Letters to the Editor

Dear Editor:

Daniel Deaton's article in the summer 1992 issue entitled "Questions Surrounding the Withdrawal of Artificial Hydration and Nutrition from Patients in a Persistent Vegetative State" is a very good review of the topic. His biblical analysis should be helpful to Christians wrestling with this controversial issue.

He claims on at least three occasions, however, that his analysis is not based on "quality of life" judgments. This disclaimer is perhaps understandable because many have contrasted "sanctity of life" and "quality of life" as if they were mutually exclusive.

The practice of medicine is almost entirely about quality of life. Having a backache or a respiratory infection diminishes one's quality of life. The patient most often goes to the physician in an effort to improve his or her quality of life. Quality of life is a very personal and subjective assessment of the positivity or negativity of several attributes which characterize one's life.

Human life has inherent value which cannot be diminshed by its greater or lesser quality. James Walter and Thomas Shannon address this from a Roman Catholic perspective in their book Quality of Life (Paulist Press, 1990) and conclude that "the so-called two ethics of life are not two but really one." The older ordinary/extraordinary distinction which has evolved into a "proportionality of benefits and burdens" discussion is really talking about quality of life judgments made by the patient or surrogate. This is inherent to the practice of and discussion about medicine and need not be avoided as if it were sacrilege.

Sincerely,

Robert D. Orr, M.D.

Director of Clinical Ethics

Loma Linda University Medical Center

Editor:

A Christian physician friend recently sent me a copy of the Summer 1992 issue of Journal of Biblical Ethics in Medicine. I must tell you that the concept of "advocating the Lordship of Christ in medicine" is most welcome, if not long overdue. I would, however, take issue with one of the articles in the particular issue I read, "Questions Surrounding the Withdrawal of Artificial Hydration and Nutrition from Patients in a Persistent Vegetative State, by Daniel E. Deaton.7

My first problem with the piece is two terms in the article. One is "persistent vegetative state," abbreviated throughout as PVS. Chaplain Deaton himself asks, "How reliable is the diagnosis of PVS?" His own reply is, "I conclude that the diagnosis of the permanence of PVS is reliable, though not infallible."

What, then, is to be said of the article called "Vegetative State After Closed-Head Injury: A Traumatic Coma Data Bank Report, in Archives of Neurology, Vol. 48 (June 1991), pages 580 - 585? That report cites a scientific study tath followed recovery rates of 84 patients with a firm diagnosis of PVS. Of those patients, "41% became conscious by six months, 52% regained consciousness by 1 year, and 58% recovered consciousness within the 3 year follow-up interval."

The other term used by Chaplain Deaton that is problematic, at best, is "artificial hydration and nutrition," abbreviated throughout as AHN. Nutrients and fluids supplied to a person through tubes are real nutrients and fluids; there is nothing "artificial" about them.

"PVS" and "AHN" are nonce expressions coined by proponents of euthanasia (hardly "advocates of the Lordship of Christ in medicine") to promote the goal of killing off "burdensome" people. If they can get people thinking in their own language, they are half-way to their

goal.

Re "AHN": A "Resource Paper" published by the U.S. National Conference of Catholic Bishops in April, 1992, called "Nutrition and Hydration: Moral and Pastoral Reflections, " uses the expression "medically assisted feeding." If simple feeding (albeit "medically assisted) can be obfuscated by technical-sounding language, laymen will be deceived into thinking of it as "medical treatment." Indeed, Chaplain Deaton accepts the notion that tube feeding is "medical treatment" that may be removed from certain patients who are not dying from a particular pathology.

Removing a respirator from a patient whose lungs are not functioning allows that person to die from his condition. But stopping the feeding of someone who is unconscious -- from whatever cause -- does not "allow" the person to die; it kills him. The death does not result from the conditino, but from starvation. The intent is to cause death. That is killing. And it is also playing into the game plan of the euthanasia promoters ...

Re "PVS": No human being is ever a vegetable. No matter how unconscious, comatose, or mentally incompetent a person becomes, he or she is in a "persistent human state." But when society begins to think in terms of "vegetables" rather than "humans," it is an easy thing to write these people off. That is exactly what happened in eighteenth and nineteenth-century Americans with the slaves, and in Nazi Germany with Jews: These victims-to-be were first dehumanized in the language. Christians -- especially those who are trying to be restore Christian principles to modern medicine -- should not be misled into using the language of the anti-Christians. That's like speaking of abortion as "pregnancy termination"; it hides the truth.

I suggest that those who are going to engage in the debate about these issues begin by reading the materials of the enemies of "the Lordship of Christ in medicine," so they will not fall into the trap of accepting the deceptive language and ideas of the enemy.

For Life,

Thomas Longua, Vice President

Colorado Right to Life

Dear Dr. Terrell

I wrote the enclosed comment of Daniel Deaton's article in the Summer 1992 issue of JBEM. Initially I wrote it just to be able to voice my concern and not really intending to mail it, [but] just to file it away in the computer floppy disc. But then, after reading the purposes of BEM I find Deaton's article so at variance with your avowed purpose that I had to send it, for two reasons. First, as a chastisement against the Journal for printing such a piece. And, second, as a direct response to Deaton and perhaps the other readers of JBEM that such a manner of solving ethical medical problems in the light of scripture should not be considered, or even read for that matter.

