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The Limits of Autonomy: Force-Feedings in Catholic Hospitals and in Prisons

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THE LIMITS OF AUTONOMY: FORCE-FEEDINGS IN CATHOLIC HOSPITALS AND IN PRISONS

*The right of sovereignty was the right to take life or let live. And then this new right is established: the right to make live and to let die.*¹

For perhaps the first time in human history, the definition of death changed in the 1970s with the advent of new medical technologies. At one time, death meant the cessation of heartbeat, breathing, and brain function. But with the proliferation of defibrillators and respirators in hospital wards, able to sustain heartbeat and breathing indefinitely, brain function became the means by which death is now defined, “with appropriate blurriness.”²

These medical advancements have created an area of compromised individual autonomy. When persons become unconscious patients, their wishes are difficult to determine and act upon. In the case of patients who lack capacity to voice their wishes concerning medical treatment and decisionmaking, disagreement among family members, or between a medical proxy and an institution, can lead to court battles.

In this article, I will discuss how society and law have grappled with these definitions since the 1970s as they pertain to medical autonomy—that is, a person’s right to be informed about all medical risks and options and to agree to or deny any of them, even if the decision should result in the individual’s death. First, I will discuss the history of autonomy as the concept has evolved in medical ethics and the courts. Second, in order to illustrate how bodily autonomy is defined—to whom it extends and to whom it does not, and in what settings—I examine one medical treatment, the use of a feeding tube, and where it can be legally used despite a competent individual’s refusal. I will discuss two places where a person can be fed against his or her will: a Catholic hospital and a prison.³

Only since the 1970s has the concept of autonomy been enshrined in medical ethics.⁴ Until that time, care decisions were mostly made by doctors unilaterally.⁵ But a host of changes in medicine and society brought about greater demands for patient autonomy.⁶ New medical technologies, social movements, and the exposure of medical atrocities all produced a revolution in medical ethics that granted individuals the

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1. MICHEL FOUCAULT, 17 March 1976, in “SOCIETY MUST BE DEFENDED”: LECTURES AT THE COLLÉGE DE FRANCE 1975–76, at 239, 241 (Mauro Bertani & Alessandro Fontana et al. eds, David Macey trans., Picador 2003).
 2. SHERWIN B. NULAND, *HOW WE DIE: REFLECTIONS ON LIFE’S FINAL CHAPTER* 42 (Vintage Books ed. 1995).
 3. See Ann Neumann, *The Longest Hunger Strike*, GUERNICA (Jan. 15, 2013), <http://www.guernicamag.com/features/the-longest-hunger-strike/>.
 4. See Jacob Appel, *Rethinking Force-Feeding: Legal and Ethical Aspects of Physician Participation in the Termination of Hunger Strikes in American Prisons*, 26 PUB. AFF. Q. 313, 319 (2012).
 5. For a more complete discussion of the tradition of paternalism in medicine, see JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* (2002). While the ongoing debate regarding paternalism has criticized doctors’ decisionmaking on behalf of patients, recent critics charge that the debate has moved too far toward patient autonomy and must be tempered by recognition of doctors’ beneficence.
 6. See Mellar P. Davis et al., *Just Whose Autonomy Is It?*, 19 J. CLINICAL ONCOLOGY 3787 (2001).

ability to make medical decisions for themselves.⁷ Subsequent court cases established “right-to-die” jurisprudence.⁸ Unfortunately, this legal and ethical acceptance of autonomy is not universal in the United States.

The idea that a person should have autonomy in making medical decisions has been around for over a century. Several sources cite the *Union Pacific Railroad v. Botsford* decision in 1891 as perhaps one of the earliest legal acknowledgements of the concept.⁹ The case was brought to determine whether the plaintiff, Clara L. Botsford, who had been injured while occupying the upper berth in a train sleeping car, could be forced to undergo a medical examination, without her consent, upon a request made by the defendant railway company three days before trial. The court determined that it could not require a medical examination without her consent, citing “indelicacy.”¹⁰ The court stated, “No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of the law.”¹¹ Despite *Botsford*, it took another seventy years for this concept of personal autonomy in medical decisions to gain traction, both in the courts and the medical community.¹²

Jacob Appel, an American author, bioethicist, and social critic, believes that the development of new medical technologies in the 1960s and 1970s led to the integration of the concept of autonomy into medical ethics.¹³ While these medical advancements—coupled with cardiopulmonary resuscitation (CPR), 9-1-1 lines, and the population’s shift to urban living, where an ambulance team could readily reach the stricken in their homes or on the street—saved countless lives, they also created an area of ethics that was unexplored. Sometimes a patient’s heart and lungs could be restarted, but if the victim was without oxygen for a sustained duration of time, the amount of brain damage could be irreparable. In these cases, death often became a decision: whether or not to pull the proverbial plug. Medical ethics—including the adoption of informed consent and patient-autonomy guidelines—developed to meet these areas of new and ill-defined practice. In addition to medical advancements, social movements (such as those for civil rights and women’s rights), and media

7. See *id.* For a discussion of the historical development of informed consent and the philosophical analysis of patient autonomy, see RUTH R. FADEN & TOM L. BEAUCHAMP, *A HISTORY AND THEORY OF INFORMED CONSENT* (1986).

8. See, e.g., *Cruzan v. Dir.*, Mo. Dep’t of Health, 497 U.S. 261 (1990); *Washington v. Glucksberg*, 521 U.S. 702 (1997).

9. See e.g., *Cruzan*, 497 U.S. 261; WILLIAM H. COLBY, *UNPLUGGED: RECLAIMING OUR RIGHT TO DIE IN AMERICA* 84 (2006); Mara Silver, *Testing Cruzan: Prisoners and the Constitutional Question of Self-Starvation*, 58 *STAN. L. REV.* 631, 640 (2005).

