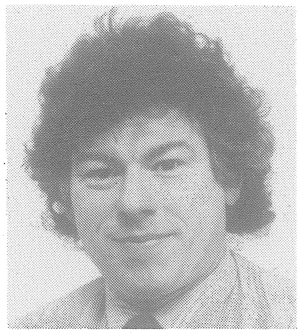
Commentary

PVS, feeding tubes, and medical futility



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SUMMARY

Persistent Vegetative State and the Withdrawal of Food and Fluids
Report prepared for the Medical Council of New Zealand
by the Bioethics Research Centre February 1993

The recent report commissioned by the Medical Council of New Zealand from the Otago Bioethics Centre focussed on the withdrawal of artificial nutrition and hydration from patients in Persistent Vegetative State (PVS). The report noted that PVS patients have irreversible brain damage which has rendered them permanently unconscious and destroyed their capacity to have any meaningful experiences (experiences which mean something to the individual who has them). This implies that to provide or impose such treatment is at best to do something futile and at worst to intrude in a person's life in an unjustifiable way. Because the patient is unable to have the experiences had by a normal person it is wrong to regard the withdrawal of food and fluid as "starving a person to death". We recommended that a decision to withdraw food and fluid was ethically permissible but ought to be discussed with those closest to the patient and who might be regarded as having his or her best interests at heart.

A number of correspondents have expressed concerns about the recent report of the Centre concerning persistent vegetative state (PVS). (See letter in *Readers' Views*.) These concerns focus on two issues:

1 Is it ever right to decide that a person's case is hopeless and therefore that his or her life should not be sustained?

2 Is it ever right to withdraw food and fluids from any person in our care?

These are crucial issues at a time when economics is increasingly likely to intrude in health care. Both issues need to be examined in the light of the idea of *substantial benefit*. Substantial benefit is "an outcome which now or in the future would be regarded by the patient as worthwhile"[1]. Therefore if I had severe and painful cancer which could not be cured I would not want a battery of distressing operations which would not help me and would only be a further burden. Consider the following hypothetical situation.

Alicia is a 59 year old woman. She is brought into hospital having had a fit. It emerges that this has followed three weeks of mental deterioration and increasingly troublesome headache which has been put down to a 'dose of the flu'. She is found to have a malignant brain tumour.

In this imaginary scenario, the doctor could say to her that he has two choices. First, he can operate merely to decompress the tumour and improve her thinking and general well-being but only for, say, six months to a year or, second, he can operate to try and remove the tumour completely in which case she will be bedridden, mute, paralysed down one side, and probably in coma possibly live for years and years.

Faced with Alicia's choice, most people would go for the first option and opt for quality of life rather than mere length of life. The obvious reason is that the kind of prospect offered by the second operation is a life which nobody could reasonably regard as worth living and 'saving life' is not an end in itself. This agrees with a well-respected strand in many traditional approaches to medical ethics, summarised in a recent article in the British edition of the Roman Catholic journal, *The Tablet*:

> Roman Catholic ... moral theologians writing in this field have refused to view physical life as an absolute value ... an important factor to be considered in assessing any particular life-sustaining medical procedure is - how alive will it keep me as a person?

While they would have no truck with any suggestion that killing, or its equivalent could be part of medicine, they always refused to accept that a patient is obliged to take every available means to sustain life for as long as possible.[2]

The key idea is that it is the distinctively human features of a human life that give it special moral significance. If these features are fading fast or even absent (as in PVS) then it seems legitimate for a person to forego medical treatments to prolong life. In fact, there seems to be widespread agreement that there is a level of existence at which any reasonable individual would not wish to be kept alive. If, when given the choice in advance as Alicia was, it is acceptable to choose not to be kept alive in a meaningless state of existence then surely we can make that choice for someone who did not have the opportunity. On the basis of arguments like these the report concluded that there might be truly hopeless situations in which a reasonable person would not want to be kept alive and that this allows us to withdraw artificial nutrition and hydration. Both these conclusions need carefully to be examined in the context of these general points.

1 First, are there situations where mere prolonging of life would not be the best or most loving response to the predicament of a friend or family member? Without doubt, there are medical situations where life-prolonging treatment would, in fact, be cruel and intrusive; the dying cancer patient who wishes only a peaceful and dignified death is an example. But is PVS such a case?