A Critique of Deaton in the Light of II Timothy 3:16

I would like to copy II Timothy 3:16-17:

16. All scripture is given by inspiration of God, and is profitable for doctrine, for reproof, for correction, for instruction in righteousness;

17. That the man of God may be perfect, thoroughly furnished unto all good works.

Paul wrote this to Timothy ... shortly prior to Paul's execution. There is little doubt Paul is speaking of all scripture but there is some discussion among Christian scholars concerning the extent of the writings to which Paul is referring, with some authorities stating he obviously means the Jewish scripture since they are the teachings by which Timothy was taught (see vs 15) and the New Testament had not been collected at this time. On the other hand, other scholars feel Paul is writing about the entire Bible since the vast majority of it had been written by this time and the books were already in the churches where there were men gifted with discernment of the spirits and able to distinguish between inspired writings and other types. Whichever school is correct, today we tend to consider all the Bible, new as well as old testaments, inspired and capable of Paul's instruction to Timothy concerning

scripture's power for doctrine, reproof, correction, and instruction in righteousness. And, that the man of God may be perfect, that is something to which nothing need be added, thoroughly furnished, that is he should have all that is needed to insure success in his work whether a minister or a spiritual layman -- or someone setting forth so-called ethics, ethics which impact fully, strongly, absolutely upon the patient, physicians, nurses, and family -- in fact, anyone coming in contact with the particular medical situation in question. Ethics which beyond a shadow of a doubt can only be answered by prayerfully being led through the Bible by The Holy Spirit.

And, indeed, I felt that is exactly what Deaton had in mind when he stated the aim of his paper was to bring the issue of ANH (artificial hydration and nutrition) under the scrutiny of Christian ethics -- paragraph 5. And, of course, I knew he was on track when in paragraph 7 he mentioned human life as being made in the image of God and is a gift as a trust from Him. Paragraph 8 tells how God assigns value to human life, giving it and taking it away. And because sin, paragraph 9, is a word rarely used today except by the most fundamental Bible-waving, brimstone preaching, soul-saving redeemers of lost souls, I knew I was on to something big and eagerly read on.

But then the tone of things began to diverge. My first suspicion that things were beginning to run amuk was Deaton's reference to "Patients have the right ..." and there I questioned just where in scripture was the outline of a human's rights given. I know of the Bill of Rights, a nice and yet human writing. And with every new self-professed, abused, unrecognized minority group coming to the forefront, we have another list of rights: animal rights, right to medical care, right to profane God, right to do whatever, say whatever, and certainly write whatever. Deaton then launched into a rather pseudo-scholarly list of questions he felt he should answer and when he was successful, at least to his satisfaction, he then drew some conclusions. But there is where I feel the true heart of his paper came to light. He cited 36 references or Endnotes as they are referred to, and never once mentioned the Bible. Here is a man with three degrees in theology, serving as a chaplain in the Naval Hospital in San Diego, a member of a bioethics committee, writing a paper on ethics for a publication professing to be a Journal of Biblical Ethics in Medicine and he could not find, did not find, omitted, overlooked, forgot about, the Bible! Incredible, unbelievable, in this day when the world is polarizing in its views about God, Jesus, abortion, prayer, and on and on ... we have this sort of publication. I truly shudder when I think about the poor servicemen with shattered bodies and torn minds, spirits awash in a sea of confusion, being subject to the same type of counseling this paper represents. In formulating principles concerning care of human life, created by God, it is correct to rely upon the word of God, not some vain writings.

In closing, I can only think of I Corinthians 1:25-31: "Because the foolishness of God is wiser than men: and the weakness of God is stronger than men. For ye see your calling brethren, how that not many wise men after the flesh, not many mighty, not many noble, are called: but God hath chosen the foolish things of the world to confound the wise: and God hath chosen the weak things of the world to confound the things which are mighty; and base things of the world and things which are despised, hath God chosen yea, and things which are not, to bring to nought the things that are: that no flesh should glory in his presence."

Sincerely,

David G. Haney

Rock Island, Illinois

LCDR Deaton responds.

The responses to my article, though largely adverse, are encouraging in that they show the need for further Biblical and theological reflection on the perplexing issue of the sustaining of organic life in persons who are exceedingly unlikely ever to recover their cognitive function. They also will provide an opportunity for me to clarify some of the points of contention.

I have no real quarrel with Dr. Orr's observations concerning the use of the term "quality of life." My caution in the use of the term stems from my objection

to utilitarian and hedonistic judgments about "quality of life" being used as a basis for deciding whose life is worth living. So long as the inherent value of human life in the image of God is not diminished or rejected, "quality of life" may be a useful expression in decisions about which treatments or interventions are too burdensome or do not significantly contribute to the patient's well-being.

