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ETHICS & MEDICINE

An International Christian
Perspective on Bioethics

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Contributors will be notified as soon as possible of editorial decisions, though this process can take some time.

Contributors are asked to follow the pattern of published material for length, subheadings and so forth. Different referencing conventions acceptable provided consistency is maintained within the paper. An outline c.v. should accompany each paper.

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From the Editor

BIOETHICS IN BUDAPEST; OR, A TALE OF TWO CITIES

In the summer of 1991, an international conference on The Christian Stake in Bioethics was convened in Edinburgh by what is now the Centre for Bioethics and Public Policy, with which this journal is closely associated. It brought together scholars and clinicians from many countries (including the U.S., South Africa, Holland, Hungary and Malta). The decision was taken to begin a series of such gatherings, to be held every two years; and an invitation was extended from Hungary to co-host the 1993 meeting, on behalf of a group of Christian doctors and academics (now organised as the Centre for Christian Bioethics in Budapest).

Ethics and Medicine readers and others from 13 or 14 nations gathered in the former parliament chamber in Budapest in June of this year for a stimulating three days of addresses and round-table discussions on issues right across the bioethical agenda. The conference was opened by the President of Hungary, and the platform was sprinkled with distinguished guests from Hungarian public life. Some two hundred people attended the major sessions, and speakers included Professor Stanley Jaki, eminent Hungarian academic well-known in the west

One of the most striking features of contemporary bioethical debate is nowhere plainer than in Singer's prolific contribution—its self-conscious detachment from the western tradition, its disavowal of the Judeo-Christian heritage which is wrapped around the culture of our nations, its petulant denial of the over-arching significance of Christian-Hippocratic values for the best in our medical tradition.

for his work on religion and science; Dr. Dominique Folscheid of Rennes, editor of the French-language quarterly *Ethique*; and three members of the board of *Ethics and Medicine* (Sims, Williams, Cameron). It is hoped to publish a selection of papers from the conference in a

forthcoming issue; selections may also appear in other languages, particularly French and Hungarian. (In a separate initiative, the *Ethics and Medicine* contingent travelled on to Timisoara in Romania for a conference of the Romanian Christian Medical Fellowship.)

The Budapest conference was at the same time a most serious, academic meeting, and a Christian meeting. Indeed, two Turkish guests were plainly bemused by their first-ever experience of a bioethics conference which was unabashed in its avowal of the Lordship of Jesus Christ. The meeting was also ecumenical, in the most positive sense of that weary word—a gathering of Christians from many nations and many strands of the

We have every reason to believe that contemporary bioethics is set to be the determinative influence in the re-shaping of the west along post-Christian lines.

Christian tradition to make common cause on a matter of great common importance. It was a splendid embodiment of the central concern of this journal.

Yet it was unusual. Readers who from time to time attend conferences in bioethics will not need to have that pointed out. In Amsterdam, for example, in October of 1992 the 'International Association of Bioethics' was founded, at a conference which had sponsorship from the European Commission (a development which some would see as sinister). The conference was convened by Peter Singer, the radical philosopher-bioethicist from Australia, who was duly elected President of the association—which is currently being run from his base in Monash. One of the most striking features of contemporary bioethical debate is nowhere plainer than in Singer's prolific contribution—its self-conscious detachment from the western tradition, its disavowal of the Judeo-Christian heritage which is wrapped around the culture of our nations, its petulant denial of the over-arching significance of Christian-Hippocratic values for the best in our medical tradition. Even among academic disciplines, bioethics stands out in its secularity—particularly, not least, in current philosophical discussion, which has seen a renaissance of overtly Christian participation. Yet, as we have often argued in these pages, medicine is closely intertwined with the distinctive values of the western tradition and their theological undergirding. It is in process of trying to divorce its parents. At the

same time, the connections of contemporary bioethical discussion and the world of public policy are intimate. The participation of the EC (and, less surprisingly, the Dutch government) in the founding of Peter Singer's organisation bears eloquent and disturbing testimony to the extent of that intimacy. So we have every reason to believe that contemporary bioethics is set to be the determinative influence in the re-shaping of the west along post-Christian lines.

But there was encouragement in Budapest. Our responsibility in encouraging such an 'alternative bioethics', which will remain in touch with its tradition and with the transcendent grounding of human nature in the *imago Dei*, is great. We have lately used these columns to enquire whether there is no foundation, or individual, with the will and the resources to endow a substantial project along these lines. In the light of Budapest, and Amsterdam, we do so again.

* * *

In this issue. November 1992 saw two developments in the debate about Persistent Vegetative State—the *Bland* judgment in the English High Court, and the CBPP conference at St Thomas's Hospital. We print here several papers read at that conference, introduced by an updated Legal Comment from the conference chairman, Dr John Keown, of Queens' College, Cambridge.

* * *

Our tenth year (1994) will open with an increase in the size of *Ethics and Medicine* by 50%! See 10:1 for details.

Papers from both the Edinburgh (1991) and Budapest (1993) conferences will be published during the year.

