2009

The Artificial Nutrition Debate: Still an Issue … After All These Years

Cheryl Monturo

West Chester University of Pennsylvania, cmonturo@wcupa.edu

Follow this and additional works at: http://digitalcommons.wcupa.edu/nurs_facpub

Part of the Critical Care Nursing Commons, and the Dietetics and Clinical Nutrition Commons

Recommended Citation


This Article is brought to you for free and open access by the Nursing at Digital Commons @ West Chester University. It has been accepted for inclusion in Nursing Faculty Publications by an authorized administrator of Digital Commons @ West Chester University. For more information, please contact wcressler@wcupa.edu.
The Artificial Nutrition Debate:

Still an Issue…After All These Years

Until the case of Terri Schiavo, most in bioethics, law and health care believed the debate over withdrawal and withholding of artificial nutrition was settled. Guidelines predicated on judicial rulings were developed for this difficult and highly emotive process. Few cases triggered any serious reconsideration of the position that artificial nutrition and hydration were similar to other life-extending measures and could be withdrawn or withheld in specific circumstances. Despite the appearance of resolution, there is growing concern that the consensus has eroded. 1, 2

The purpose of this paper is to provide a historical review of the bioethical opinion concerning artificial nutrition since it represents both a bioethical consensus and perhaps the seeds of dissent concerning this difficult and highly emotive issue.

Artificial Nutrition

Clinical Evolution

Artificial nutrition is a viable and highly effective therapy to ameliorate the effects of temporary or chronic conditions for those unable to ingest food and fluids. 3 Despite the positive impact of technology, widespread utilization of this treatment in end-of-life, persistent vegetative state (PVS), severe cognitive impairment, and advanced progressive dementia creates an ethical dilemma for some who believe that the withdrawal or withholding of artificial nutrition is cruel, inhumane, and tantamount to starvation.

The focus of this paper is on enteral nutrition, which dates to ancient Egypt and Greece and continued as rectal feedings into the 18th and 19th centuries. 4 Similarly, feeding into the upper gastrointestinal tract through a nasopharyngeal tube was first documented in the sixteenth century (His' study as cited in 5), and was quite common in the latter part of the nineteenth
century. Technological advances in tube development, formulas, and surgical procedures continued throughout the 19\textsuperscript{th} and early 20\textsuperscript{th} centuries.\textsuperscript{5,6} Innovation continued into the late 20\textsuperscript{th} century with introduction of the percutaneous endoscopic gastrostomy (PEG) in 1981\textsuperscript{7}, offering patients a decreased risk of complications during placement. Despite the value of this groundbreaking technology, some voiced concerns about the potential for over-utilization and creation of ethical dilemmas.\textsuperscript{8}

Religious Evolution

Significant to the bioethical debate are religious positions on the morality of withdrawal and withholding of artificial nutrition. While considerable variation occurs within individual religions, basic tenets are available. In a recent review on end-of-life decisions, the authors categorized several religious views on life-sustaining therapies noting that Protestants and Buddhists accept withdrawal of artificial nutrition, while Catholics, Greek Orthodox, Muslims and Orthodox Jews reject this practice.\textsuperscript{9} Information from other religions including Hindu, Sikh, Taoism and Confucianism are less clear on this issue.\textsuperscript{9}

Notwithstanding this recent review, most religious views on artificial nutrition are not well represented in the literature, although more is available about Catholicism and Judaism. The Catholic Church historically obliges an individual to strive towards prolongation of life, although it does not require one to do so if great effort is required or if little hope exists.\textsuperscript{10} More recently confusion erupted over a Papal address to the International Congress on Life Sustaining Treatments and Vegetative States in March 2004. During this address Pope John Paul II categorized all food and water, regardless of the means by which they are delivered, as obligatory and a natural vs. medical action to preserve life. Accordingly, cessation of artificial nutrition resulting in death is viewed as euthanasia by omission in PVS patients.\textsuperscript{2} Despite this
confusion, some theologians argue that little has changed in the Catholic teaching on artificial
nutrition and hydration. Consistent with Bülow’s review on Judaism, some conservative rabbis regard artificial
nutrition and hydration as basic and therefore dissimilar to medications and machines. Conversely, others classify artificial nutrition and hydration as medicine, thereby allowing for its withdrawal. Although these guidelines provide some insight into various faiths, no group is
homogenous, and therefore it is difficult to apply these tenets uniformly for individual patients.

