Journal* 1(2): 133-140, June 1991.

The medical director, administrator, and a hospice nurse at the Hospice of Washington write that the provision of hydration and nutrition can be complex for a dying patient; in 1985 they found it necessary to develop a written policy for their institution. They describe patients who are near death and say that tube feeding can become burdensome; none of their patients voiced a symptom of hunger or

thirst. The policy says that the hospice will do nothing to hasten a patient's death, but that patients who are near death do not tolerate substantial volumes of feedings, do not report hunger or thirst, and dislike tubes. Patients are always offered symbolic food and drink in sips, spoon-feeding, low-volume tube feeding or an alternative. Attorney John Robertson comments (pp. 139-140) and says the policy is important because it places feeding in the real context of the dying patient and is a useful guideline for hospitals as well as hospices.

Liaschenko, Joan, and Davis, Anne J. **Nurses and Physicians on Nutritional Support: A Comparison.** *Journal of Medicine and Philosophy* 16(3): 259- 283, June 1991.

This review article provides 50 references to nursing and medical literature concerned with the withdrawing and withholding of foods and fluids with emphasis on empirical studies. The authors note that disagreement can be found in the discussions about incompetent and PVS patients; there is general agreement on the wishes of the competent patient. Nurses' roles are discussed and the authors say that the articles reviewed illustrate the tension between ethical principles and the lived reality of ethical agents.

Lo, Bernard. **The Death of Clarence Herbert: Withdrawing Care Is Not Murder.** *Annals of Internal Medicine* 101(2): 248-251, August 1984.

Doctor Lo examines the clinical and ethical judgment needed by physicians, noting that in the Herbert case, the court recognized that clinical judgment can be uncertain and involves probability. Physicians should obtain a consensus on a prognosis and response to therapy, recognize if disagreements exist between doctors and those responsible for the daily care of the patient, and make certain that communication with a comatose patient's family is compassionate and clear.

Lynn, Joanne and Childress, James F. **Must Patients Always Be Given Food and Water?** *Hastings Center Report* 13(5): 17-21, October 1983.

According to the authors, a patient can sometimes be best treated by not undertaking or continuing treatments that would sustain life,

especially if experiencing substantial suffering. They describe various medical methods of feeding or providing fluids, and hold that food and water may be withheld when there is no possibility of any benefit or when the burden to the patient becomes disproportionate. They say that certain patients near death can be harmed by such treatment and that suffering can increase. "Ordinary" care, obligation to continue, and symbolic treatment are included in this discussion about stopping nutrients for a limited group of patients.

McCormick, Richard A. **Caring or Starving? The Case of Claire Conroy.** *America* 152(13): 269- 273, April 6, 1985.

Father McCormick says that the key issues remain the notion of the dying patient, the nature of artificial hydration-nutrition, the intention of death and the burden-benefit analysis. He discusses each of these issues, indicating that his own opinion is that permanently comatose and some noncomatose, but elderly incompetent patients, may be classified broadly as dying. He goes on to say that tubal feeding is a medical procedure; its discontinuance does not aim at death. He says that the benefit-burden question may include quality of life, and cautions that clear criteria are needed, since the potential for abuse is enormous.

McHugh, James T. **Principles in Regard to Withholding or Withdrawing Artificially Assisted Nutrition/Hydration.** *Issues in Law & Medicine* 6(1): 89-93 , Summer 1990.

The Catholic bishop of Camden, NJ, prepared guidelines for Catholic priests in New Jersey, saying that such artificially assisted feedings are not "customarily burdensome," and that they sustain the life of a person who is alive but impaired. He states that in many cases the intent in withholding or withdrawing nutrition or hydration is to cause or hasten death. Justifiable principles can be applied when the patient is unconscious and imminently dying or conscious and imminently dying; they cannot be used for the conscious, irreversibly ill, but not imminently dying patient, or an unconscious patient who is not dying.

Maestri, William F. **Nutrition-Hydration: Are**

There Any Limits? *Pastoral Life* 40(2): 17-23, February 1991.