* * *

We are delighted to announce the appointment of not one but two review editors. Agneta Sutton, Deputy Director of the Linacre Centre in London, now has responsibility for British and (other) European material. C. Ben Mitchell, Director of Biomedical and Life Issues for the Christian Life Commission of the Southern Baptist Convention, is responsible for North America. There will of course be overlap, and there is more to the bioethics world than these two (though not much more, at the moment), but our feeling is that two is definitely better than one. The review section, which has limped a little in recent issues, will be picking up and offering a thorough coverage of key titles in our field.

At the same time, a decision has been taken in principle to assemble a second board, to be based in the United States, serving alongside what will be known (and developed) as the European board. Watch the masthead in the next few issues!

From Dr John Keown, Queens' College, Cambridge

COURTING EUTHANASIA?: TONY BLAND AND THE LAW LORDS

LEGAL SUMMARY

Tony Bland's doctor committed no crime in stopping his tube-feeding, even if he intended to kill him, because:

1. stopping tube-feeding was an *omission* and
2. the doctor was under *no legal duty to continue* tube-feeding as it was
3. *medical treatment* which was
4. *not in the patient's best interests* since it was
5. *futile* because
6. *a responsible body of doctors did not regard life in Bland's condition as a benefit.*

THE FACTS

Before his death on 3 March 1993, Tony Bland had lain in hospital for over three years in a 'persistent vegetative state' ('PVS') in which, it was believed, he could neither see, hear nor feel. The medical consensus was that he would never regain consciousness.

He was, however, neither dead nor dying; his 'brain stem' still functioned and he breathed and digested naturally. He was fed by nasogastric tube and his excretory functions were regulated by catheter and enemas. Infections were treated with antibiotics. His doctor and

parents wanted to stop the feeding and antibiotics on the ground that neither served any useful purpose. The hospital trust applied for a declaration that it would be lawful to do so.

The application was supported by an *amicus curiae* (or 'friend of the court'—a barrister appearing with the court's permission to expound the law impartially) instructed by the Attorney-General, the Government's chief law officer. The application was opposed by the Official Solicitor (an officer of the Supreme Court who acts on behalf of persons who are not competent) representing Tony Bland.

THE COURTS' RULING

The declaration was granted by Sir Stephen Brown, President of the Family Division of the High Court, whose decision was unanimously affirmed by the Court of Appeal and by the House of Lords in *Airedale N.H.S. Trust v. Bland* [1993] 2 *Weekly Law Reports* 359.

THE LAW LORDS' REASONING

Intent to kill and foresight of death

Counsel for Bland argued that stopping Bland's feeding would be murder or at least manslaughter: the doctor would be intentionally causing death just as if he severed the air pipe of a deep-sea diver. Lords Lowry, Browne-Wilkinson and Mustill accepted that the doctor's intention was to kill, a proposition which Lords Goff and Keith neither approved nor rejected.

That the majority accepted this proposition, without giving reasons, is surprising, for it does not follow that because a doctor stops feeding a patient he therefore intends to kill him. Foresight of a consequence, even if the consequence is certain to follow from one's action or omission, does not establish that the consequence was intended.

This proposition is sometimes criticised on the ground that it is artificial. 'Surely', the criticism runs, 'if you foresee a result of your action, especially if the result is bound to follow, you must intend it'. But the criticism is demonstrably misconceived. That foresight and intention are not equivalent can be shown by simple examples from everyday life.

Take the case of the parents who allow their baby to be immunised. Although they may foresee as certain that the injection will cause their child pain, it is not their purpose to cause their child discomfort but rather to have it immunised against disease. Or take the housewife who goes shopping in the rain. She intends to get the groceries, not to get soaked. Or take the case of the student who, having graduated, celebrates by drinking ten pints of lager. He (or she) may foresee, and foresee as certain, that the following morning will bring a raging hangover. But the hangover is in no way intended, and if there were any way of avoiding it, he (or she) would jump at it. Such simple examples could be multiplied, but enough have

been given to show that the distinction exists and it will be readily apparent that it can be of crucial importance in deciding upon the morality of a given action. (See generally, F. J. Fitzpatrick, *Ethics in Nursing Practice: Basic Principles and their Application* (London: The Linacre Centre, 1988) Ch. 7).

This is *not* to say that one acts morally provided one does not *intend* bad consequences. For it is obvious that one can act unethically by bringing about bad consequences even if they are foreseen but not intended. This proposition can be illustrated by the hypothetical case of the 'couch-potato' parents who, instead of feeding their baby, sit constantly entranced by the television. Even though the parents may only foresee and not *intend* the slow starvation of the baby, they nevertheless incur moral culpability for the consequences of their neglect for they are under a moral duty to feed their baby. By contrast, parents may not feed their baby simply because they have no food, as is the case, for example, in a number of third world countries. The parents may well foresee (perhaps as certain) that their child will starve, but they do not intend this consequence and their omission to feed attracts no moral culpability for they are simply incapable of discharging their duty.

In short, a person who *intends* to bring about a bad consequence *always* acts immorally; one who *foresees* that his act or omission may bring about a bad consequence *may* act immorally, depending upon the circumstances.