10. See generally *Union Pac. Ry. Co. v. Botsford*, 141 U.S. 250 (1891).

11. *Id.* at 251.

12. See Appel, *supra* note 4, at 319.

13. See *id.* I have also discussed this with Appel in person. Those technologies include respirators, defibrillators, feeding tubes, and other medicines or treatments that are increasingly employed during the last weeks and months of a terminal patient’s life.

exposure of gross violations of patients' rights (including forced sterilization¹⁴ and infection programs¹⁵), spurred a public call for more informed consent from patients. These public outcries challenged existing authorities, including the medical profession, state governments, and religious institutions, regarding the rights of individuals over their own bodies.¹⁶

Law and accepted medical ethics, however, are not always shaped and applied in tandem; often laws can be developed only through additional court cases or are limited by exceptions that render particular demographic groups outside their application. Furthermore, the confounding nature of determining consent for patients and prisoners who are—or later become—incompetent is particularly challenging.¹⁷ This evolution means that today's medical ethics are only legally enforceable once corresponding laws are developed. Enforcement is often subject to the ability of patients (including those from minority groups or with limited resources) to identify such ethics and demand the compliance of medical practitioners, whether individual doctors or institutions. When those patients are subject to undesired treatment, their rights are left unrecognized and ignored.

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14. From 1909 until 1963, California sterilized 20,000 institutionalized young men and women. See Elizabeth Cohen & John Bonifeld, *California's Dark Legacy of Forced Sterilizations*, CNN (Mar. 15, 2002), <http://www.cnn.com/2012/03/15/health/california-forced-sterilizations/index.html>. Texas, Oklahoma, Michigan, Pennsylvania, Indiana, and other states also had forced sterilization programs. For a complete discussion of the history of forced sterilizations in the United States, see MARK A. LARGENT, *BREEDING CONTEMPT: THE HISTORY OF FORCED STERILIZATION IN THE UNITED STATES* (Rutgers Univ. Press 2011).
 15. One such long-term program, which caused public outrage, was the Tuskegee Syphilis Experiment, named for the Alabama institute where it took place. In 1972, several newspaper articles brought attention to a long-term medical study, initiated in 1932 by the U.S. Public Health Service, that examined the health of several hundred men infected with syphilis. Most of the study participants were poor black sharecroppers. Although nearly four hundred men were already infected with syphilis, the Public Health Service decided to not provide them with medical treatment. By the time the study was brought to light, 128 men had died. Additionally, it was revealed that the subjects had not been informed of their illness or possible treatments for it. The incident forced Congress in 1974 to hold hearings on the study; the scandal became a touchstone for patients' rights advocates. See Henry T. Greely, *Our System of Human Subjects Protection: Its History and Current Functioning*, in *MEDICINE AFTER THE HOLOCAUST: FROM THE MASTER RACE TO THE HUMAN GENOME AND BEYOND* 186, 187 (Sheldon Rubenfeld ed., 2010).
 16. In the wake of Tuskegee, laws enforcing informed consent for research subjects were enacted. See *U.S. Public Health Service Syphilis Study at Tuskegee: How Tuskegee Changed Research Practices*, CTNS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/tuskegee/after.htm> (last updated Sept. 24, 2013). For more on the development of informed consent, see TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* (Oxford Univ. Press 6th ed. 2008).
 17. In the past four decades, legal documents such as advanced directives and living wills have been developed to determine patients' medical desires. Medical or health care proxies, the legal designation of a friend or family member as the person responsible for a patient's decisions should they become incapacitated, are now recognized and utilized in most states. While these documents can still be contested in court—and routinely are—they represent a legal attempt to truly honor a patient's right to medical autonomy.

Regarding the use of feeding tubes, two particular cases established that individuals possess a right to refuse life-saving medical treatment:¹⁸ *Cruzan v. Director, Missouri Department of Health*¹⁹ and *Washington v. Glucksberg*.²⁰ Yet today, prisoners who are on hunger strike are routinely force-fed because courts have failed to apply *Cruzan* and *Glucksberg* to prisoners.²¹ In addition, the Catholic Church has thwarted patient autonomy when religious ideology is determined to be in conflict with patients' medical decisions.²²

After a car accident in 1983, Nancy Cruzan was in a persistent vegetative state.²³ Her parents agreed to place her on a feeding tube three weeks after her accident, but four years later, they came to the conclusion that their daughter would not recover.²⁴ The 1990 *Cruzan* decision by the U.S. Supreme Court established “the sanctity of self-determination” and noted *Botsford*, stating that the “principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical

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18. See Silver, *supra* note 9, at 639. The term “life-saving” (or “life-sustaining” or “life-support”) is problematic and misleading in cases when the patient is brain dead, in a persistent vegetative state, or unresponsive. In these instances—for example, two recent cases involving a brain dead child in California and an unresponsive pregnant woman in Texas—what is being supported or sustained is not the life of the individual, but his or her biological functions by artificial means. See Elizabeth Landau, *When “Life Support” Is Really Death Support*, CNN (Dec. 29, 2013, 9:36 PM), http://www.cnn.com/2013/12/28/health/life-support-ethics/index.html?sr=sharebar_twitter.
19. See *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261, 270 (1990) (“The logical corollary of the doctrine of informed consent is that the patient generally possesses the right not to consent, that is, to refuse treatment.”).
20. See *Washington v. Glucksberg*, 521 U.S. 702, 720 (1997) (“We have also assumed, and strongly suggested, that the Due Process Clause protects the traditional right to refuse unwanted lifesaving treatment.”).
21. *Cruzan* and *Glucksberg* suggest that a person has the autonomy to deny a feeding tube by holding that the Due Process Clause may protect the right to refuse unwanted life-saving medical treatment. Although recent media coverage of force-feeding prisoners at Guantánamo has perpetuated the idea that force-feeding is an anomaly, it is well documented that hunger-striking prisoners are routinely force-fed throughout the United States. See Christie Thompson, *California Hunger Strike Raises Issue of Force-Feeding on U.S. Soil*, PROPUBLICA (July 12, 2013, 1:20 PM), <http://www.propublica.org/article/california-hunger-strike-raises-issue-of-force-feeding-on-u.s.-soil> (discussing the case of New York prisoner William Coleman); see also *NY Court Upholds Force-Feeding of Prison Inmate*, WALL ST. J. (Jan. 20, 2012, 3:02 AM), <http://online.wsj.com/article/AP0a70a6eb8943416d89121d9e1457fa8e.html>; *Force-Inmates*, MIGALHAS INT’L (Jan. 18, 2012), http://www.migalhas.com/mostra_noticia.aspx?cod=148425; Lee Davidson, *House Approves Amended Inmate Force-Feeding Bill*, SALT LAKE TRIB. (Feb. 27, 2012, 11:30 PM), <http://m.sltrib.com/sltrib/mobile/53577874-90/inmate-allow-bill-feeding.html.csp>.
22. The question of whether medical and religious ethics are jointly formed is indeed an old one. Since Pope John Paul II in 2004 changed the definition of “ordinary means” (first expressed by Pope Pius XII in 1957), bioethicists have debated the morality of feeding tube usage in some patients, thus reapplying this old question to new medical technologies—particularly when regarding application of Catholic ethics to a pluralistic society, i.e., hospital patients. See Nicole Van Groningen, “*Church Autonomy*” in *Medical Ethical Decision Making*, SANTA CLARA UNIV. (July 2008), <http://www.scu.edu/ethics/practicing/focusareas/medical/anh.html>.
23. See *Cruzan*, 497 U.S. at 266.
24. See COLBY, *supra* note 9, at 89.

treatment may be inferred from our prior decisions.”²⁵ The Cruzans were able to have their daughter’s feeding tube removed, however, only when they later provided the court with “clear and convincing evidence” that Nancy would have wanted that.²⁶ She died twelve days after the tube was removed, on December 26, 1990.²⁷

In the 1997 U.S. Supreme Court case *Washington v. Glucksberg*, doctors, patients, and Compassion & Choices²⁸ sought to establish that the Washington State Constitution did not prevent “aid in dying”—that is, a doctor’s legal ability to prescribe lethal medication to a terminally ill patient for the patient’s self-administration. The Court ruled in the state’s favor, holding that “the asserted ‘right’ to assistance in committing suicide is not a fundamental liberty interest,”²⁹ but confirmed the central holding of *Cruzan*.³⁰ The key *Glucksberg* passage reads:

The right assumed in *Cruzan* . . . was not simply deduced from abstract concepts of personal autonomy. Given the common-law rule that forced medication was a battery, and the long legal tradition of protecting the decision to refuse unwanted medical treatment, our assumption was entirely consistent with this Nation’s history and constitutional traditions.³¹

Yet both *Cruzan* and *Glucksberg* drew the ire of the Catholic Church and deeply informed the Church’s hospital policies, ultimately contributing to a disruption in the universal application of patient autonomy regarding the use of feeding tubes. The Catholic Church’s views on feeding tubes—or patient autonomy and health care policy in general—are not small matters; the Church operates more than one-fifth of all hospital beds in the United States (over six hundred hospitals), forty-five of which

25. *Cruzan*, 497 U.S. at 278.

26. *Id.* at 268–87.

27. See Tamar Lewin, *Nancy Cruzan Dies, Outlived by a Debate Over the Right to Die*, N.Y. TIMES, Dec. 27, 1990, at A1, available at <http://www.nytimes.com/1990/12/27/us/nancy-cruzan-dies-outlived-by-a-debate-over-the-right-to-die.html>.

28. Compassion & Choices describes itself as the largest aid-in-dying advocacy group in the United States. See Mary Steiner, *Compassion Drives ‘Aid in Dying’ Movement*, COMPASSION & CHOICES (June 2, 2013, 9:58 PM), <http://www.compassionandchoices.org/2013/06/03/compassion-drives-aid-in-dying-movement/>.

29. *Washington v. Glucksberg*, 521 U.S. 702, 728 (1997). The U.S. Supreme Court failed to acknowledge the plaintiff’s assertion that patients who seek aid in dying are not suicidal, but instead terminally ill, and therefore actively dying. Aid in dying is now legal in four states in the United States: Vermont, Oregon, Washington, and Montana. Voters passed the Death with Dignity Act in Oregon in 1994. See OR. REV. STAT. ANN. §§ 127.800–897 (West 2013). Similar legislation was passed in Washington in 2008. See WASH. REV. CODE ANN. §§ 70.245.010–904 (West 2013). The Montana Supreme Court found that the state constitution did not prevent doctors from prescribing lethal medication to terminally ill patients in 2009. See *Baxter v. State*, 224 P.3d 1211 (Mont. 2009). In May 2013, the Vermont House and Senate both passed the End of Life Choice bill, making it the first state to do so through the legislative process. See VT. STAT. ANN. tit. 18, §§ 5281–5292 (West 2013). The bill, very similar to those in Oregon and Washington, allows competent, terminal patients to request a lethal dose of medication from their physician that the patient may then self-administer to hasten death. See *id.* § 5283.