Bioethical Review

As the oldest and most widely read bioethics journal, the Hastings Center Report (HCR) influenced discussions in both health care and public policy. The Hastings Center, founded in 1969, focused on concerns of death and dying, and subsequently began publication of the HCR in 1971. Although not a complete picture of all bioethical discussions concerning artificial nutrition, the HCR is representative of the general bioethical sentiments and opinions. A combination of classic content analysis and grounded theory formed the basis for data collection and analysis of articles from 1971 through 2007. Only those articles with a primary focus on artificial nutrition were included resulting in a sample of 63 articles and/or letters. Although artificial nutrition includes both enteral and parenteral nutrition, authors used this phrase interchangeably with enteral nutrition and/or tube feedings in the sample. A critical analysis revealed the emergence of 8 inductively derived categories describing the context of artificial nutrition withdrawal or withholding (see Figure 1). Since many articles reflected more than one category, the following review is framed within a chronology of bioethical and legal events.

The Right to Die Movement (1971-1982)
Publications from 1971 through 1982 lacked a primary focus on artificial nutrition and were therefore not included in the sample. However, it is important to review this period of time since it contains important bioethical and legal events that frame the remaining years of the analysis.

The Karen Ann Quinlan case was the first legal case of removal of life-sustaining therapy, a respirator. Although not an issue of artificial nutrition, removal of the feeding tube was also an option, but this was refused by her father and guardian, Joe Quinlan, stating: “That is her nourishment!” Discussion of the Quinlan decision was extensive in the *HCR*, but the focus was not on artificial nutrition. Shortly after Quinlan, cases involving newborns and infants arose in the courts in reference to withdrawal and withholding of treatment. The Danville babies’ case focused on treatment and non-treatment issues, but the article was also not specific to artificial nutrition. Other early articles discussed death in broad terms, noting the effect of advancing technology, issues of dignity concerning death, and the right to die.


In 1983, The President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research found no distinction between artificial nutrition and other life-sustaining treatments. From 1983 through 1987, several newborn, infant, and adult cases arose centered on issues of artificial nutrition. Despite court rulings supporting parental choice to withhold nutrition and necessary surgery to correct anomalies preventing normal feeding, federal regulations known as the ‘Baby Doe Directives’ were imposed assuring that there would never be an adequate reason to withdraw or withhold nutrition and fluids from a newborn based solely on a handicap. At the same time, artificial nutrition publications in the *HCR* became prolific yielding 3 to 6 articles/letters each year during this five-year period.
The category illness and treatment trajectory was the predominant focus of articles from 1983-1987, but many articles also addressed the category of family. Within the category family, content focused on both the expressive and legal/ethical facets of family involvement in patient care. Several court cases examined issues of surrogacy, substituted judgment, and best interest standard, while the expressive nature of withdrawal or withholding of artificial nutrition was captured in the themes of hope, acceptance, and symbolism. Several articles used the word ‘starvation’ in reference to withdrawal or withholding of artificial nutrition, providing further support for the highly powerful and emotive nature of symbolism.

A final category, personhood, was acknowledged through a focus on individual rights and principles in addition to primacy of rights. Individual rights were evident in discussions of patient privacy, autonomy, and liberty. Primacy of rights examined the issues of provider, patient, institutional, and societal rights in relation to withdrawal and withholding of artificial nutrition, much of which focused on Elizabeth Bouvia’s refusal of tube feeding.

From 1988 through 1989, publications focused on artificial nutrition decreased to two each year. Although the focus remained predominantly within the illness and treatment trajectory category, topics focused on treatment in terms of its active or passive nature, such as euthanasia and the cause of death. Technology was discussed in terms of the slippery slope for the vulnerable, referring to the ongoing abortion debate.