The author presents his view of Catholic tradition in the value of life and the state of the discussion of supplying nutrition and hydration via medical technology to the PVS patient. He says that a significant number of theologians and philosophers agree that such feeding is a medical treatment which may be refused or discontinued under certain circumstances. He concludes that limiting treatment does not relieve the duty to care for the patient.

Marks, Donna L. **Grayv. Romeo: Right of Privacy Overextended to Allow Withdrawal of Nutrition from Patient In Persistent Vegetative State.** *John Marshall Law Review* 22(4): 925-941, Summer 1989.

The author describes the case of patient Marcia Gray. The United States District Court in Rhode Island ruled to allow withdrawal of an artificial feeding tube, and subsequently, the hospital was required to accede to the wishes of the patient's guardian by removing a gastrostomy tube that had been in place for almost three years.

Martyn, Susan R. and Bourguignon, Henry J. **Coming to Terms with Death: The Cruzan Case.** *Hastings Law Journal* 42(3): 817-860, March 1991.

The authors provide an analysis of the Cruzan court decisions, and discusses proxy decision makers, slippery slope arguments, and constitutionality.

May, William E.; Barry, Robert; Griese, Orville; et al. **Feeding and Hydrating the Permanently Unconscious and Other Vulnerable Persons.** *Issues in Law & Medicine* 3(3): 203-217, Winter 1987.

The article is a document prepared for the Pope John XXIII Center, which studies biomedical issues. It concludes that in our society "it is not morally right, nor ought it to be legally permissible to withhold or withdraw nutrition or hydration provided by artificial means to the permanently unconscious or other categories of seriously debilitated but nonterminal persons."

Meilaender, Gilbert. **On Removing Food and Water: Against the Stream.** *Hastings Center Report* 14(6): 11-13, December 1984.

The author writes that if the patient is comatose but is not dying, the nourishment is not aimed at curing disease; it is given to sustain a human being. To withdraw feeding tubes can only result in death, and he thinks that it would be hard to say that this was not the aim. He notes that it is difficult to separate the personhood from the body, even if care does not restore cognitive capacities. If such care is burdensome, the aim of withdrawal would be to relieve the patient's burden with an unintended affect of a hastened death. Meilaender says that feeding the permanently unconscious is neither useless nor excessively burdensome.

Meisel, A., et al. **Hospital Guidelines for Deciding About Life-Sustaining Treatment: Dealing with Health Limbo.** *Critical Care Medicine* 14(3): 239-246, March 1986.

Saying that hospital ethics committees need specific guidelines to be consistent, the authors provide the guidelines developed at Presbyterian-University Hospital in Pittsburgh. Intravenous fluids and special feeding procedures are listed with respirators and kidney machines as part of the paraphernalia of modern intensive care medicine.

Meyers, D.W. **Legal Aspects of Withdrawing Nourishment from an Incurably Ill Patient.** *Archives of Internal Medicine* 145(1): 125-128, January 1985.

The author recommends benefits-burdens analysis of the medical, moral and legal perspective to determine whether it is appropriate to withdraw nutrition. The patient's wishes should be honored, and withdrawal is seen as appropriate in the case of irreversible coma or in a terminal patient whose death is expected within a year. Hospital ethics committees should be required to review withdrawal cases unless there is a written statement of intent made while the patient was competent. He says that very few cases fall in this withdrawal of nourishment category.

Miles, Steven H. and Ryden, M.B. **Limited-Treatment Policies in Long-Term Care Facilities.** *Journal of the American Geriatrics Society* 33(10): 707-711, October 1985.

This report by University of Minnesota scientists says that in a random sample of

nursing homes in that state, 73% of those answering accept care plans to limit medical treatment. Among these limitations, tube feedings were not recommended when oral feeding became impossible.

Mishkin, Barbara. **Courts Entangled in Feeding Tube Controversies.** *Nutrition in Clinical Practice* 1(4): 209-215, July/August 1986.

Attorney Mishkin provides a full explanation of eight court cases concerned with withholding or withdrawal of artificial nourishment or hydration: Herbert, Conroy, Hier, Henninger, Jobs, Corbett, Brophy and Bouvia. (Henninger and Bouvia concern competent patients and are not included in this Scope Note.) She says that some physicians or hospital administrators are “uneasy” about withdrawing this treatment from competent patients, from comatose patients or from terminally ill patients. Mishkin says most decisions are still made by patients, family and physicians, not by litigation.