30. See *Glucksberg*, 521 U.S. at 724.

31. *Id.* at 726.

are the sole providers in their respective regions.³² These hospitals, to varying degrees depending on the diligence of the local bishop and compliance of medical staff, are operated according to seventy-two Ethical and Religious Directives (ERDs) that are written by the United States Conference of Catholic Bishops (USCCB) and approved by the Vatican.³³ The ERDs are categorized as “laws” that all Catholics—from the pope, to the hospital orderly, to the grandmother in the pews—are required to abide by.³⁴ There is a long tradition of dissent among Church leadership and laity; yet it is not uncommon for the public, the media, and the Church itself to speak as though it has only one voice representing all those whom identify as Catholic. When the Church is unable to influence public practice, it often turns to the media and the law to exert its ideology. For example, while 98% of all Catholic women use contraception at some time in their lives, the Church maintains the position that its affiliates (colleges, hospitals, charities, etc.) will not allow contracted insurance companies to cover contraception for employees.³⁵ In this and other cases, the Church’s influence on health care policy is well documented.³⁶

Since the decision of *Roe v. Wade* in 1972, Catholic health care has been a study of tensions. While the Vatican and its U.S. contingent, the USCCB, have engaged in various campaigns to enforce—by law or social influence—their own unique version of medical ethics, the Catholic Health Association, which is pragmatically engaged with the day-to-day provision of health care, has become less beholden to the leadership’s current ideologies. For instance, the association has consistently given its support to the Obama administration’s health care reform act,³⁷ specifically the Health and Human Services’ final accommodation for religious organizations opposed to contraception³⁸—despite the USCCB’s opposition to the limited scope of the

32. See Becky Garrison, *Playing Catholic Politics with U.S. Healthcare*, THE GUARDIAN (London) (Dec. 31, 2010, 5:00 PM), <http://www.theguardian.com/commentisfree/belief/2010/dec/31/catholic-us-healthcare-abortion>; *Catholic Health Care and Social Services*, U.S. CONFERENCE OF CATHOLIC BISHOPS, <http://www.usccb.org/about/media-relations/statistics/health-care-social-service.cfm> (last visited Dec. 31, 2013).

33. See U.S. CONFERENCE OF CATHOLIC BISHOPS, *ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES* (5th ed. 2009).

34. *Id.* at 12.

35. See *Guttmacher Statistics on Catholic Women’s Contraceptive Use*, GUTTMACHER INST. (Feb. 15, 2012), <http://www.guttmacher.org/media/inthenews/2012/02/15/index.html>; Dan Mercia, *Obama Proposal Would Let Religious Groups Opt-Out of Contraception Mandate*, CNN (Feb. 1, 2013, 7:48 PM), <http://www.cnn.com/2013/01/31/politics/religion-contraceptive-insurance>.

36. See Ann Neumann, *The Conscience Clause: It’s Not Just About 770,000 Hospital Employees*, THE REVEALER (Feb. 9, 2012, 9:39 PM), <http://therevealer.org/archives/10392>.

37. In my opinion, “reform” is a hyperbolic portrayal of what the Patient Protection and Affordable Care Act (also known as “Obamacare”) represents.

38. Exemption and Accommodations in Connection with Coverage of Preventive Health Services, 45 C.F.R. § 147.131 (2013); see also *Women’s Preventive Services Coverage and Non-Profit Religious Organizations*, CTRS. FOR MEDICARE & MEDICAID SERVS., <http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/womens-preven-02012013.html> (last visited Dec. 21, 2013).

accommodation.³⁹ As we have seen with abortion, however, the Church has found it effective to focus on state-level access and not just federal legislation. While working with “pro-life” organizations, the Church has been instrumental in the enactment of limitations to a women’s ability to have an abortion across the country, including age limits, waiting periods, parental consent requirements, closures of clinics, and the regulation of anti-abortion drugs.⁴⁰ Furthermore, the Church has been very effective at pressuring medical practitioners at Catholic hospitals to comply with Church doctrine, which fully opposes abortion and many non-abortifacient methods of contraception.⁴¹ It has also promoted an environment of shame and persecution of both abortion providers, seekers, and recipients, as well as for pro-choice legislators.⁴²

Catholic hospitals have been able to ignore an individual’s right to make personal medical treatment decisions through ethical and legal exemptions in the form of

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39. See Barbara Mann Wall, *The Role of Catholic Nurses in Women’s Healthcare Policy Disputes: A Historical Study*, 61 NURSING OUTLOOK 367, 371–72 (2013).
40. After the expansive *Roe v. Wade*, 410 U.S. 113 (1973) decision, the Supreme Court in *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), created the “undue burden” standard for evaluating government measures to limit women’s access to abortions, effectively curtailing women’s rights by eliminating the “fundamental rights” language as laid out in *Roe v. Casey*, 505 U.S. at 845–46. As a result, procedures such as age limits, waiting periods, parental-consent requirements, closure of clinics, and the regulation of anti-abortion drugs have been deemed constitutional and are now commonplace. See *State Policies in Brief: An Overview of Abortion Laws*, GUTTMACHER INST. (Oct. 1, 2013), http://www.guttmacher.org/statecenter/spibs/spib_OAL.pdf (“[Twenty-six] states require a woman seeking an abortion to wait a specified period of time . . . [Thirty-nine] states require some type of parental involvement in a minor’s decision to have an abortion.”). While the Catholic Church does not exercise any direct role in creating such laws, its influence is felt in the legislative process. See Rishona Fleishman, *The Battle Against Reproductive Rights: The Impact of the Catholic Church on Abortion Law in Both International and Domestic Arenas*, 14 EMORY INT’L L. REV. 277, 301–04 (2000) (“[W]hile the Church has no state sanctioned role in U.S. politics, it does continue to influence legislation.”).
41. See Claire A. Smearman, *Drawing the Line: The Legal, Ethical, and Public Policy Implications of Refusal Clauses for Pharmacists*, 48 ARIZ. L. REV. 469, 484 (2006) (“[T]he growing power of the nation’s Catholic hospitals and health care systems creates the largest threat to the availability of a full range of reproductive health care services for women.”); Lisa C. Ikemoto, *When a Hospital Becomes Catholic*, 47 MERCER L. REV. 1087, 1109 (1996) (stating that the services most likely to be dropped when a hospital becomes Catholic are those related to abortion and anti-contraception); Jennifer Templeton Schirmer, *Physician Assistant as Abortion Provider: Lessons from Vermont, New York, and Montana*, 49 HASTINGS L.J. 253, 273 (1997) (stating that many Catholic hospitals prohibit their staffs from performing abortions and anti-contraceptive procedures, as well as from discussing or dispensing birth control). For an overview of the Catholic Church’s reasons for opposing contraception, see *Fact Sheet: Contraceptive Mandates*, U.S. CONFERENCE OF CATHOLIC BISHOPS, <http://www.usccb.org/issues-and-action/human-life-and-dignity/contraception/fact-sheets/contraceptive-mandates.cfm> (last visited Dec. 21, 2013).
42. Bishops and other members of the Catholic Church have criticized Catholic legislators for their views on abortion. See, e.g., James L. Heft, *Religion and Politics: The Catholic Contribution*, 32 U. DAYTON L. REV. 29, 35–36 (2006) (discussing the threats from fellow Catholics and bishops of excommunication to then-presidential candidate John Kerry and every Catholic who voted for him in 2004 for Kerry’s pro-choice position on abortion); see also Ken Lovett, *Catholic League: Abortion Plan Will Cost Andrew Cuomo Shot at Presidency*, N.Y. DAILY NEWS (June 4, 2013, 6:23 AM), <http://www.nydailynews.com/blogs/dailypolitics/2013/06/catholic-league-abortion-plan-will-cost-andrew-cuomo-shot-at-presidency-0> (explaining how New York Governor Andrew Cuomo’s support for abortion rights would cost him a chance at the presidency and quoting Catholic League President Bill Donohue’s statement that Cuomo’s pro-choice stance is “political suicide”).