These ethical distinctions are, to a significant degree, reflected in the law. A commits murder when he intends (not merely foresees) to kill (or seriously injure) B and causes B's death by an act. The law is more lenient than morals in that it is not murder for A to shorten B's life by an *omission* unless A is under a legal duty to act. It is, therefore, lawful for a passer-by (A) to allow an accident

This was, in sum, a hard case which made bad law, largely by approving a consequentialist ethic radically inconsistent with the principle of the sanctity of life.

victim (B) to bleed to death in the street, even with intent to kill. But if A were under a legal duty to act (as where B was a baby and A his mother) then A could be convicted of murder.

In the light of this discussion, it is surprising that the majority of the Law Lords should have accepted the proposition that Tony Bland's doctor intended to kill him; the doctor may simply have *foreseen* death. But, having accepted that the doctor's intention was to kill, why did their Lordships proceed to uphold the declaration that the acceleration of Bland's death by the withdrawal of the feeding-tube would not amount to murder?

No act and no legal duty to act

The answer is that they held that the withdrawal of feeding amounted to an *omission* not an act and, crucially, that the doctor was under no legal duty to continue feeding. All five of their Lordships' speeches merit close consideration on this central issue of the extent of the doctor's duty in this case but, for reasons of brevity, the focus here will be on that of Lord Goff, with whom the other four were in general agreement.

Stopping feeding was, implied Lord Goff, an omission and not a positive act. Withdrawing life support was no different from withholding it in the first place. Further, tube-feeding constituted 'medical treatment': there was 'overwhelming evidence' that in the medical profession tube-feeding was so regarded. The provision of food by tube was, he added, analogous to the provision of air by a ventilator.

The tube-feeding was, moreover, treatment which the doctor was under no duty to continue as it was not in Bland's best interests. The House had held in *Re F.* [1990] 2 A.C. 1 (a case concerning the sterilisation of an incompetent adult) that a doctor could treat an incompetent patient only if it was in the patient's best interests; the decision to withhold, or to withdraw, treatment was, said His Lordship, governed by the same criterion.

The treatment was not in Bland's best interests because it was futile, and it was futile 'because the patient is unconscious and there is no prospect of any improvement in his condition'. In deciding whether treatment was futile, the doctor had to satisfy the test laid down in *Bolam v. Friern Hospital Management Committee* [1957] 1 W.L.R. 582, and applied in *Re F.*, by acting in accordance with a responsible body of medical opinion.

THREE CRITICISMS

Lord Goff's reasoning is, with respect, vulnerable to at least three major criticisms. First, why is pouring food down a tube 'medical treatment'? What is being treated? Further, the analogy between tube-feeding and mechanical ventilation is unpersuasive. A ventilator assists a patient to breathe but a tube does not assist a patient to digest, and it replaces, rather than assists, swallowing. Moreover, the withdrawal of a ventilator does not prevent the patient from breathing spontaneously but the withdrawal of tube-feeding results in certain death. And if the delivery of food by tube is medical treatment, is the removal of waste products by catheter and enema also medical treatment?

Secondly, even if tube-feeding is medical treatment, why is it futile? Is it not achieving its purpose of nourishing the patient? To hold that the treatment is futile because the patient will not recover consciousness is surely to confuse the worthwhileness of the *treatment* with the worthwhileness of the patient's *life*. Yet all their Lordships held in essence that the tube-feeding was not worthwhile because Bland's life was not worth living. Lord Keith, for example, stated that a doctor was under no obligation to treat a PVS patient

where a large body of informed and responsible medical opinion is to the effect that no benefit at all would be conferred by continuance. *Existence in a vegetative state with no prospect of recovery is by that opinion regarded as not being a benefit*, and that, if not unarguably correct, at least forms a proper basis for the decision to discontinue treatment and care . . . (at 362. Emphasis added.)

Traditional medical ethics considers the propriety of withdrawing treatment in terms of whether, in the light of the patient's condition (or, less happily, 'quality of life'), the treatment is worthwhile. That is, it asks whether the benefits of the treatment to the patient outweigh its burdens. It never asks whether the patient's *life* is worthwhile, for the notion of a worthless life is as alien to the Hippocratic tradition as it is to English criminal law, both of which subscribe to the principle of the sanctity of human life which holds that, because all lives are intrinsically valuable, it is always wrong intentionally to kill an innocent human being. This principle is, by contrast, rejected by the so-called 'new' (consequentialist) morality which openly espouses the notion of the 'life not worth living'.

That the House of Lords has now also espoused this notion is apparent not only from its acceptance that Bland's life was of 'no benefit' but, even more explicitly, from the acceptance by Lords Lowry, Browne-Wilkinson and Mustill that it can be lawful and in accordance with 'responsible' medical opinion to withhold tube-feeding *even with intent to kill*.

Lord Lowry rejected the contention of counsel for Bland that such medical opinion was merely a disguise for a philosophy which, if accepted, would legalise 'euthanasia', that is, the intentional killing of a patient as part of his medical care. But was not his Lordship declaring passive, non-voluntary euthanasia to be lawful in this very case?

Further, it is difficult to restrict their Lordships' reasoning to patients in PVS. Lord Browne-Wilkinson expressly left open the case of the patient with a slight chance of improvement, or with very slight awareness. He could have gone further: what of a patient with senile dementia or severe mental handicap? And, as Lord Goff recognised, their reasoning exposes the law to a charge of hypocrisy: if a doctor may intentionally cause death by withdrawal of treatment, why not by lethal injection?