Discussion in other categories remained consistent with the earlier publications focusing on various legal and ethical facets of family involvement and legislative issues such as substituted judgment, best interests, and advance directives. Finally, individual rights and principles were mentioned within the personhood category, but the discussion was superficial.
In 1990, the Supreme Court ruled in favor of individual states’ requirement to provide clear and convincing evidence concerning patient wishes before treatment with artificial nutrition could be discontinued. This ruling pertained to individuals in a PVS, favoring those with explicitly conveyed wishes, preferably in writing, to family, friends, and healthcare providers in advance of a life-threatening situation. The focus of this ruling was the incapacitation of a healthy young woman, Nancy Cruzan from Missouri, who was found unresponsive after a car accident, resuscitated and remained in a PVS for almost 8 years. Ms. Cruzan received enteral nutrition for 8 years, however after 3 years of aggressive therapy, her family requested removal of the enteral tube. A legal battle ensued between the Cruzan family and the state of Missouri, who opposed the family’s wishes, eventually leading to the United States Supreme Court. After providing additional evidence to the State, Ms. Cruzan’s family received permission to remove her enteral tube and she died 12 days later in December 1990. As a result of this landmark case, the Patient Self-Determination Act was passed in 1990. This Act requires that health care facilities receiving government funds determine if patients have an advance directive and if not, facilities are mandated to offer the opportunity to complete one.

Thirteen articles and/or letters concerning artificial nutrition published in HCR during 1990 focused on the Nancy Cruzan case. Although the categories were not significantly different from the remaining articles in this time frame, the discussion provided more detail, such as the depth with which the legal, ethical and expressive aspects of family involvement in decision-making were presented in terms of surrogacy, substituted judgment, best interests standard, hope and acceptance.

Discussion within the illness and treatment trajectory category introduced the notion of time trials. Time trials are the institution of treatment for a specified time with subsequent
evaluation and decision-making to continue or withdraw the treatment. This topic was discussed in terms of Missouri state law and the inability to withdraw treatment once initiated.\textsuperscript{34,35} Other articles discussed the nature of treatment in terms of the positive and negative connotations of treatment withdrawal, and the goals of treatment in terms of the dichotomy between preservation of life and the right to die for Nancy Cruzan.

Within the category of personhood, recurring ideas evolved focused on patient autonomy and the potential loss of this right for patients in a PVS. Provider issues were discussed in terms of the right to identify futile care and involvement of a bioethics committee in the case of a newborn with necrotizing enterocolitis.\textsuperscript{36} Legislative issues were highlighted during this time-period in terms of the individual, family and states’ rights in the absence of an advance directive. \textit{Post-Cruzan (1991-2003)}

Despite the plethora of articles in 1990, no articles concerning artificial nutrition appeared in 1991, and there was a precipitous drop to only 1-2 articles per year for the subsequent five-year period (1992-1996). Perhaps this was an attempt to focus on the myriad of bioethical issues pushed aside due to the notoriety of Cruzan. While some articles during this period still referenced Cruzan, others focused on individual case studies. Illness and treatment trajectory remained the predominant category; however the concerns extended beyond the unconscious incompetent patient to those who were competent but without adequate swallowing function. Concern also arose in the use of subterfuge and withdrawal of artificial nutrition, without the awareness and agreement of the entire health care team.\textsuperscript{37} This appeared ironic in light of previous discussion concerning the legal, ethical or moral acceptance of withdrawal or withholding of artificial nutrition. Perhaps this was the first indication that this issue was resolved at the judicial and bioethical establishment levels, but not at the bedside.
Additional comments in the personhood category related to the notion of individual principles and primacy of rights between patients, providers, institutions, and society, although discussion of these issues remained superficial. Finally, within the category legal issues, patient rights and the legal nature of withdrawal emerged in terms of informed consent and suicide. Informed consent was questioned in the case of a conscious and assumed competent patient who insisted on eating ‘real’ food despite oral dysphagia, and Judge Antonin Scalia distinguished refusal of food and water as suicide in the Cruzan decision.

Publications continued to decline after 1996 with none for a four-year period (1997-2000), three in the subsequent two years (2001-2002), and then none again in 2003. In light of this relative dearth of artificial nutrition focused publications for a 7-year period, the resurrection of discussion and publicity in terms of the Schiavo case and Pope John Paul II’s subsequent address in 2004 was striking.

Two thousand and one (2001) marked a distinct shift in patient focus to a burgeoning population, the older adult with dementia, from the unconscious incompetent or the competent individual. This type of patient is examined in the context of the development of the percutaneous endoscopic gastrostomy (PEG) and was discussed in terms of the over utilization of technology.