various religious “conscience clauses.”⁴³ Catholic hospitals receive 50% of their funding from state and federal sources (in the form of Medicare and Medicaid funding, less than 3% of funding is from Catholic sources), and, like “secular” hospitals, they serve a pluralistic populace.⁴⁴ Despite this fact, Catholic hospitals and other religious entities have been protected from complying with standard medical ethics and practices by a web of conscience clauses that began with the Church Amendment in 1973, enacted in the wake of *Roe v. Wade*.⁴⁵

Indeed, conflict with the Church over the “conscience clause” regarding the provision of contraception in President Obama’s health care law has proven most telling.⁴⁶ In essence, the accommodation and existence of such “conscience clauses,” when coupled with patients in traumatic situations who are left to make decisions without full disclosure of services or meaningful referrals, allow Catholic hospitals to be places where the medical choices of the institution—as dictated to administrators, doctors, nurses, and patients alike by the Vatican-approved ERDs—supersede the choices of the patients they serve. As many have asked, “whose conscience” are the laws seeking to protect?⁴⁷ In practice, these clauses do not protect the religious freedom of patients, but instead protect the institution’s chosen ideological stance.

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43. See Martha S. Swartz, *Conscience Clauses or “Unconscionable Clauses”: Personal Beliefs Versus Professional Responsibilities*, 6 YALE J. HEALTH POL’Y L. & ETHICS 269 (2006).
44. See CATHOLICS FOR A FREE CHOICE, CATHOLIC HEALTH CARE UPDATE: THE FACTS ABOUT CATHOLIC HEALTH CARE IN THE UNITED STATES 2 (2005), available at <http://www.catholicsforchoice.org/topics/healthcare/documents/2005factsaboutcatholichealthcare.pdf>.
45. See 42 U.S.C. § 300a-7 (2011); see also 42 U.S.C. §§ 238n, 1395w-22(j)(3)(B), 1396u-2; 48 C.F.R. § 1609.7001(c)(7) (2012); JODY FEDER, CONG. RES. SERV., THE HISTORY AND EFFECT OF ABORTION CONSCIENCE CLAUSE LAWS 1-2 (2005), available at <http://www.law.umaryland.edu/marshall/crsreports/crsdocuments/RS2142801142005.pdf>.
46. See 42 U.S.C. § 18023 (2011) (stating that, under federal law, a health insurance plan or health care provider does not need to cover or provide abortion services if it is contrary to its religious or moral beliefs); 45 C.F.R. § 147.131 (exempting religious organizations from having to provide contraception coverage in the health insurance plans they offer to their employees, but requiring health insurance providers to offer separate contraception coverage to such employees at no additional cost); see also *Hobby Lobby Stores, Inc. v. Sebelius*, 723 F.3d 1114 (10th Cir. 2013), cert. granted, 82 U.S.L.W. 3139 (U.S. Nov. 26, 2013) (No. 13-354) (holding that requiring Hobby Lobby to comply with 45 C.F.R. § 147.131 would violate its religious beliefs); *Conestoga Wood Specialties Corp. v. Sec’y of U.S. Dep’t of Health & Human Servs.*, 724 F.3d 377 (3d Cir. 2013), cert. granted, 82 U.S.L.W. 3139 (U.S. Nov. 26, 2013) (No. 13-356) (holding that “for-profit, secular corporations cannot engage in religious exercise,” and therefore the contraception mandate under 45 C.F.R. § 147.131 does not violate plaintiff’s religious freedom); *Autocam Corp. v. Sebelius*, 730 F.3d 618 (6th Cir. 2013) (agreeing with the Third Circuit’s holding in *Conestoga Wood*); *Zubik v. Sebelius*, No. 13-1459 (W.D. Pa. Nov. 21, 2013) (order granting preliminary injunction against enforcement of 45 C.F.R. § 147.131).
47. Sandhya Bathija, *Whose Conscience Counts?*, AMERICANS UNITED (Oct. 2009), <https://www.au.org/church-state/october-2009-church-state/featured/whose-conscience-counts>; E. Christian Brugger, *Whose Conscience? Whose Religion? The Enemy Is Partially Us*, ZENIT (Jan. 24, 2012), <http://www.zenit.org/en/articles/whose-conscience-which-religion-the-enemy-is-partially-us>; Linda Greenhouse, *Whose Conscience?*, N.Y. TIMES OPINIONATOR (Feb. 8, 2012, 9:00 AM), <http://opinionator.blogs.nytimes.com/2012/02/08/whose-conscience/>.

