Vegetative State

I. Rationale for the Opinion

As Christian physicians, we seek to practice our profession in accordance with the Word of God, and the leading of the Holy Spirit. Medical science and technology have made it possible to keep patients alive when they are in a vegetative state. Even among Christians there is considerable controversy over the status and treatment of these patients. Biblical teaching does not provide explicit guidance to patients, their surrogates, and their physicians for making treatment decisions in these challenging situations. We issue this opinion to help Christian physicians care for such patients.

II. General Principles

A. God is the Creator and is sovereign in all circumstances and conditions.

B. God created all humans in His image, and therefore all human life has inestimable worth.

C. God has entrusted us with our lives and resources. We are responsible to Him for our healthcare decisions. We desire to be wise and trustworthy stewards of what God had given us to use.

D. When humans die, their eternal destiny rests with a just and loving God. For a Christian, to be absent from the body is to be at home with the Lord; therefore, death need not be resisted at all costs. (See the opinion on Patient Refusal of Therapy).

E. All patients, regardless of their diagnosis or condition, must be treated with dignity, and we should continue to pray for their healing.

F. As physicians, we are never to kill patients or assist in their suicide (See Opinions on Physician-Assisted Suicide and Euthanasia).

III. Definitions

A. While much of the medical literature refers to individuals who suffer severe cortical dysfunction as "vegetative," we must be careful not to dehumanize our patients through our language, attitudes, or actions. Patients said to be in a vegetative state are neither dead nor less than human ("vegetables").

B. A person is said to be in a vegetative state when he or she exhibits no evidence of cortical brain function, but exhibits some brain stem function. This is a descriptive term. A person is said to be in a persistent vegetative state when repeated careful clinical examinations confirm that the condition has continued for some length of time. This is a diagnostic term. A patient is said to be in a permanent vegetative state when sufficient time has passed that the professionals involved believe there is no reasonable probability that the condition will improve. This is a prognostic term. Patients in a vegetative state are unaware of themselves and their environment and are unable to

interact with others. They may breathe on their own and retain some brainstem reflexes, possibly including the ability to swallow.

IV. Recommendations

A. To respect the sanctity of human life and to be good stewards of it, Christian physicians ought to ensure that the diagnosis and prognosis of the permanent vegetative state are correct. Once the prognosis is established, and recognizing that God is not dependent on our technology to effect His perfect plan, the use of medical technology to prolong these patients' earthly existence may not be morally required in all cases.

B. The decision regarding the use of technology should have been made by the patient (by use of an advance directive prior to cortical injury) or be made by the patient's surrogate attempting to decide as the patient would have decided. Patients and surrogates may decide to refuse procedures and/or artificial supports to life or to have them discontinued. While artificially administered nutrition and hydration may be considered an artificial support to life, food and water by mouth should be offered to all patients. Sincere Christians differ about the morality of withholding or withdrawing artificially administered nutrition and hydration from patients in a permanent vegetative state. There are compelling arguments on both sides. Since we hold that withdrawal of nutrition or hydration for the specific purpose of taking a patient's life is impermissible, we suggest that anyone (either patients and surrogates or physicians) faced with such a decision weigh both sides of the issue prayerfully and seek God's will in reaching a decision.

C. Remembering that God is sovereign, we suggest that each Christian physician seek His guidance prayerfully, and solicit the wise counsel of others in the management of these patients. If a physician, because of moral convictions, is unable to comply with the patient's or surrogate's wishes to withhold or withdraw artificially administered nutrition and hydration, it is appropriate for the physician to withdraw from the care of the patient as soon as another physician assumes that care.

D. As Christian physicians we desire to share the love of Christ with others. We will treat the families of patients who are in a vegetative state with compassion, kindness, humility, gentleness, and patience, as we assist them in making these decisions.

Approved by the House of Delegates
Passed with 61 approvals, 2 opposed, 4 abstentions
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Explanation

The vegetative state was first described in 1972. It is now a commonly recognized clinical entity which results primarily from failed technology. Before the medical profession was able to resuscitate patients and maintain physiologic support, almost all patients with such severe brain damage succumbed to their acute illness or injury. Using current technology, thousands of patients have been successfully resuscitated only to find at a later time that they were able to recover homeostatic stability, but not cognition. After several days or weeks of intensive support, most of these survivors in the permanent

vegetative state can continue to live for long periods of time if they receive good nursing care plus artificially administered fluids and nutrition. With such care, there have been reports of 30-year survival.

The potential for prolonged survival of these severely brain-damaged individuals raises questions about the definition of life vs death, the appropriate goals of medicine, the cost of medical care for severely disabled individuals, and the degree of certainty needed for decision-making in such cases.

Secular Perspective

The secular debate about care for PVS patients has been dominated by discussions of data. Are there clear boundaries for the clinical diagnosis of the PVS? What are the chances for survival of a particular patient? How early after a devastating brain injury can we have a high degree of certainty of the long-term outcome?