In PVS the patient experiences nothing because those parts of the brain (the higher centres such as the cerebral cortex) involved in our distinctively human experience and activity have been destroyed. That is a fundamental feature of the diagnosis of PVS and therefore the idea of PVS patients 'waking up from coma' is just not possible. (The diagnosis may, of course, be mistaken and therefore strict criteria ought to be laid down and adhered to.) True PVS is a situation in which no medical treatment can be of substantial benefit to the patient in that there is nothing that the patient would currently or in the future regard as worthwhile. Therefore any treatment that is given is, from the patient's point of view, futile. What is more it may be positively damaging in that many are quite clear on the fact that they would never want to be kept alive in a state like that. If that statement is valid then it is morally wrong to do things to them that violate their own fundamental values, just as it is to overturn their reasonable wishes about their affairs after their death. There are, therefore, a number of morally good reasons why we would not force intrusive medical treatment on a person after he had reached a point where it could not benefit him.

This is totally different from a decision to 'murder' patients or to do away with the helpless or those who are `fighting to live'. We are talking about human beings who have lost that principle of life that makes us persons rather than just animal bodies. These human beings also require medical and nursing interventions such as naso-gastric tubes to keep them alive in this reduced, some would say degrading, state. Our conclusion was that there was no reason why we should feel compelled to continue such treatment.

2 The second major question is whether naso-gastric or other means of tube-feeding can be regarded in the same way as can other medical treatments and withdrawn when it cannot possibly benefit the patient. The Pro-life Committee of the U.S.Catholic Conference clearly thinks it can: "laws dealing with medical treatment may have to take account of exceptional circumstances where even means of providing nourishment may be too ineffective or burdensome to be obligatory"[3]. Naso-gastric feeding and fluids are, for most patients, medical treatments and the thing that many older people most fear is that they will depart life festooned by tubes going in and out of their bodies. This is particularly odious in the case of a PVS patient for whom it is not of substantial benefit.

Is it starving a person to death or letting her die of thirst if tube-feeding is withdrawn? PVS patients do not eat and drink. They merely absorb food placed into their stomach by somebody else. They are therefore in one sense like many patients in terminal conditions who choose not to eat or drink and whom we would never dream of tube-feeding. Most would allow the dignity of quiet death to those who can no longer eat or drink and who have no interest in being nourished and hydrated. Such people die of exactly the effects to be observed in PVS patients and they do not suffer. It is, therefore, quite inconsistent to insist on tube-feeding in PVS. If I were ever in that state, I hope someone would be humane enough to resist such misdirected attempts to prolong my biological life. PVS patients experience neither hunger nor thirst and therefore we are not starving them to death or watching them die of thirst when we withdraw a tube. Proper care of the mouth and skin is the only respectful minstry we can meaningfully perform for them.

There is a profound difference between our recommendations and the intentional killing of patients. We have argued that we are justified in stopping treatments which cannot benefit a person and may represent a real harm through their intrusiveness, and futility. The decision is consistent with those many medical situations in which we do not intervene because our interventions can achieve nothing. We cannot equate this with a decision to end a patient's life here and now for any one of a number of reasons which have little to do with a loving regard for that person. This overlooks a distinction which is vital in understanding the limitations of medical practice and our responsibility to use the tools we have to benefit our patients and not harm them.

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[1] Campbell, Gillett, and Jones *Practical Medical Ethics* Auckland: Oxford University Press, 1992, p10.

[2] K.Kelly 'Rest for Tony Bland' *Tablet* 13 Mar 1993, p332.

[3] Quoted in J.Paris & R.McCormick, 'The Catholic tradition on the use of Nutrition and fluids' *America* 2 May 1987, p356.

Paul Wallis Appeal

The death of Paul Wallis early in February 1993 was a very sad occasion for many people in Dunedin who had worked with him, and come to like and admire him. Those who attended the Bioethics Summer School in February 1992 will remember his contribution to the discussion on "Terminal Care - how do we safeguard a person's autonomy?" Members of the Law Faculty of the University of Otago were distressed to lose one of their most talented students.

The Faculty of Law propose that a prize for *Jurisprudence* be instituted in his memory, to be awarded annually to the student who performs best in that subject. Jurisprudence was an area in which Paul's talents were especially evident, as witnessed by his paper "The Protection of Job Security: A Property Analysis" which won him the Joshua Williams Memorial Essay prize in 1992.

Accordingly, the Faculty of Law are soliciting donations to establish a capital sum of approximately $1500, the interest on which will constitute the prize in each year. They are making this appeal not only to staff and students of the Faculty of Law, but also to others who came into contact with him and might like to contribute to this way of remembering Paul. If you would like to make a donation to the prize fund, please send your cheque to Professor J Stuart Anderson, Dean of Law, made payable to "University of Otago, Faculty of Law".