Missouri Catholic Bishops. **On Ending Nancy Cruzan’s Nutrition and Hydration.** *Origins* 20(31): 493, 495, January 10, 1991.

The bishops note that it is not always necessary to use every possible measure to prolong life indefinitely, but state that there should be a presumption in favor of life when the case is controversial. They say that such decisions should be based on moral principles and are best left to the patient, family, and physician.

Musgrave, Catherine F. **Terminal Dehydration: To Give or Not to Give Intravenous Fluids.** *Cancer Nursing* 13(1): 62-66, February 1990.

The author makes an analysis of health professionals’ attitudes to the dehydration process in dying patients, and says that from a very early age patients know that “plenty of fluids” are considered important for health. She discusses the decision making process, the clinical difficulties, and the problems involved, offering guidelines for the care of such patients.

Oliver, D. **Terminal Dehydration.** Letter. *Lancet* II 1984(8403): 631, September 15, 1984.

St. Christopher’s Hospice in London reports that blood tests of 22 patients who died shortly after the tests were taken, indicated that they died with normal electrolyte balance and

without intravenous fluids. Their deaths were reported to be peaceful and without distress.

O’Rourke, Kevin D. **Evolution of Church Teaching on Prolonging Life.** *Health Progress* 69(1): 28-35, January/February 1988.

The author presents Catholic theological history to provide a background for current health care decisions, and notes that “evidence seems to be lacking that removing or withholding tube feeding from individuals in a deep coma or a persistent vegetative state results in great pain for the patient.”

O’Rourke, Kevin D. **Should Nutrition and Hydration Be Provided to Permanently Unconscious and Other Mentally Disabled Persons?** *Issues in Law & Medicine* 5(2): 181-196, Fall 1989.

The author says PVS patients have the fatal pathology of an inability to chew and swallow. He thinks decision makers concerned with PVS patients must grasp the distinction between causing death and allowing a fatal pathology to run its course. He discusses the views of various medical societies and of the Catholic church on the question and concludes that they are in accord.

Paris, John J. **When Burdens of Feeding Outweigh Benefits.** *Hastings Center Report* 16(1): 30-32, February 1986.

Father Paris, who was an expert witness for the Brophy family, says that the issue is preserving vegetative or comatose life for many years without reversing brain damage or restoring normal life. He thinks that if the procedure does not offer hope of any benefit, there is no moral obligation for the patient to undergo it, the physician to provide it, nor the judge to order it.

Rosner, Fred. **Withdrawing Fluids and Nutrition: An Alternate View.** *New York State Journal of Medicine* 87(11): 591-593, November 1987.

The author says that the denial of food and fluids is biologically fatal, and that he thinks the AMA is in error in allowing the removal of nutrition and hydration. He asks if it is not more dignified to live, and urges caution in accepting fluids and nutrition as medical treatment rather than supportive care. He notes that what is legal

is not always moral.

Rosner, Fred. **Withdrawing Fluids and Nutrition: An Alternate Way.** *Bulletin of the New York Academy of Medicine* 64(5): 363-375, June 1988.

Rosner says that withdrawing or withholding nutrition and fluids is not death from the disease process but rather euthanasia. Writing that this is becoming a country where rights seem to take precedence over all other considerations, he says that Judaeo-Christian principles consider people to have obligations rather than rights. He says Judaism forbids withholding nutrition and fluids from a terminally ill patient.

Sandstead, Harold H. **A Point of View Nutrition and Care of Terminally Ill Patients.** *American Journal of Clinical Nutrition* 52(5): 767-769, November 1990.

The author views all treatments involving technology as artificial and those using normal physiology as natural, but goes on to say that there can be no one set of rules in caring for the terminally ill.

Schmitz, Phyllis. **The Process of Dying With and Without Feeding and Fluids by Tube.** *Law, Medicine & Health Care* 19(1-2): 23-26, Summer 1991.

Ms. Schmitz, a member of a hospice health care team, offers her observations regarding dehydration, food desires, feeding, and comfort care in dying patients.

Schneiderman, Lawrence J. **Exile and PVS.** *Hastings Center Report* 20(3): 5, May/June 1990.