Thirdly, if the criterion for withholding treatment is the worthlessness of the patient's life, why is this to be determined by medical opinion? Lord Mustill observed that it could be said that the decision was ethical and that there was no logical reason why the opinions of doctors should be decisive. His brethren entertained no such reservations. Indeed, Lord Browne-Wilkinson expressly stated that one doctor could decide, because of his ethical views about the sanctity of life, that his patient was 'entitled to stay alive' whereas another doctor who 'sees no merit in perpetuating a life of which the patient is unaware' could lawfully stop his patient's treatment.

His Lordship omitted to explain how it is possible to make a comprehensive assessment about the 'worth' of another's life and how, even if it were, doctors have any

greater insight into the meaning and worth of human lives than do judges or, for that matter, bus conductors. The importation of the *Bolam* test in this context, that is, to allow 'responsible' medical opinion (or any body thereof) to determine whether the life of a PVS patient is worth preserving is even less defensible than its importation by their Lordships in *Re F.* to allow doctors to determine whether it is in the best interests of an incompetent adult to be sterilised.

CONCLUSION

This was, in sum, a hard case which made bad law, largely by approving a consequentialist ethic radically

inconsistent with the principle of the sanctity of life. Rather than subverting this principle, their Lordships should have affirmed it by ruling that, just as it is murder intentionally to kill by an act, it is murder intentionally to kill by an omission where there is a duty to act; that a doctor is under a duty to feed his patient (unless the feeding would impose unreasonable burdens on the patient or he is in extremis), and that a doctor who fails to discharge that duty, with intent to kill, commits murder.

Maureen Tudor, Principal Medical Officer, Royal Hospital and Home, Putney, London

PERSISTENT VEGETATIVE STATE: SOME CLINICAL OBSERVATIONS

On 1 April 1972 an article appeared in the *Lancet* under the heading 'Points of View'. The authors were Professors Bryan Jennett and Fred Plum. The article was entitled 'Syndrome in search of a name'.

They described the syndrome which developed in about 8% of patients who survived cerebral insult due to:

1. Trauma:
 - a) direct blows to head;
 - b) Transmitted via spinal cord due to falls.
2. Anoxia:
 - a) cardiac arrest;
 - b) anaesthetic accident;
 - c) suffocation;
 - d) drowning.
3. Ischaemia: cerebral thrombosis.
4. Haemorrhage:
 - a) cerebrovascular haemorrhage;
 - b) sub-arachnoid haemorrhage.

But according to Bricolo, Turazzi & Feriotti such a condition should not be pronounced earlier than one year after injury.

How does this syndrome present to the clinician at the bedside? In the first week or so patients are in deep coma, never opening their eyes. When they do react to stimuli they show varying degrees of extensor response in the limbs. After about 2-3 weeks the survivors begin to open their eyes, at first in response to pain only, later to less arousing stimuli. Soon afterwards, they lie for periods with their eyes open and moving and at others they appear to sleep. The eyes are open and may blink to

menace but they are not attentive. Whilst roving eye movements may be present and appear to track there is no consistency in this tracking. It would appear that there is wakefulness without awareness. The extensor response of the whole body is usually referred to as decerebrate rigidity.

Usually this wears off after about 2-3 weeks and a noxious stimulus, be it noise, light or pain, will provoke a flexor withdrawal. But the withdrawal is slow and dystonic, not the usual brisk response. A significant grasp reflex often appears provoked by a chance touch of the bedclothes.

Sometimes there may be fragments of a co-ordinated movement such as scratching, or even movement of the limbs to remove a noxious stimulus.

Chewing and bruxism are common and may go on for long periods. Food and/or liquids placed in the mouth may be swallowed. Grunting or groaning may be the response to a noxious stimulus, but in the main these patients are silent. They do not speak, and do not make a meaningful response to the spoken word. However, loving relatives see signs of recovery. Their hopes are raised especially when hands are grasped and food taken by mouth, but these are often primitive reflex responses.

The electro-encephalogram (E.E.G.) may be isoelectric—but this is rare. There may be high voltage slow waves or alpha rhythm, but the activity is unresponsive to visual, auditory or noxious stimuli.

Jennett and Plum then reviewed the various terms used in 1972 to describe this post-cerebral insult state.

1. *Brain Death* (Chanda & Chow 1971)—*Coma Dépassé* (Mollaret & Goulon 1972)

Applied to patients so damaged that there is no evidence of function in the nervous system above the spinal cord. Pupils are fixed, spontaneous respiration has ceased. The E.E.G. is always isoelectric. But cardiac function may continue and there may be stimulus evoked limb movements due to persisting spinal reflexes.

2. *Akinetic Mutism, 'Coma Vigile'*

This latter term was probably first used by the French to describe the state of patients with severe typhoid or typhus fever. Akinetic Mutism was a term coined by Cairns in 1941 to describe an intermittent disturbance of consciousness. Skultety in 1968 stated that Akinesia and Mutism do not always go together. He considered that akinetic mutism was primarily a disorder of responsiveness.

