Implications of the Papal Allocution on Feeding Tubes

BY THOMAS A. SHANNON AND JAMES J. WALTER

The recent papal allocution To the International Congress on Life-Sustaining Treatment and Vegetative State: Scientific Advances and Ethical Dilemmas has been the occasion for much discussion concerning the use of artificial feeding tubes for nutrition and hydration. Briefly, the Pope stated in the March address that such tubes were "not a medical act" and that their use "always represents a natural means of preserving life" and is part of "normal care." Therefore, their use is to be morally evaluated as ordinary and obligatory. "If done knowingly and willingly," the removal of such feeding tubes is "euthanasia by omission." The person's medical condition is not relevant in making a determination about the use of feeding tubes because the food and water delivered through such tubes is ordinary care and provides a benefit—"nourishment to the patient and alleviation of his suffering."

What is interesting about this papal allocution is that it seems to represent a significant departure from the Roman Catholic bioethical tradition with respect to both the method and the basis upon which such decisions are made. The method announced by Pope John Paul II seems to be deontological. The use of feeding tubes to deliver artificial nutrition and hydration is declared "ordinary," and such an intervention apparently ought not be foregone or withdrawn. Historically, the method for making a determination about the use of a medical intervention was to consider the proportional benefits and its harms to the individual, family, and community. The method is a teleological balancing of the impact of the intervention. This has been the central teaching of the tradition from the mid-1600s through Pope Pius XII and the 1987 Declaration on Euthanasia by the Congregation for the Doctrine of the Faith. The examples of disproportionately harmful impacts in the Roman Catholic tradition range from the use of expensive medications, food beyond the budget of the individual, and interventions that are painful in both the short and long term, to the refusal of a physical examination if that will cause excessive embarrassment to the individual. Included in such a listing and specifically noted in the Declaration on Euthanasia is the financial impact on both the patient and family. Interventions that will provide a significant financial hardship need not be utilized.

The question of the use of artificial feeding tubes has been much debated in Roman Catholic bioethics, especially when used for patients in persistent vegetative state. One early statement was from the revered Jesuit moral theologian Gerald Kelly:

I see no reason why even the most delicate professional standard should call for their [oxygen and intravenous nutrition and hydration for a patient in a terminal coma] use. In fact, it seems to me that, apart from very special circumstances, the artificial means not only need not but also should not be used, once the coma is reasonably diagnosed as terminal. Their use creates expense and nervous strain without conferring any real benefit.

There were further arguments made on both sides of the issue by theologians, bishops, and bishop conferences. Over time a consensus seemed to develop that the forgoing or withdrawal of artificial feeding tubes could be judged morally optional in some circumstances.

The reason the papal statement is so startling to many is that it came out of the blue. It seems to depart from the tradition of Roman Catholic bioethics on how to analyze such questions and substitutes a deontological principle for the traditional weighing of benefits to burdens. Thus it raises a number of very practical questions for patients, theologians, medical personnel, and Catholic hospital administrators.

One question concerns the authority of the statement. Traditionally, allocutions are given to a variety of groups that meet in Rome, but they have not always been seen as the locus for announcing a major policy shift. Instead, they have been used by Popes for discussing particular issues, as Pius XII was wont to do. He used allocutions to discuss organ transplantation and the use of analgesics to relieve pain at the end of life. Many of these allocutions were understood to be made in relation to the state of the question in moral theology, and it was well understood that the statements were subject to interpretation by moral theologians. So a first question is, What is the authority of this text?

A second question is whether the text should be read broadly or narrowly. That is, should the text be understood to apply to all instances in which a feeding tube is involved, or should it be restricted to the specific case of the patient in a persistent vegetative state? Profound personal and institutional implications follow from one’s reading of the application of the text.

A third question concerns how the allocation will be implemented. That is, what will the U.S. bishops do with it? Will they consider it a directive that must be implemented in all Catholic health care institutions, will they need to study what it means in terms of its implications for Catholic health care, or will they leave its meaning up to individual health care institutions? The Catholic right-to-life movement may also influence the debate. Clearly, this movement holds that questions related to the beginning of life are to be resolved deontologically, with little or no attention given to circumstances. It may also now hold that end-of-life questions are to be resolved in a similar way. The political and religious power of the right-to-life movement was clearly manifest in the Terri Schiavo case in Florida. Such questions are of direct concern to Roman Catholics, but their resolution will have implications beyond Catholicism. Additionally, it must be noted that Pope John Paul II has appointed almost every single bishop in the United States, and it is clear that primary criteria for such appointments are fidelity to Church teaching and loyalty to the Pope.