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In 1976, Karen Ann Quinlan was the first person to be the subject of a national debate about the removal of life support. Twelve years later the *Cruzan* case came to the courts, and ten years after that came the case of Terri Schiavo.⁴⁸ Schiavo was a Florida woman whose parents unsuccessfully recruited Republican Senators and the President to commandeer medical guardianship in 2005, against the rulings of a district court⁴⁹ and the wishes of Schiavo's husband.⁵⁰ The *Quinlan*, *Cruzan*, and *Schiavo* court cases represent the Catholic Church's holy trinity of young, white, childless women⁵¹ removed from feeding tubes or, as "pro-life" activists have characterized it, "killed" by a "culture of death" that failed to see the women as vulnerable or disabled.⁵² *Cruzan* prepared the Church for *Schiavo*, which was publicized by a coalition of Church leaders, associated activists, and politicians in an unprecedented way.⁵³

These cases, particularly Schiavo's, caused the Church to change the ERDs to shift the decision to remove a feeding tube from a patient or the patient's family to the hospital administration when the patient's wish is "contrary to Catholic moral teaching."⁵⁴ ERD 58 specifically states:

In principle, there is an obligation to provide patients with food and water, including medically assisted nutrition and hydration for those who cannot take food orally. This obligation extends to patients in chronic and presumably irreversible conditions (e.g., the "persistent vegetative state") who can reasonably be expected to live indefinitely if given such care.⁵⁵

Because Catholic hospitals are protected by the conscience clauses that allow them to deviate from general medical ethics, and because vulnerable patients and their families often do not know what their options are and look to attending doctors for direction, patients are effectively denied an established legal right that would, outside

48. See *Schindler v. Schiavo*, 780 So. 2d 176 (Fla. Dist. Ct. App. 2001); Abby Goodnough, *Supreme Court Refuses to Hear the Schiavo Case*, N.Y. TIMES, Mar. 25, 2005, at A1, available at <http://www.nytimes.com/2005/03/25/politics/25schiavo.html>.

49. See *id.*

50. See Ann Neumann, *The Resurrection of Terri Schiavo*, RELIGION DISPATCHES (Aug. 10, 2009), http://www.religiondispatches.org/archive/politics/1747/the_resurrection_of_terri_schiavo/.

51. I submit that it is no coincidence that the three most prominent right-to-die cases were about young, white women. The race, age, and gender of these three individuals are significant in that they contributed to a particular media interest and attracted the paternal, protective instincts of the Catholic Church. Furthermore, because the Church has successfully focused its attention on female bodies of reproductive age (regarding abortion and contraception), these three women codified the Church's "pro-life" platform as inclusive of reproductive rights and end-of-life rights.

52. See Bobby Schindler, *Terri Schiavo, Her Death Marked a Beginning*, WND.COM (Mar. 31 2013, 1:56 PM), <http://www.wnd.com/2013/03/terri-schiavo-her-death-marked-a-beginning/>.

53. See *PBS Newshour: The Schiavo Case Receives Strong Media Coverage* (PBS radio broadcast Mar. 24, 2005), available at http://www.pbs.org/newshour/bb/media/jan-june05/schiavo_3-24.html; William H. Colby, *From Quinlan to Cruzan to Schiavo: What Have We Learned?*, 37 LOY. U. CHI. L.J. 279 (2006).

54. U.S. CONFERENCE OF CATHOLIC BISHOPS, *supra* note 33, at 31.

55. *Id.*

a Catholic institution, be recognized.⁵⁶ In other words, patients in Catholic hospitals have fewer autonomy rights than those in non-Catholic hospitals.

The comparison of feeding tube usage in Catholic hospitals and prisons is at first surprising given the divergent nature of public regard for each institution. Hospitals are for healing and Catholic hospitals are held in deserved high regard in the public consciousness. Prisons, in contrast, are for the punishment and reform of criminals; they are expected to exercise justice and discipline, at a cost to the prisoner, but also, arguably, for the benefit of the prisoner and society in general. Yet much can be learned from the comparison. The Catholic hospital is not the only place where patients' rights are, in theory and practice, second to those of the managing organization; prisoners are routinely denied the right to refuse a feeding tube. To stay on a hunger strike long enough for prison officials to contemplate force-feeding is not easy; a hunger strike requires physical strength and emotional conviction. But the force-feeding of striking prisoners is not rare, although it is rarely publicized.⁵⁷

William Coleman, a hunger-striking prisoner in Connecticut, has been routinely force-fed since 2008.⁵⁸ Coleman began his hunger strike on September 17, 2007, two weeks after he was incarcerated, to protest his conviction. He says that he is innocent. He asserts that his hunger strike is the only remaining way he can exercise his First Amendment rights. He also asserts that being force-fed is a violation of his right to deny medical treatment and characterizes it as torture. Since he first stopped eating, he has not consumed solid food, although he has intermittently taken fluids like milk, juice, and Ensure. He has lost more than 106 pounds, four teeth, and has suffered untold damage to his internal organs from malnutrition. Just over one year after he started his hunger strike, the medical staff sought and received a temporary injunction to force-feed Coleman with a tube.⁵⁹