3. *Permanent, Irreversible, or Prolonged Coma, Stupor or Dementia*

Jennett and Plum rejected such terms. They felt persistent was safer than permanent or irreversible and prolonged was not strong enough and unless quantified was meaningless. This state cannot be termed coma as ordinarily defined as it is not continu-

communicative and unresponsive from a variety of lesions.

According to Ingvar 1972 the complete Apallic Syndrome means complete loss of higher function with an isoelectric E.E.G. and much reduced cerebral blood flow and metabolism in supratentorial structures. The syndrome described by Jennett and Plum however is produced by lesions largely sparing the cortex structurally and the E.E.G. may even show persisting Alpha-Rhythms.

LOCKED-IN SYNDROME

This term was coined by Plum and Posner in 1965 to describe the tetraplegic mute, but fully alert state which results when the descending motor pathways are interrupted by an infarction of the ventral pons. Such patients are fully awake, responsive and sentient. But response is limited to blinking, jaw and eye movements.

Jennett and Plum proposed the term 'persistent vegetative state' for those patients who, following insults to the brain, may never again have recognisable mental function, but may recover from sleep type coma.

In this state:

1. Eyes open and or/move.
2. They respond to stimuli such as pain, noise, smell, taste.
3. There is limited response of limbs, i.e., reflex and primitive.
4. They never speak or attempt to vocalise.

COMMON FACTORS

1. Absence of function in cerebral cortex as judged behaviourally.
2. Lesions may be in cortex itself, in subcortical structures of hemispheres, or in brain stem or in all these structures.
3. E.E.G.'s show persistent alpha rhythms.
4. Wakefulness without awareness.

In Jennett and Plum's view, an essential component of this syndrome is the absence of any adaptive response to the external environment; the absence of any evidence of a functioning mind which is either receiving or projecting information in a patient who has long periods of wakefulness. All these patients are speechless and unable to signal appropriately by eye movements, although they sometimes follow moving objects in a slow intermittent pattern.

Common to all is a non-functioning cerebral cortex despite site of lesion. P.V.S. is not a state through which those who recover from cerebral insults are likely to pass. And as mentioned before such a condition should not be pronounced earlier than 1 year after injury (Bricolo, Turazzi & Ferriotti).

In 1978 Drs. Levy, Knill-Jones and Plum in *Annals of New York Academy of Sciences* formulated a neurological profile to assess comatose patients.

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ation of coma which characterises the clinical course of these patients. Stupor and Dementia are equally unsuitable terms.

4. *Decerebrate or Decorticate State*

These terms most often applied to different types of motor function and might be taken to imply a specific structural lesion. These terms are unsuitable for bedside diagnosis.

5. *Apallic Syndrome*

This term was proposed by Kretschner in 1940. He used it to describe patients who are open-eyed, un-

In this they assessed:

1. Verbal responses.
2. Eye opening.
3. Pupillary reactions.
4. Spontaneous eye movements.
5. Oculocephalic movements.
6. Oculovestibular reactions.
7. Corneal reactions.
8. Respiratory pattern.
9. Motor responses.
10. Deep tendon reflexes.
11. Skeletal muscle tone.

In their study of 310 patients in non-traumatic coma, 36 recovered only to the vegetative state, *i.e.* 11.6%. Their conclusions concur with Jennet and Plum in that in the P.V.S. patients have:

1. Orientating eye movements—eye opening; pupillary reactions.
2. Movement of limbs in response to noxious stimuli.
3. Groaned.

In their view patients in coma may develop the Vegetative State in a matter of a few days, but if they are still vegetative after a month the chance of regaining independence is relatively small.

At the moment at the R.H.H.P. we have 35–40 patients in the Persistent Vegetative State. Are they in this situation due to overactive medical intervention? Was such intervention justifiable? Should one/would one intervene?

A MORAL AND ETHICAL PROBLEM

A patient is referred to us in what the referrers call the Persistent Vegetative State. What do we do?

1. Full physical medical examination on admission.
2. Inspect drug regime and adjust accordingly after one week.
3. Full therapy assessments. Therapists involved are:
 - (a) *Physiotherapists* to organise a physical programme, assess presence of contractures and whether they can be corrected by a physical programme or will need surgery.
 - (b) *Occupational Therapists*—(awareness reactions) coma arousal programme instituted.
 - (c) *Speech Therapists* to assess initially feeding/swallowing problems. To prognosticate as regards ability to speak/communicate.
 - (d) *Psychological* assessment if possible.
 - (e) *Social Worker* assessment of both patient and relatives.
 - (f) *Nursing Assessment*
4. Three weeks post-admission a case conference is called of all the team concerned with the patient. At this, reports are received and a decision made as to what if any input is required to improve the standard of life of that patient. If it is the general view that improvement is impossible, then the patient is referred back to the referring authority but with advice as to how to maintain the physical condition which we feel is paramount so as to ease the task of the carers.

If it is the team's opinion that the standard of life can be improved, goals are set plus an end point for such goals. The end point is set on a monthly basis. The programme may include:

1. Continuation of coma arousal programme.
2. Definition of physiotherapy needs and formulation of programme to maintain/improve physical state *i.e.* by tenotomies.
3. Assessment of seating to improve coma arousal and other activities.
4. Video fluoroscopy to assess feeding and swallowing.