Estimating that there are 5,000 to 10,000 PVS patients maintained in health facilities, Schneiderman says that what is known about that state as opposed to what is assumed, is that the patient is isolated from any form of communication. He calls PVS an exile which he says is a condition equal to, if not worse than death. The author discusses human community and historic banishment, and thinks that treatment continues to cause PVS. He concludes that withdrawing treatment is not only ethically permissible, but an obligatory act of beneficence.

Scofield, Giles R. **Getting Down to Cases.** *Issues in Law & Medicine* 7(2): 213-226, Fall 1991.

(See V, Different Viewpoints.) Attorney Scofield notes that in the hypothetical case of Mr. Stevens, respect for persons concerns common law battery and consent as well as right to privacy. He thinks that to equate tube feeding with eating demeans any symbolic offering of food and water, or human communal activity. The author provides background and analysis of surrogate decision making.

Siegler, Mark and Weisbard, A.J. **Against the Emerging Stream: Should Fluids and Nutritional Support Be Discontinued?** *Archives of Internal Medicine* 145(1): 129-131, January 1985.

The authors express concern that there may be too rapid acceptance of withdrawal of fluids or nutritional support. They focus on those certain patients who have a “capacity for consciousness” and who have not previously rejected such support. They say the benefit of sustaining such a life would preserve the physician-patient relationship, and respect societal values of compassion and protection for the unproductive. They recommend further debate, and a slow and conservative approach to denial of fluids.

Smothers, Ronald. **Atlanta Court Bars Efforts to End Life Support for Stricken Girl, 13.** *New York Times*, October 18, 1991, p. A10.
(See III, In re Jane Doe.)

Vaccari, Michael A. **The Inability to Swallow as a Fatal Pathology: Comments on the McHugh/O'Rourke Correspondence and the Removal of Life-Sustaining Treatment.** *Issues in Law & Medicine* 7(2): 155-167, Fall 1991.

The author disagrees with an earlier article (V, O'Rourke 1989) and holds that the fatal nature of a pathology has no meaningful relationship to ethical decisions; burdensome or futile treatment are the factors necessary to make such decisions.

Additional Readings

Childress, J. F. and Dalle Mura, S.L. **Caring for Patients and Caring for Symbols: Reflections on Artificial Nutrition and Hydration.** *BIOLAW*

Special Section 1(1): S:1-S:8, August 1986.

Davidson, B, et al. **Ethical Reasoning Associated with the Feeding of Terminally Ill Elderly Cancer Patients. An International Perspective.** *Cancer Nursing* 13(5):286-292, October 1990.

Fry, Sara T. **Ethical Aspects of Decision-Making in the Feeding of Cancer Patients.** *Seminars in Oncology Nursing* 2(1): 59-62, February 1986.

Kelly, Gerald. **The Duty of Using Artificial Means of Preserving Life.** *Theological Studies* 11(2): 203- 220, June 1950.

Knox, Linda S. **Ethical Issues In Nutritional Support Nursing: Withholding and Withdrawing Nutritional Support.** *Nursing Clinics of North America* 24(2): 427-436, June 1989.

Mishkin, Barbara. **Withholding and Withdrawing Nutritional Support: Advance Planning for Hard Choices.** *Nutrition in Clinical Practice* 1(1): 50-52, January/February 1986.

Mumma, C.M., **Withholding Nutrition: A Nursing Perspective.** *Nursing Administration*

Quarterly 10(3): 31-38, Spring 1986.

Rothenberg, Leslie S. **To Feed or Not to Feed: That Is the Question and the Ethical Dilemma.** *Journal of Pediatric Nursing* 1(4): 226-229, August 1986.

Thomasma, David C.; Micetich, K.C.; and Steinecker, P.H. **Continuance of Nutritional Care in the Terminally Ill Patient.** *Critical Care Clinics* 2(1): 61-71, 1986.

Watts, D.T.; Cassel, C.K.; and Hickam, D.H. **Nurses' and Physicians' Attitudes Toward Tube-Feeding Decisions in Long-Term Care.** *Journal of the American Geriatrics Society* 34(8): 607-611, August 1986.

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