56. I have spoken about this in various locations and contexts, and invariably am told that a patient who wishes to have a tube removed—or not inserted in the first place—should simply go to another, non-Catholic hospital. Yet, as we have seen with abortion, legal rights are often stifled by lack of information and access. Abortion is legal in the United States, yet four states have only one provider. See Tracy Connor, *40 Years After Roe v. Wade, More States Restricting Abortion*, NBCNEWS.COM (Jan. 21, 2013), http://usnews.nbcnews.com/_news/2013/01/21/16624980-40-years-after-roe-v-wade-more-states-restricting-abortion?lite. Other restrictions on age, waiting periods, and procedural requirements have been rampantly enacted in recent years. See Michael Keller & Allison Yarrow, *The Geography of Abortion Access*, THE DAILY BEAST (Jan. 22, 2013), <http://www.thedailybeast.com/articles/2013/01/22/the-geography-of-abortion-access.html>. The fact that abortion is legal in the United States does not guarantee access to those in Catholic institutions. Incapacitated patients are challenged when they need to move to another hospital, just as patients seldom have a choice of which hospital they use, or knowledge of what the choice of hospital could mean.

57. See Appel, *supra* note 4, at 316–20.

58. In January 2012, David McGuire, Coleman's lawyer at the American Civil Liberties Union (ACLU) of Connecticut, provided me with Coleman's mailing address in prison. Since then, Coleman and I have regularly corresponded via letters and over the telephone.

59. See *Comm'r of Corr. v. Coleman*, 38 A.3d 84, 89–90 (Conn. 2012).

Coleman and the ACLU sued the State of Connecticut and the Commissioner of the Department of Corrections to stop the feedings.⁶⁰ Coleman wanted to be kept comfortable, according to his living will, and to be allowed to die. The court explained that it “must determine whether the commissioner’s interests outweigh the incarcerated defendant’s common law right to refuse nutrition and liquids without interference.”⁶¹ It ruled that in the interest of preventing “copycat hunger strikes and the duty to preserve Coleman’s life, even against his wishes, the feedings were ‘justified.’”⁶²

In other similar cases, courts often cite two reasons for force-feeding prisoners: prevention of suicide and maintenance of prison order.⁶³ “Curiously absent from any state arguments or judicial opinions are the more philosophical notions that a prisoner should be forced to live out his sentence as a form of retribution for his crimes.”⁶⁴ Instead, courts most often note the state’s interest in the prisoner’s health and well-being and that of the other prisoners and staff. There is scant evidence that hunger-strikers disrupt prisons. Prison wardens who seek permission to force-feed prisoners routinely receive it without any proof of disruption.⁶⁵ Indeed, the 2013 case

60. See *ACLU of Connecticut Legal Docket*, ACLU OF CONN., <https://www.acluct.org/wp-content/uploads/2013/08/UPDATEDLegalDocket.pdf> (last visited Dec. 21, 2013).

61. *Coleman*, 38 A.3d at 94.

62. Appel, *supra* note 4, at 313. Despite the categorization of force-feeding as torture by the world’s major medical associations, the force-feeding of prisoners continues in the United States, most recently at Guantánamo prison. See also WORLD MED. ASS’N, DECLARATION OF TOKYO—GUIDELINES FOR PHYSICIANS CONCERNING TORTURE (1975), available at <http://www.wma.net/en/30publications/10policies/c18/> (stating that a prisoner capable of rational judgment shall not be fed artificially); Carol Rosenberg, *AMA Opposes Forced Feedings at Guantánamo*, MIAMI HERALD (Apr. 30, 2013), <http://www.miamiherald.com/2013/04/30/3372407/guantanamo-hunger-strike-holds.html> (discussing a letter from Jeremy Lazarus, AMA President, to Charles T. Hagel, U.S. Sec’y of Defense, stating that force-feeding detainees violates AMA ethical values); *Red Cross Chief Blasts U.S. for Force-Feeding Gitmo Inmates*, RT (May 15, 2013, 1:53 PM), <http://rt.com/usa/red-cross-guantanamo-maurer-770> (discussing statements made by Peter Mauer, President, Int’l Comm. of the Red Cross); *Hunger Games: Critical Health Fears as Gitmo Strike Marks Day 100*, RT (May 16, 2013, 12:43 PM), <http://rt.com/usa/red-cross-guantanamo-maurer-770> (discussing the force-feeding of prisoners which continues in the United States at Guantánamo prison). For more details on Guantánamo, see THE CONSTITUTION PROJECT, THE REPORT OF THE CONSTITUTION PROJECT’S TASK FORCE ON DETAINEE TREATMENT (2013).

63. For other examples of cases where prisoners’ health and prison order are cited, see *Bezio v. Dorsey*, 937 N.Y.S.2d 393 (3d Dep’t 2012) (holding that a state may take affirmative action to prevent the suicide of a prisoner in the event of a hunger strike to preserve the state’s interest in protecting the health of inmates); *Stevenson v. Lanham*, 736 A.2d 363 (Md. Ct. Spec. App. 1999); *Doe v. United States*, 150 F.3d 170 (2d Cir. 1998) (discussing a prison’s responsibility to provide care to preserve life, prevent suicide, and maintain prison order); *In re Caulk*, 480 A.2d 93 (N.H. 1984) (discussing the potentially negative implications of hunger strikes on prison order and the state’s need to force-feed prisoners in order to promote the interests in preserving human life and preventing suicide).

64. Silver, *supra* note 9, at 643.

65. Only three states have laws against force-feeding prisoners: Florida, Georgia, and California (although a judge in California ruled that prisoners on hunger strike there in 2013 could be force-fed if they did not have a do-not-resuscitate order in writing). See David Ingram & Jane Sutton, *Analysis: In Force-Feeding Detainees, Obama Has Courts on His Side*, REUTERS (Apr. 26, 2013, 7:53 AM), <http://www.reuters.com/article/2013/04/26/us-usa-guantanamo-forced-feeding-idUSBRE93P04N20130426>. Other recent prisoner force-feedings have taken place in Washington, Utah, Illinois, Wisconsin, and

in Guantánamo—where a hundred or more of the 166 prisoners there were on hunger strike and dozens were force-fed—may show that force-feedings contribute to the spread of hunger strikes.