We have found that adequate seating has improved awareness and arousal. Many of these people have been in bed since the day of their accident—hence looking at the ceiling and maybe in a single room. Our first object is to get them sitting up. It is amazing the response this produces. Body tone improves, head control appears. They look around and may focus on objects or companions.

Many come to us on naso-gastric tube feeding. Imagine being awake, possibly aware but mute; the most immediate thing you see is a naso-gastric tube in front of your eyes. This tube may feed you, but with it you have difficulty trying to speak or even swallow your saliva. Your appearance is not pleasing either to yourself or your relatives. Hence we advocate the insertion of a fine bore Percutaneous Endoscopic Gastrostomy as soon as possible. Already two major changes have been made, which in themselves may help stimulate a physical and mental response. Our aims are primarily:

1. To improve the standard of life of that individual.
2. To ease the burden of those who provide the care.

PROGNOSIS

As already noted, Drs Levy, Knill-Jones and Plum in a study of 310 patients in a non-traumatic coma, 36 recovered only to the PVS state, *i.e.* 11.6%. It would appear that no figures are as yet available for those traumatically injured, *i.e.* self-infliction or road traffic accidents.

We are generally accumulating and analysing our figures as regards the survival period for those in the PVS state. The period of survival appears to depend on:

1. Age at time of incident.
2. Frequency and severity of seizures.
3. Incidence and frequency of chest infections.
4. Incidence and frequency of urinary infections.
5. Occurrence of pressure sores.
6. Stable hypothalamus controlling temperature, respirations, sweating, B.P., urinary output.

If for 6 months post-trauma there have been:

1. No infections regardless of site.
2. No pressure sores.
3. No seizures either with or without medication.
4. The patient is adequately hydrated and nourished

we consider the life expectancy in such a person is little short of the statistical average for someone of that age and sex.

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THE CASE FOR LETTING VEGETATIVE PATIENTS DIE

As the *agent provocateur* of this debate—medical, moral and legal, by having coined the term 'persistent vegetative state', I feel that I am required to defend not only the term but the consequences that have flowed from the paper that Professor Plum and I published in the *Lancet*—ironically on April Fool's Day, 1972.

Re-reading it after 20 years I find more reassurance than embarrassment, because we seem to have defended ourselves in advance against most of the criticisms subsequently made. We began with a quotation from Sir William Gowers, the famous London neurologist, 'If we have a conception for which no name exists, which we need frequently to speak of, it is not wise, I think, to shrink from an attempt to give it a name'. We went on to suggest that if a new situation arose in medicine there is a need for a name if it is to be understood and discussed, and in order to facilitate communication between doctors, relatives and intelligent laymen about its implications. We rejected alternatives such as apallic, coma, dementia, decerebrate and decorticate. We preferred a term that was based on describing behaviour rather than pathology and anatomy which usually could not be known accurately. In any event behaviour is the best evidence on which to base a judgment of mental activity.

We were also keen to have a term which invited clinical and pathological investigation rather than giving a false impression of a problem already completely understood. As for the word vegetative, the *OED* states 'To live a merely physical life devoid of intellectual activity or social

This is part of the evidence adduced to indicate that these patients are not capable of experiencing distress or pain, let alone having higher cognitive activity.

intercourse—capable of growth and development but devoid of sensation and thought'. We stated that 'exactly how long such a state must persist before it can confidently be declared permanent will have to be determined by careful prospective studies'.

I would next like to fill in some additional medical facts that are helpful as background to the moral debate. About 40% of vegetative patients resulting from acute brain damage are due to head injury and most of the rest

arise from depriving the brain of oxygen as a result of anaesthetic accidents, near-drownings and strangulations; and a few follow hypoglycaemia in diabetics. The pathology at post-mortem is quite different in the anoxic as distinct from the traumatic cases. In the hypoxic cases the nerve cells in the cerebral cortex are actually destroyed and over a period of months and years there is progressive degeneration resulting in shrinking of the brain, and the degenerated fibres can be shown up by special staining. The degeneration affects literally all the fibres coming from the cortex to the spinal cord and if the cortex had been stripped off in an experimental animal you would not expect a more complete pattern of degenerative fibres than is found in vegetative patients. In the traumatic cases exactly this same degeneration is found, the result of tearing of all the fibres to and from the cortex at the moment of impact of the head against the ground. Soon after the damage (whether anoxic or traumatic) the brain can look almost normal to the naked eye and on CT scan, but 5 months later 10–20% of brain substance has been lost and after 3 years 35%, representing 400g or more of brain substance lost. This compares with only about 200g lost in the most severe and advanced cases of Alzheimer's disease. Evidence of this degeneration can be provided in life by radiological imaging using CT scanning or MRI; these show progressive enlargement of the fluid-filled ventricles and spaces on the surface of the brain.

The most reliable evidence of the functioning of the brain in living vegetative patients comes from a sophisticated investigative tool called positron emission tomography (PET)—available in this country only in the Hammersmith hospital. However, a series of vegetative patients have been investigated by PET in New York. In them the consumption of glucose in the cortical grey matter was reduced by 60%—which compares with only 30–50% decline during clinical anaesthesia. The vegetative level of activity has previously been recorded only in the very deepest experimental barbiturate narcosis. This is part of the evidence adduced to indicate that these patients are not capable of experiencing distress or pain, let alone having higher cognitive activity.

