Artificial Nutrition and Hydration at the End of Life: Religious and Clinical Implications

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Abstract

Food and water: items essential to biological survival but also endowed with deep cultural meaning—including religious meaning. This position paper seeks to evaluate the decision-making surrounding artificial nutrition and hydration (ANH) during end-of-life (EOL) care. While the timing and administration of ANH at the EOL remains a matter of widespread debate among Christian, Jewish, and Islamic communities, several of the bioethical principles espoused by these religious institutions have contributed significantly to the issue’s evolution in United States public discourse. These principles include those such as treatment proportionality, states of consciousness, and personhood. In summary of the relevant medico-legal, clinical, and religious perspectives regarding ANH in the United States, this work seeks to identify unique patient populations that may benefit from abstaining from ANH therapy; in particular, those with no reasonable hope of physical or mental recovery and whose human faculties have so severely diminished as to render them incapable of experiencing human relationships.
Hospitality, comfort, satiety, and celebrations—themes most people associate to food and drink. Indeed, the monotheistic faiths of Christianity, Judaism, and Islam endow particular food and drink with sacred meaning in many contexts. When considering the proper role of food and drink administration at the end-of-life, several ethically-relevant questions arise: is food and water to be considered ‘ordinary,’ basic care in all cases? By withdrawing or withholding food and water from a terminally ill patient who needs it to sustain life, is one starving that patient to death? By attending to the various religious, medical, and legal views to these questions and others, one can discern the ways food and water take on new meaning at the end of life. In so doing, perhaps one can define an acceptable ethic for its use.
Thesis Statement

For those patients who suffer terminal conditions without reasonable hope of recovery, and whose human faculties have so severely diminished that he or she is incapable of communication and other meaningful interaction (i.e. human relationships), ANH should be considered disproportionate treatment and preferably withdrawn/withheld.
**Catholicism**

Terms ‘ordinary’ and ‘extraordinary’

Doctrine of Double Effect; Thomas Aquinas

1957 Pius XII: “life, health, temporal activities are subordinate to spiritual ends”

2005 JP II: ANH not a “medical act,” always morally obligatory

**Judaism**

Body as ‘goses’ v. ‘treifah,’ morally relevant states of being

Orthodox v. Reformed communities views

**Islam**

Death as ‘predestined’ by God

Conception of personhood as unity of the spiritual, intellectual, and physical

Mu’tazilah school v. Ash’ari school of thought pertaining to morality’s origins in religion
Discussion

Obligatory/basic Care v. Medical Treatment?

Ordinary v. Extraordinary?
Discussion

Primary Cause of Death

Withholding/withdrawing ANH = death by starvation/dehydration?

Consider ventilation and “death by asphyxiation”
Discussion: For whom is ANH likely disproportionate?

1) Brain death

2) Permanent vegetative state (v. persistent vegetative state v. minimally conscious state)
   - at least 12 months in a persistent vegetative state; rates of PVS misdiagnosis are high (37-43%), often confused with MCS

3) Severe, advanced dementia
   - No mortality benefit at 6 months, no noted increase in patient discomfort; American Geriatrics Society advocates for assisted hand feeding as alternative

Why? Each meets criteria for a terminal condition with no reasonable hope of recovery AND a severe limitation of human faculties such that the experience of meaningful human relationships is no longer possible. Benefits no longer outweigh the adverse effects.
Conclusions

1) The legal status of ANH in the U.S. has undergone massive evolution over the past six decades, with state legislatures varying on whether to endorse a patient’s right to withhold/withdraw ANH.

2) Though well-established disagreement within Christian, Jewish, and Islamic communities exists regarding the use of ANH at EOL, generally-speaking, religious leadership endorses ANH as basic, obligatory care in most, if not all, circumstances.

3) Pro-obligatory ANH arguments center on ANH exclusion from classification as “true” medical treatment and the belief that withholding/withdrawing ANH leads to death by starvation/dehydration.

4) While patient’s decisions should be respected above all, for those suffering brain death, permanent vegetative state, and severely advanced dementia, ANH should be considered disproportionate medical therapy and preferably withheld/withdrawn.

5) A more thorough evaluation of the metaphysical concept of ‘personhood’ is required to inform better those for whom ANH may be beneficial or not. Religion certainly has a role to play here.


Literature Review continued…


Thank you!