The comments of Mr. Longua of the Colorado Right to Life Committee require more lengthy analysis. First, the issue of the use of terms. Mr. Longua says that PVS and AHN are "nonce expressions coined by proponents of euthanasia" and as such are the "deceptive language and ideas of the enemy." In fact, the term "persistent vegetative state" first appeared in a 1972 article in The Lancet in which two doctors described a "syndrome in search of a name." The doctors offered the name PVS as a description of the absence of any clinical sign of cortical function combined with alternating periods of sleep and wakefulness. The word "vegetative" was taken from the Oxford English Dictionary meaning "an organic body capable of growth and development but devoid of sensation and thought." The origin of this term is not an intentional demeaning of human beings but rather an attempt to distinguish the condition from that of a coma, stupor, and other mental states. The doctors justified their term as follows: "It suggests even to the layman a limited and primitive responsiveness to external stimuli; to the doctor it is also a reminder that there is a relative preservation of autonomic regulation of the internal milieu."

With Mr. Longua, I deplore euphemisms such as "pregnancy termination," etc. But for 20 years PVS has been used as the clinical description of a certain condition. I have no objection to other descriptions such as a "non-sentient state" or "decorticate state." However, to write a paper about the condition without using terminology that virtually everyone else is using would be foolish and reactionary.

Similarly, AHN is commonly used to refer to nutrition and hydration delivered by artificial means. This artificial delivery of nutrition and hydration requires the supervision of highly trained personnel and is highly invasive. Among the side-effects of AHN I have observed in the ICU where I work are infection, fluid overload, diarrhea, bleeding, electrolyte imbalances, and pneumonia caused by the aspiration of nutrients into the lungs. Is it not at least arguable that these artificial feedings are more akin to medical treatment than to the provision of a glass of water or a bowl of soup to a hungry and thirsty patient?

It is difficult for me to follow the logic of those who accept the discontinuing of mechanical ventilation in patients who can no longer breathe naturally without accusing the doctors of suffocating the patient, and who accept the discontinuation of patients from renal dialysis in whom kidney function naturally has ceased without accusing the physicians of poisoning the patient, but who accuse those who would disconnect medically assisted feedings of killing the permanently unconscious patient who is no longer able to swallow. In all these situations, death would have occurred if treatment had not been begun in the first place. The intent of the withdrawal of treatment in each case is not to cause death but to cease treatments that offer no reasonable curative benefit. Each is an example of a life-sustaining intervention that can not reverse the patient's underlying condition.

Concerning the article by Levin, et al., noted by Mr. Longua, I welcome the reference and hope that more studies like it will help physicians determine with greater accuracy the likelihood of recovery from PVS. In my article I cited American Medical Association and American Academy of Neurology reports to the effect that the odds of recovery from PVS after one year are very small, especially in older patients. I therefore recommended that AHN not be withdrawn before at least a period of a year has passed from the time of the original diagnosis. Indeed, the Levin article notes that : "severely head-injured patients rarely are capable of comprehending simple commands within one year if they have not done so by six months." However, the article does report that 6% of the patients followed did improve between the first and second years. Beyond two years, the article concludes: "improvement at such a late state must be regarded as a rare event." Given the possibility that even this small number of patients may regain sentience between the first and second years, I

would be willing to advocate a two year waiting period before considering withdrawal of AHN until a more precise method for diagnosis of the permanence of PVS should become available. Of course, an accurate diagnosis may be obtained in some patients (i.e., those whose cerebral cortices have been severely damaged or atrophied) in a much shorter period of time. In these cases, AHN may be ethically withdrawn following the determination that recovery of consciousness is not naturally possible.

Finally, a word about Dr. Haney's comments. The ad hominem remarks about my ministry need not be answered. However, I am troubled by the assumption that since the Bible is not quoted throughout my paper, it is omitted, overlooked, or forgotten. Obviously, the issue of PVS/AHN is not directly addressed in Scripture. The primary Biblical issue is spelled out in my first affirmation -- namely, the sanctity of human life in the image of God (Genesis 1:26-27) and the prohibition of the taking of innocent human life (Genesis 9:6; Exodus 20:13). The central Biblical issue is whether the withdrawal of AHN from someone in a permanent PVS constitutes the wrongful killing of an image bearer of God.

As a Christian who seeks to live by the authority and guidance of the Word of God, I welcome correction from anyone who has discovered in Scripture specific teaching or principles that can be applied to the complex ethical challenges brought about by the rapid advancement of medical technology. While I wholeheartedly affirm the truth of II Timothy 3:16-17 and I Corinthians 1:25-31, simply stating these truths contributes nothing to the arduous task of actually applying the inspired and unchanging Scriptures to perplexing and ever-changing issues such as PVS/AHN.

1. Jennett, Brian & Plum, Fred, "Persistent Vegetative State After Brain Damage: A Syndrome in Search of a Name," The Lancet , April 1, 1972, pp. 734-737.

2. Ibid., p. 736.

3. Levin, Harvey S., et al., "Vegetative State After Closed Head Injury: A Traumatic Coma Data Bank Report," Archives of Neurology Vol. 48, June, 1991, pp. 580-585.

4. Ibid., p. 580.

5. Ibid., p. 585.