Another set of questions will have an impact on people and institutions. For the past several decades in the United States, people have been encouraged to make some sort of advance directive. The purpose of the directive, of course, is to help the individual clarify his or her wishes with respect to health care in the event that he or she becomes incompetent. Such directives help ensure that the person’s wishes are carried out, can be the means by which a proxy decisionmaker is designated, and can reassure the family that the patient’s wishes are being honored. In addition, advance directives might also ease the family’s responsibilities at a time of great stress. If there is an advance directive, the family will know that they are doing what the patient wanted—and this may be a great comfort.

Should Catholics no longer be encouraged to make advance directives? Or should they simply be directed to include no statement about the use of artificial feeding tubes? But suppose that the individual has already directed that he or she does not want a feeding tube, or that it should be removed when it no longer proves beneficial. Will family members be torn between the wishes of the patient and what they understand to be the teaching of the Catholic Church? By following what the family thinks is Church teaching, they will violate the wishes of the patient, and they may in fact cause harm to the patient. Yet if they do not follow what they think is Church teaching, they might think they are sinning or at least failing to be good Catholics. Practically speaking, the bedside of a dying patient is not the place to have a crisis of faith or morals.

What is a Catholic hospital, nursing home or palliative care facility to do? If the bishop of the diocese in which a facility is located mandates a literal implementation of this directive, then presumably the facility would be under an obligation to develop policies that prohibit the forgoing or removal of feeding tubes regardless of the instructions of the patient, advance directive, and family.
ing tubes regardless of the instructions of the patient, advance directive, and family. As a matter of practical fact, most Catholics probably will not know what, if any, instructions the local bishop has given, and they certainly will not know what policies the local Catholic hospital has. They will find out what the policies are when they confront the reality of the policies at a time of critical decisionmaking—the absolutely worst time for such a discovery.

Several difficult situations might present themselves here. One can envision patients or families insisting on either forgoing or removing a feeding tube, and one can then see hospitals refusing such a request.

The medical staff is then caught in the middle, and in the United States, one will consequently have a law suit with major implications for the church-state relationship—one that will make the mandating of the provision of contraceptives in the California Supreme Court ruling in March 2004 against Catholic Charities of Sacramento pale in comparison. One solution that has been proposed is for the patient to be transferred to another hospital—as if one's insurance plan would facilitate such a transfer or another hospital would accept the patient under these circumstances.

Another solution would be for patients who might want feeding tubes withdrawn or forgone not to be admitted to such a facility to begin with. Upon admission to a hospital, patients are informed about advance directives and given the opportunity to fill one out. This practice could be complemented with a statement that, because the health facility they are entering is owned by the Catholic Church, any instructions concerning the forgoing or removal of feeding tubes will be disregarded. The patient could then determine whether to be admitted. But the problems with this solution are almost infinite: this facility is where the physician sent the patient; this is the facility that performs this particular procedure; this is the hospital covered by the insurance plan; and so on. And what of people admitted to the facility through the emergency room?

There may be any number of administrators and physicians, nurses, or other health care providers who will conscientiously object to a strict interpretation and unilateral application of the new teaching. This will present a problem for the hospital at least with respect to the sort of privileges that it grants to physicians. What should the facility do with administrators and staff, the ethics committee, the various chaplains, and other people involved in the daily working of the facility who might conscientiously disagree with the allocation?

What if the patient in the facility is not a Catholic and demands either the forgoing or removal of a feeding tube? Will there be exemptions for non-Catholics? On what basis would these be granted, since the papal allocation states that such a practice would be euthanasia by omission? One would assume that a Catholic facility instructed by a bishop to implement the Pope's allocation strictly would do so across the board, lest it participate in euthanasia by omission.

The fact that this allocation is understood by many Catholic moral theologians to sit uneasily with the dominant method and basis for determining when a treatment is ordinary or extraordinary pales in comparison with the myriad of personal and institutional issues that the allocation raises. Institutional policies that prohibited the forgoing or withdrawing of artificial feeding tubes could lead to a lawsuit with monumental implications for the relationship between church and state. Also, what would be the implications, financial and otherwise, for Catholic hospitals that are in cooperative relations with non-Catholic health care facilities?

The decisionmaking process at the end of life is difficult enough as it is. It is a time fraught with tension, pain, suffering, sorrow, guilt, and grieving. The strict implementation of a policy such as that in the Pope's allocation seems to us simply to prolong the agony by prohibiting responsible medical and moral evaluation of the patient's condition. Ironically, it would also be at odds with the long Catholic tradition of medical ethics. It also has the potential to cause enormous difficulties for Catholic health care facilities and their staffs. While we certainly support every effort to prevent euthanasia, we do not support policies that require medical staff to provide unwanted medical treatment. Such policies might even drive people toward euthanasia, by making them feel that they have lost a traditional and sympathetic ally in their final journey.