The category religion is mentioned for the first time in reference to artificial nutrition in 2001. The issue of religion and the historical context of burdensome treatments revealed the basic tenets of the Roman Catholic tradition versus the beliefs of modern day religious leaders and laity. Notwithstanding the idea that medically assisted nutrition equates to ordinary or basic care, the original tenets set forth by De Vitoria may apply to food and water as extraordinary if one’s condition dictates.
Four other categories (cost, provider issues, legal issues, and ethics/morality) were also evident in this small sample. Institutional cost was discussed in terms of inadequate staff to orally feed those who are capable, in favor of a PEG tube. Individual principles concerning the quality of life were confused with provider rights and the ultimate sanctity and value of life. The legal nature of treatment withdrawal was evident in terms of the conscious yet incompetent patient suffering from devastating brain damage, but not in a vegetative state. Despite bioethical and legal discussion for more than 30 years, the apparent lack of societal consensus concerning withdrawal or withholding artificial nutrition was clear in this sample, as it continues to be now.

An Unresolved Moral and Ethical Dilemma (2004-2007)

While the Supreme Court was ruling on the issue of clear and convincing evidence in the Cruzan case in 1990, another young woman, Theresa Schiavo, suffered a cardiac arrest secondary to a significant electrolyte imbalance. She remained anoxic after her arrest, suffering irreversible brain damage resulting in a PVS. After eight years of receiving enteral nutrition, Mr. Schiavo requested that the tube be removed, consistent with his wife’s previous verbal wishes. Between 1998 and 2003, Ms. Schiavo’s gastrostomy tube was removed and replaced twice as a result of numerous court orders and challenges. In 2003 the case gained national attention and local officials entered the discussion. The Florida legislation enacted “Terri’s Law,” which empowered the governor to reinsert the tube and to appoint a special guardian ad litem. Finally in March 2005, Mr. Schiavo’s original request to remove her tube was honored, and after 13 days, Ms. Schiavo died. Despite a seemingly resolved issue post Cruzan, the Schiavo case highlighted the vulnerable and yet unresolved moral and ethical dilemma of withdrawal of artificial nutrition.
The Schiavo case was the focus of most publications concerning artificial nutrition in the HCR from 2004-2007. Discussion was wide-ranging in 2004 and 2005 with several categories sharing an equal focus including illness and treatment trajectory, personhood, legal issues, ethics and morality, religion and family. Within illness/treatment trajectory, diagnosis and prognosis were discussed as in previous years, however the concern centered on the correctness of diagnosis - PVS, minimally conscious states, and/or treatable brain damage. This discussion paralleled the Schiavo case in which family and some medical experts argued that Ms. Schiavo was misdiagnosed and not in fact in a PVS. For the first time this discussion spilled over into issues of personhood, questioning if those in a PVS were in fact disabled, and noting Americans’ negative view of disability and incompetence, while obsessing over autonomy. Privay, primary of rights, autonomy, and patient wishes provided a basis for discussing the ongoing Schiavo case.

The topic of religion in relation to artificial nutrition was first discussed in 2001 with an overview on the historical underpinnings of the Catholic Church. In 2004 and 2005, authors reiterated this content and applied it to the Papal address on feeding tubes. Some projected a socioeconomic impact if all were required to be artificially nourished as could be interpreted from the address. The discussion flowed naturally from religious topics such as life is a gift from God to the ethics and morality of the value of Ms. Schiavo’s life, the basic ethical principles of beneficence and nonmaleficence, and evaluation of the burdens and benefits using terms such as proportionate vs. disproportionate, extraordinary vs. ordinary and morally required or obligatory.

One of the primary issues in the Schiavo case was the role of various family members. This topic appeared in several publications in reference to the disagreement amongst Ms.
Schiavo’s family as well as the difficulty in acknowledging the death of a child. Although a complicated and tragic case, Dresser highlighted the positive aspect of the Schiavo case in bringing together other families around the discussion of advance directives.

Finally, the legal aspects of publications during this time were extensive in discussing the basics from previous years such as substituted judgment, best interests standard, clear and convincing evidence, surrogacy and advance directives, while introducing new issues including government intervention in the form of legislation concerning treatment. Subsequent to the flurry of discussion on Schiavo during 2004 and 2005, no articles on artificial nutrition appeared in the *HCR* in 2006 or 2007.

**Discussion**

This historical review of bioethical opinion revealed inductively derived categories addressing a myriad of physiological, psychological and social concerns over withdrawal or withholding of artificial nutrition. Key points within these categories are discussed below providing a necessary foundation to address these highly emotive issues in the future.