Some of the secular debate has gone beyond the data to look at personal, professional and societal values. Since most people surveyed consider life in the PVS to be "as good as dead" or "worse than death", some have suggested that a patient with no cortical brain function (including those in the PVS, infants born with anencephaly, etc.) should be considered dead, so-called "neocortical death." This would not only save financial resources and caregiver burden, but would introduce another large source for transplantable organs. Most are hesitant to make this major move because of the significant conceptual problem with seeing a "dead" person who is still breathing.

In spite of this current reluctance to redefine death to include PVS patients, there is not societal consensus on how to treat PVS patients. There is a wide variability of recommendations about the use of life-sustaining treatment in such patients. Since most people would opt to forego life-sustaining treatment for themselves if they should be in the PVS, some have argued that the default management option for PVS patients should be non-treatment, shifting the burden from those who want to discontinue treatment to those who want to continue it.

Christian Perspective

There is not a unanimous Christian voice or perspective on this issue. When the Ethics Commission of the CMDS wrote an opinion statement on the **Withholding and Withdrawing of Nutrition and Hydration** in 1989, it could not reach consensus on the use of this modality in PVS patients. Discussion has continued, and differences of opinion remain.

There are some Christians who maintain that, because patients in the PVS can survive for a long time, the sanctity of that individual human life is the most important consideration, and we are therefore obligated to provide the needed sustenance, even if we decide to withhold other more invasive treatments. They would argue that artificially administered fluids and nutrition are not treatment, but are a sign of continued loving care.

There are others who maintain that, because patients in the PVS are exceedingly unlikely to recover cognizance and they cannot take nourishment without mechanical assistance, they are terminally ill, and we therefore have no moral obligation to artificially postpone their deaths. They would maintain that artificially administered fluids and nutrition are treatment, and are therefore optional when a decision has been made to no longer attempt to forestall death.

This statement on **The Vegetative State** is an attempt to articulate pertinent principles, clarify definitions, and to give some guidance to Christian healthcare professionals, pastors and laypersons as they deal with the realities of this clinical entity.

Abstracts

O'Mathuna DP. Responding to Patients in the Persistent Vegetative State. Philosophia Christi 1996;19(2):55-83.

The author discusses the PVS in the light of Christian beliefs. He explores the possible suffering of the PVS patient, Christian arguments for the withholding of food and liquids and raises the issue of the Biblical concept that man is made in the image of God. He concludes, "Our God is in the business of

protecting and nourishing broken, discarded lives which seem to have little meaning. He can use these tragedies to let his glory shine into a dark and painful world. His images should respond likewise."

Freeman CW. What Shall We Do With Norman? An Experiment in Communal Discernment. Christian Bioethics 1996;2(1):16-41.

"We were a group of Christian friends searching for affirmations that lay at the heart of our faith and reached to the limits of our existence and moral authority. As we have reflected on our role in deciding whether and to what extent we could assist in allowing our terminally ill friend, seventy-nine-year-old Norman to die, we were deeply troubled by the moral ambiguity of our involvement. Through a careful process of authority through communal discernment, our responsibility for Norman became clear: we were to assist him in living the life he embraced in baptism – a life which included a destiny that was conformed to the crucified and risen one. That was not the destiny we chose for Norman; it was the destiny he owned. We recognized with Norman that our lives are not our own to be guided by autonomy and liberty, but rather to be lived for the glory of Jesus the Christ."

Donovan KG. Decisions at the end of life: Catholic tradition. Christian Bioethics 1997; 3(3):188-203.

"Medical decisions regarding end-of-life care have undergone significant changes in recent decades, driven by changes in both medicine and society. Catholic tradition in medical ethics offers clear guidance in many issues, and a moral framework accessible to those who do not share the same faith as well as to members of its faith community. In some areas, a Catholic perspective can be seen clearly and confidently, such as in teachings on the permissibility of suicide and euthanasia. In others, such as withdrawal of nutrition and hydration, the Church does not yet speak with one voice and has not closed out the discussion. Yet, it is not in the teaching in individual issues that a Catholic moral tradition offers the most help and comfort, but in its account of what it means to lead a life in Christ, and to prepare for a Christian death. As in the problem of pain and suffering, it is the spiritual support more than the ethical guidance that helps both patients and physicians bear the unbearable and fathom the unfathomable."

Fenwick AJ. Applying Best Interests to Persistent Vegetative State - A Principled Distortion? Journal of Medical Ethics 1998;24(2):86-92.

"'Best interests' is widely accepted as the appropriate foundation principle for medico-legal decisions concerning treatment withdrawal from patients in persistent vegetative state (PVS). Its application appears to progress logically from earlier use regarding legally incompetent patients. This author argues, however, that such confidence in the relevance of the principle of best interest to PVS is misplaced and that current construction in this context is questionable on four specific grounds. Furthermore, it is argued that the resulting legal inconsistency is distorting both the principle itself and, more particularly, individual patient interests."

Orr RD, Harris CE. The PVS Debate. Today's Christian Doctor 1999;XXX(1):8-13.

In this article, 2 members of the CMDA Ethics Commission take opposing viewpoints about the moral requirement for continued use of tube feedings in a case study involving a family whose son has been in a persistent vegetative state with no improvement for 7 years.