In contravention of *Cruzan* and *Glucksberg*, but in clear keeping with other cases throughout the country, the justices in Coleman’s case “reject[ed] the defendant’s argument that starving himself to death is not suicide because it yields the same result as suicide: self-inflicted death.”⁶⁶ Because Coleman will only stop his hunger strike if his conviction is overturned, and he has no further chance to appeal, the court reasoned that Coleman could not justify continuing his hunger strike, and concluded that he must be suicidal.⁶⁷

Although Coleman has completed his initial sentence, he continues to be held because he refuses to sign the sexual offender list, a “choice” that has garnered him five more years of incarceration. Regardless, he does not want to leave prison unless his sentence of guilt is reconsidered. Coleman continues his hunger strike even though the medical staff has interpreted the court decision on force-feeding in various ways. Feeding orders seldom designate how or when a prisoner should be fed, although they do stipulate that force can be used. Coleman has gone through periods of relative physical stability because of regular feedings—sometimes facilitated by a semi-permanent tube placed in his right nostril—and periods of physical and mental decline without feedings. Coleman’s hunger strike is the longest in the United States that I can find record of.

In both the cases of William Coleman and Nancy Cruzan, the patient, or his or her proxy, decided that death—by denial or removal of a feeding tube—was preferable to living in his or her current state. Only after years in court was Cruzan’s tube removed,⁶⁸ which portends that, while force-fed prisoners are still considered to be

New York. See Ann Neumann, *Guantánamo Is Not an Anomaly—Prisoners Are Force-Fed in the U.S. Every Day*, WAGING NONVIOLENCE (May 4, 2013), <http://wagingnonviolence.org/feature/guantanamo-is-not-an-anomaly-prisoners-in-the-us-are-force-fed-every-day/>. For court cases, see *McNabb v. Dep’t of Corr.*, 180 P.3d 1257 (Wash. 2008); *White v. Suneja*, No. 10-cv-332-JPG, 2010 WL 4719663, at *2 (S.D. Ill. Nov. 15, 2010); Bruce Vielmetti, *Judge Extends Involuntary Treatment Order for Wold*, JOURNAL SENTINEL (Milwaukee) (Nov. 30, 2011), <http://www.jsonline.com/news/crime/judge-closes-hearing-to-public-in-murderforhire-case-q838ui6-134779723.html> (discussing the case of Darren Wold); *In re Lilly*, 804 N.W.2d 489 (Wis. 2011); *Bezio*, 937 N.Y.S.2d 393; *Stevenson*, 736 A.2d 363. In 2012, Utah passed a law in response to the death of hunger-striking prisoner Carlos Umana. See *Involuntary Feeding and Hydration of Inmates*, UTAH CODE ANN. §§ 77-16b-101–105 (West 2013); see also Robert Gehrke, *Utah Inmate’s Starvation Death Spurs Bill on Force-Feeding*, SALT LAKE TRIB. (Feb. 10, 2012, 10:54 PM), <http://www.sltrib.com/sltrib/politics/53484550-90/inmate-bill-hunger-brown.html.csp>.

66. *Comm’r of Corr. v. Coleman*, 38 A.3d 84, 90 (Conn. 2012).

67. See *id.* at 100–01.

68. See *Nancy Cruzan’s Legacy the Public Is Wiser About the ‘Right to Die’*, PHILA. INQUIRER (Dec. 27, 1990), http://articles.philly.com/1990-12-27/news/25923204_1_nancy-cruzan-cruzan-case-budget-bill. Although not explicitly, *Cruzan* established that feeding tube removal at “secular” hospitals is at the discretion of patients and their proxies. Yet conscience clauses and the policies of the Catholic Church regarding tube removal have infused the decisionmaking process with confusion, misinformation, and coercion in Catholic hospitals. See DAVID F. KELLY, GERARD MAGILL & HENK TEN HAVE, *CONTEMPORARY CATHOLIC HEALTH CARE ETHICS* (2d ed. 2013); Scott Hensley, *Obama Pushes*

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without full medical autonomy, perhaps the courts will continue to pressure Catholic institutions to comply with standard medical ethics—at least where feeding tube usage is concerned.

The issue of patient autonomy is not just about the patient; it is about doctors as well. Those employed by institutions that insist on force-feeding prisoners or patients are unable to comply with standard medical ethics and because of coercion, the need for job security, isolation from the medical community, or other forces, they are prevented from exercising their own conscience regarding the practice. State-employed prison clinicians must “act in contravention of growing medical consensus that such conduct is an ethical violation.”⁶⁹ At least one commentator has suggested that “regulation of professional licensure” may be the “most direct, albeit politically challenging, mechanism for halting physician participation.”⁷⁰

Culture and law, though, continue to be the driving forces that shape society’s position regarding medical autonomy. Perhaps the most compelling argument for re-examining the use of feeding tubes is this identification, comparison, and analysis of two sites in the United States where a person’s decision to discontinue life-sustaining⁷¹ treatment will not be followed. Such inquiry begs the question of why the constitutional right to autonomy in medical treatment decisions arguably stops at the Church door or the prison wall.

Hospitals to Honor Patients’ Choices, COMPASSION & CHOICES (Apr. 16, 2010, 3:59 PM), <http://www.compassionandchoices.org/2010/04/16/obama-pushes-hospitals-to-honor-patients-choices/>.

69. Appel, *supra* note 4, at 326.

70. *Id.*

71. *See supra* text accompanying note 18.