**Illness and Treatment Trajectory**

The acceptance of death as a normal phenomenon in American society is problematic, since many believe death to be an option not an eventuality, and as such, a subsequent lack of realism influences this discussion. A large number of reviewed publications focused on the physiological issues surrounding withdrawal or withholding of artificial nutrition, and therefore fell within the category of illness and treatment trajectory. Discussion of the nature of the illness focused on the diagnosis and prognosis of the unconscious incompetent patient (PVS) in terms of the ability to withdraw artificial nutrition. Since the Quinlan case, PVS remained a recognized irreversible diagnosis in which life-sustaining treatments may be discontinued according to a
variety of rules dependent on individual state statutes. Seemingly, early bioethical opinion in this sample reflected society’s accomplishment in managing care for those in a PVS, however, Ms. Schiavo’s diagnosis of PVS vs. minimally conscious state sparked disagreement among family members. Further, government intervention and extensive media coverage added significant weight to this case focusing on the issue of starvation, with little recognition that the Cruzan family fought this battle more than 10 years prior. Perhaps it ultimately returns to the same issue; two seemingly healthy young women suffered tragic events without prior written advance directives.

In addition to the diagnosis of PVS, the question of withdrawal arose in those patients who were incompetent, but conscious with massive brain damage or dementia. The diagnosis of dementia broadened the population in question and therefore may be more problematic for those fearful of the ‘slippery slope’ analogy. Clinicians argued that an end stage patient suffering from Alzheimer’s disease was just as terminal as was a patient in a PVS. Although the argument to orally feed those with dementia but without dysphagia was self evident, the concern over accurate diagnosis of advanced dementia may be problematic.

Further, evidence points to the lack of a positive outcome when instituting enteral nutrition for weight maintenance or loss, prevention of aspiration and treatment or prevention of decubitus ulcers. As such, patients suffering from dementia or massive brain damage demand distinction from those in a PVS, and therefore require separate examination in terms of the potential need to withdraw or withhold artificial nutrition.

Implementation of time trials may be significant for those with dementia and massive brain damage, in addition to other vague diagnoses and prognoses. Since it is difficult to diagnose impending death accurately, many decisions to institute or withdraw life-sustaining
treatments, including artificial nutrition, are fraught with uncertainty. Although the issue of time
trials was raised several times in this sample \(^{34-36, 59, 60}\), it requires more attention at the bedside.

Family

Family issues received a great deal of attention in this sample, particularly in terms of
surrogacy from early cases such as Brother Fox to the Schiavo decision. Although debated in
detail, the issue of surrogacy continues to be difficult to address. With little progress in the
execution and interpretation of advance directives, clinicians rely on families to make critical
decisions. Although appropriate in many cases, disagreement in the Schiavo case resulted in a
difficult and tragic case.

Part of the discussion about family issues naturally lends itself to the expressive aspects
of family involvement. One such aspect is the notion of symbolism in terms of food and feeding.
Symbolism was evident in 1983-1984 \(^{16, 27-29}\) and again in 2005 \(^{61}\) in terms of the highly emotive
bonds of food and water within families and society in general. The Baby Doe Directives directly
opposed the court rulings of the day allowing parental choice to remove or withhold treatment.
Perhaps the nurturing aspect of food, particularly in infants, was evident in this directive and
may mirror the notion that nourishment of the infirm or vulnerable individual is paramount under
all circumstances and at all costs, consistent with Pope John Paul II’s address.\(^2\)

Ethics, Morality and Legal Issues

Despite the lack of moral, ethical and legal distinction between withholding and
withdrawing care \(^{22}\), some clinicians, families and clergy voice strong opposition to withdrawing
care once initiated. This opposition is due in part to the perception that active treatment
discontinuation ‘feels different’ than failure to initiate care. Without the ability to accurately
predict impending death, clinician comfort to initiate and discontinue treatments as necessary is critical to providing adequate and appropriate care.