The Multi-Society Task Force on PVS. Medical aspects of the persistent vegetative state (Part 1). N Eng J Med 1994;330:1499-508. (Part 2) N Eng J Med 1994;330:1572-8. (Letters) N Eng J Med 1994;331:1380-3

This consensus statement was developed by experts from the American Academy of Neurology, the Child Neurology Society, the American Neurological Association, the American Association of Neurological Surgeons, and the American Academy of Pediatrics. Part 1 addresses definition and clinical aspects, related terms and conditions, epidemiology, pathologic features, and ancillary diagnostic studies. Part 2 covers prognosis for recovery, survival, pain & suffering, treatment, and future directions.

The 2-part article includes several useful tables and graphs as well as 152 references. The data presented point out the significant differences in prognosis between PVS from traumatic (better) and non-traumatic (worse) causes, as well as the differences between children (better) and adults (worse).

Howesepian AA. The 1994 Multi-Society Task Force consensus statement on the persistent vegetative state: A critical analysis. Issues in Law & Medicine 1996;12(1):3-29

The author recognizes that the ethical and legal ramifications of the MSTF consensus statement are enormous. After carefully analyzing the statement, he concludes "...first, that the conception of (un)consciousness invoked ... is conceptually incoherent; second, that even if one were to invoke a coherent, widely accepted conception of (phenomenal) consciousness, the MSTF has failed to provide good reason for believing that all PVS patients lack consciousness so conceived; and, third, that [it] does more than simply summarize medical facts about this unfortunate psychophysical disability; rather it attempts, under the guise of medical science, to advance its own inchoate, idiosyncratic ethical and more broadly philosophical ideologies."

Andrews K. Misdiagnosis of the vegetative state. BMJ 1996;313(7048):13-16

Of 40 patients admitted to a rehabilitation facility, 17 (43%) were misdiagnosed. All of the 17 were severely disabled, but nearly all were able to communicate their preferences in quality of life issues. The author concludes "The vegetative state needs considerable skill to diagnose, requiring assessment over a period of time; diagnosis cannot be made, even by the most experienced clinician, from a bedside assessment. Accurate diagnosis is possible but requires the skills of a multidisciplinary team experienced in the management of people with complex disabilities. Recognition of awareness is essential if an optimal quality of life is to be achieved and to avoid inappropriate approaches to the courts for a declaration for withdrawal of tube feeding."

Andrews K. Recovery of patients after four months or more in the persistent vegetative state. BMJ 1993;306:1597-1600

Eleven of 43 patients in this study regained some awareness after 4 months or more in a clearly diagnosed vegetative state. Although only 2 regained full independence, all but one regained the ability to communicate. The recovery period was prolonged. The author concludes that "even patients with profound brain damage should be offered the opportunity of a specialist rehabilitation programme."

Bibliography

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Mitchell KR, Kerridge IAH, Lovat TS: Medical futility, treatment withdrawal and the persistent vegetative state. Journal of Medical Ethics 1993; 19:71-76.

Farrell MM, Levin DL: Brain death in the pediatric patient: Historical, sociological, medical, religious, cultural, legal, and ethical considerations. Critical Care Medicine 1993; 21:1951-1965.

Childs NL, Mercer WN, Childs HW: Accuracy of diagnosis of persistent vegetative state. Neurology 1993; 43:1465-1467.

Report of the Quality Standards Subcommittee of the American Academy of Neurology: Practice parameters: assessment and management of patients in the persistent vegetative state. Neurology 1995; 45:1015-1018. Also commentary by Ashwal, Cranford R, and Rosenberg.

Wijdicks EFM: Determining brain death in adults. Neurology 1995; 45:1003-1011.

Borthwick CJ: The permanent vegetative state: Ethical crux, medical fiction? Issues in Law and Medicine, 1996; 12:167-185.

Levy DE, Caronna JJ, Singer BH, Lapinski RH, Frydman H, Plum F. Predicting outcome from hypoxic-ischemic coma. JAMA 1985;253:1420-6

This was the first and one of the more authoritative empiric studies (of 210 patients) which attempted to predict long-term outcomes based on early examination after hypoxic brain damage.

Hamel MB, Goldman L, Teno J, et al. Identification of comatose patients at high risk for death or severe disability. JAMA 1995;273:1842-8

This more recent study based on data from the SUPPORT Study concludes that 5 readily available clinical variables present on the third day after the onset of nontraumatic coma can identify a large subgroup of patients at high risk for poor outcomes. The 12 authors propose that the risk identification approach offers physicians, patients, and patients' families information that may prove useful in patient care decisions and resource allocation.

Ashwal S, Bale JF, Coulter DL, et al. The persistent vegetative state in children: Report of the Child Neurology Society Ethics Committee. Ann Neurol 1992;32:570-6

This survey of members of the CNS deals with the unique challenges in the diagnosis and management of this condition in infants and children.

Christensen DW, Jansen P, Perkin RM. Outcome and acute care hospital costs after warm water near drowning in children. Pediatrics 1997;99:715-21

This retrospective chart study of 274 children admitted after near-drowning concludes that no combination of variables could accurately separate all intact survivors from the vegetative and dead patients. The authors encourage initial aggressive treatment before any consideration of limitation of treatment.