In regard to the time after which a vegetative patient may be said to be permanently in that state, the one year cut-off suggested by the BMA is consonant with recommendations elsewhere, including data currently being assembled by a Multi-Society Task Force on the vegetative state in the United States which has reviewed some 630 patients. Head injuries show rather more potential for recovery in the early months than do anoxic cases. In the Anglo-American study of 500 cases of non-traumatic

coma only 8% of those vegetative at 3 months recovered to severe disability and none to independence. Of head injuries in the Scotland/Netherlands study who were vegetative at 3 months 20% recovered to severe disability within a year, none becoming independent. In Levin's series of head injuries in the States of the few who regained consciousness after a year none became independent, whilst in Berrol's survey of rehabilitationists in California none who became conscious after 6 months became independent; he concluded that active rehabilitation was not justified for longer than a year. The same message was conveyed to me recently by Roger Wood from his sensory stimulation programme in California.

The alleged recovery of a high proportion of 250 supposedly vegetative patients from a Coma Recovery Institute in New Jersey demands careful study. This paper from two nurses in a nursing journal makes it clear that the patients at input were either vegetative or severely disabled, and they fail to specify how many were of each—or the number at different time intervals after brain damage. They give no clear measure of the state of the patients at outcome—only that they had 'functional independence', a term often found to be a euphemism for severe disability. Two of the most often quoted single cases of late recovery (by Rosenberg and Snyder) each had very good EEG activity a few months after brain damage and in neither did the CT scan show progressive degeneration. Their late recovery was therefore neither unheralded or surprising.

A questionnaire given to two large audiences of people in 1976 showed an interesting correspondence although the audiences were very different—a sophisticated San Francisco group of professionals and a class of 4th year students in Glasgow. Almost 90% considered that vegetative survival was worse than death for the patient and 95% that this was so for the family.

As evidence of how people regard the vegetative state we can of course not ask the vegetative patients themselves. However, a questionnaire given to two large audiences of people in 1976 showed an interesting correspondence although the audiences were very different—a sophisticated San Francisco group of professionals and a class of 4th year students in Glasgow. Almost 90% considered that vegetative survival was worse than death for the patient and 95% that this was so for the family. It was particularly interesting that, as long ago as 1976,

over 40% considered that to recover to very severe disability with awareness of their plight was for the patients even worse than being vegetative. Moreover both these audiences had the sensitivity to recognise that this would seldom be admitted by caring relatives, who perhaps gain more from this limited degree of recovery than do the patients.

In another face-to-face study 59 neurosurgeons from several countries were asked to give the level of probability of a poor outcome (namely dead, vegetative or severely disabled), that they would consider to justify withholding or withdrawing treatment in the acute state after severe head injury. As expected most wanted 95% or more of certainty. However, when asked to restate this probability if they, the surgeons, were themselves head injured, many of them wished treatment withdrawal at a much lower level of probability of a poor outcome. In other words they were not prepared to accept the risk of vegetative or severely disabled survival that they would impose on their patients.

Another paper analysed the responses of 500 American people asked how they would frame advance directives for treatment that aimed to save or prolong life under various circumstances. More than 80% wished no such treatment if they were vegetative, and as many as 55–60% did not wish such treatment if they were in coma with a small chance of full recovery. Moreover they voted almost identically to forego resuscitation, major surgery, a ventilator or tube feeding. These two studies indicate that the fear of severely disabled survival after brain damage is so great that many people are willing to forego a small chance even of a good recovery in order to avoid this.

A paper by 12 intensive care specialists across the United States entitled 'The physicians' responsibility towards hopelessly ill patients' included this statement: 'Insistence on certainty beyond a reasonable point can handicap the physician dealing with treatment options in apparently hopeless cases. The rare report of a patient with a similar condition who survived is not an overriding reason to continue aggressive treatment.' Similarly a paper by a physician and two philosophers on medical futility from the American College of Physicians referred to 'the mythological power of the coma patient who wakes up to override the rarity of documented confirmation of such miraculous recoveries (which have resulted moreover in incapacitating mental impairment and total dependence)'. They emphasised that Hippocrates stated 'To attempt futile treatment is to display an ignorance which is allied to madness', and that Plato referred to the inappropriateness of efforts that resulted in patients surviving but leading literally useless lives.