In the end, the ethics and morality of this issue seem to be most burdensome for patients, families, providers and society in general. What emerged as an early consensus on the delivery, withholding and withdrawal of artificial nutrition appears to be a ruse. Inherent in the discussion of symbolism and food is the assumed pain and social repugnance with removal of artificial nutrition. A few of the articles in this sample used the term starvation, as did the Schiavo case. Media depiction of the images of starvation and cruelty in this Florida case were similar to the circumstances of mid-December 1990, when another government official (the then Governor John Ashcroft) was also asked to intervene, and did so, in the case of Nancy Cruzan to prevent starvation from withdrawal of artificial nutrition. Another case of starvation reported in the Philadelphia media in a similar fashion to that of the previously discussed cases, involved the intentional withholding of oral nutrition from children by their parents, and not withdrawal of artificial nutrition. It is disturbing to see the parallels drawn by the media in these drastically different cases, but perhaps it is reflective of society’s inability to distinguish one from another. Some might argue that the cause of death is key when removing artificial nutrition. Perhaps, the underlying disease that prevented individuals from ingesting food orally causes an individual’s death, or perhaps death ensues from the direct removal of artificial nutrition. Some would classify the latter as starvation. In that sense, it is confusing at best to untangle the web of causality in an individual who is either at the end of their lives, in a persistent vegetative state, or suffering from massive brain damage, dementia, or severe multi-system organ failure.

Religion
Distinct from the broad bioethical discussion, religion was first evident in publications from 2001 and was revisited in 2004-2005 in the context of the Schiavo case, the Papal address, and the eventual death of Pope John Paul II. Interestingly, the focus was on Catholicism with a brief mention of fundamentalist religions, but noticeably absent a discussion of other religions. The dearth of artificial nutrition focused articles from 1996-2003 is most notable, given the resurrection of discussion and publicity in terms of the Schiavo case and Pope John Paul II’s comments. Perhaps it reinforces the absence of a true consensus.

Issues of withdrawing or withholding artificial nutrition are difficult for many who search for a comfortable and safe place in which to decide. Authors examined these decisions in terms of the obligation to treat, benefit vs. burden, medical futility, and ordinary vs. extraordinary or disproportionate vs. proportionate care. While some feared the finality of the consequences of withdrawal, others felt we should proceed cautiously due to the volatility of these issues, and still others spoke clearly of the need to complete work in the areas of substituted judgment and best interests standard while recognizing the innate vulnerability of this issue. From this sample, it is evident that ethicists, lawyers, and clinicians struggled with many issues, but also held strong beliefs concerning the future course of clinical care and legal decisions.

Conclusions: One Step Forward or Two Steps Back?

Despite broad discussion of various clinical situations, much has remained unchanged in proscribing a precise method to treat or not to treat nutritionally. Some highlight the need for continued work in end-of-life treatments, noting the unfinished nature of this dilemma and the call for more substantial ethical and policy guidelines. The presence of significant court rulings and numerous debates seemed to add little comfort. Some may argue that the Schiavo case and John Paul II’s Papal address eroded a long standing consensus on withdrawal of artificial
nutrition. Rather, it is now clear that these recent events are not an unraveling of a well established norm, but evidence that society never embraced this consensus as was once assumed. Perhaps, some of this continued discomfort is based on the rarely addressed issue of symbolism. Although well developed by anthropologists in terms of the implicit meaning of food and ritualistic behaviors, this issue remains relatively unaddressed in relation to artificial nutrition from a biomedical perspective.

While some suggest the need for a legal solution to address these issues, the ideal method may lie in the concept of exploring the meaning, values and beliefs concerning food and artificial nutrition. These core values and beliefs may affect treatment choices when faced with irreversible illness or at end of life, and therefore may require redirection of the current bioethical focus to one in which we can act without fear of legal or moral reprisals.
References


Figure 1. Inductively derived categories

Artificial Nutrition Withdrawal and Withholding

- **Illness & treatment Trajectory**
  - The nature and goals of treatment, the nature of illness and death, the utilization of technology, and decision-making.

- **Personhood**
  - The individual’s rights and principles, and the struggle for primary of rights between patients, providers, institutions, and society.

- **Family**
  - The expressive and legal/ethical aspects of family involvement in the care of an individual.

- **Provider Issues**
  - The personal rights and values of providers.

- **Cost**

- **Religion**
  - A particular guide to interpret the meaning of withdrawal and associated rules.

- **Legal Issues**
  - The legal aspects of patient rights, withdrawal of artificial nutrition, legislative issues, and parallels to other health care issues.

- **Ethics & Morality**
  - Ethical principles and the lack of consensus on withdrawal or withholding of artificial nutrition.