I hesitate in this company to quote the views of theologians and moralists on the balance between the quality of life and the sanctity of life, but I have of necessity had to read in this area in recent years in wrestling with the problems of this state. It was in 1957 that a Papal allocution responded to an approach by anaesthetists concerned about continuing with respirators in intensive care once recovery of cerebral function was unlikely. They were told that they were not obliged to persist with extraordinary measures. I am aware that the

definition of extraordinary measures has been variously interpreted and that these are now more commonly referred to as those that are disproportionate in relation to the benefit. There are many statements, including those by a number of Jesuits in the United States and by Archbishop Coggan previously of Canterbury, which state that treatment that offers no hope of recovery or benefit should be regarded as extraordinary and therefore not obligatory. In 1970 a doctor in the *Lancet* quoted the Pope as having said 'Would it not be a torture to impose the restoration of a vegetative existence . . . by prolonging as long as possible with every means and at all costs a life which is not fully human.' In an address to doctors the Bishop of Durham in 1972 questioned what degree of respect we should accord to vegetative patients as compared with the lives of others who are much more

And in 1977 Archbishop Coggan addressing doctors stated 'I need hardly emphasise that the view held by many that Christians believe that life must be artificially prolonged under all circumstances is not true. In the case of Karen Quinlan I am informed that it was the doctors not the priest who gave the advice which led to the prolongation of her life.'

evidently alive and in rapport with other members of society. He went on 'the so-called principle of respect for life needs to be qualified and married to an explicit concept of personality and linked with ideas about the quality of life'. And in 1977 Archbishop Coggan addressing doctors stated 'I need hardly emphasise that the view held by many that Christians believe that life must be artificially prolonged under all circumstances is not true. In the case of Karen Quinlan I am informed that it was the doctors not the priest who gave the advice which led to the prolongation of her life.'

The Quinlan case in the United States was of course a landmark—the first time that a court had authorised withdrawal of life-sustaining treatment (a respirator). Moreover her father petitioned the court with the support of her Catholic parish priest. She was in fact in the vegetative state, not as fully recognised then as now, and because she was not ventilator dependant she lived for another 10 years. Several of the next few cases that came before the courts in America were also Roman Catholics, one of them a monk whose religious superior it was who petitioned for the ventilator to be removed. And the first case in which nutrition and fluids were withdrawn and

the patient died, the case of Brophy, was also a practising Roman Catholic. Father John Paris, a Jesuit at the College of the Holy Cross in Worcester, Mass. has been a prominent campaigner for the withdrawal of fluids from vegetative patients and has analysed the history of Catholic tradition in relation to this.

I see the withdrawal of the medical treatment of tube feeding as in line with other decisions to stop treatment that is futile—as defined by the fact that it brings no benefit to the patient. Treatment is justified when there is a reasonable probability of meaningful recovery and of regaining life as a social human being or, in the words of the BMA Committee, 'It makes possible a decent life in which a patient can reasonably be thought to have a continued interest'. Doctors are increasingly urged not to use their technologies when the effect will be to extend lives of poor quality or to prolong the dying process.

It is said that many elderly Americans now fear living more than dying, because if admitted to hospital they may become passive prisoners of technology. In fact doctors have no moral or legal duty to begin or continue treatment that is deemed to be futile. Moreover competent patients have a right to refuse treatment, including that which saves or sustains life, and doctors are obliged to abide by patients' wishes even if they do not consider them wise. This principle of self determination is particularly highly regarded in the United States, as reflecting the Constitutional rights to liberty and privacy. As a result recent legislation seeks to ensure that patients can determine how they are treated at the end of life. In 1976 the first Natural Death Act was passed, requiring doctors to abide by advance directives and protecting them from civil or criminal liability for a death that followed a decision to limit treatment. Largely as a result of the case of Cruzan in the Supreme Court (discontinuing tube feeding of a vegetative patient) the federal Patient Self-Determination Act has been passed. This requires that all patients on admission to a hospital or nursing home be informed of their right to refuse treatment, to make a living will and to appoint a proxy decision-maker.

Reports from the US, UK and the Netherlands indicate that decisions not to resuscitate or to embark on emergency surgery or to initiate or continue intensive care or artificial feeding are now commonplace—probably accounting for 50% of deaths in hospital. Such a decision is commonly made after a trial of treatment has shown it to be futile—the problem with vegetative patients is that the trial before futility can be declared takes months rather than days—but that does not make it different in kind. If the judgment in the Bland case had gone the other way it would have had serious and damaging effects on the care of all hopelessly ill patients, whose doctors might then feel that they had to persist with treatment against good medical judgment and ethics. That was why the American Geriatrics Society submitted an *amicus* brief to the Supreme Court in the Cruzan case supporting discontinuation of tube feeding. An even more serious consequence could be that doctors might hesitate to initiate life saving measures for fear that, if unsuccessful, they would be unable to withdraw such treatment and might then be forced to keep a hopelessly ill patient alive indefinitely.

The problem posed by the incompetent patient is how to ensure that he is protected from unwanted, non-beneficial treatment that he would likely refuse if he were able to. It is generally agreed that the family are best placed to judge what a particular patient would have wanted, and to form a substituted judgment. However, in this country there is a greater tendency in law to rely on the family and the doctor together deciding what seems to be in the patient's best interest, rather than trying to second guess what the patient himself would have wanted. That was certainly so in the Bland case. Part of the judgment was to require future similar cases to come to court, and this should allow good practice to be established in a public forum. This could eventually lead to the evolution of guidelines and a less formal process of decision making, perhaps using ethics committees constituted to resemble mental health tribunals.

Whatever the mechanism it seems to me important also to protect incompetent patients from becoming the victims of third parties pursuing their own agendas. One example is the state claiming to have an overriding interest in preserving life, regardless of the patient's interests or the family's preference, as happened in the Cruzan case in Missouri. Another is the pro-life stance of some groups that depends on firmly held convictions regardless of their effects on individuals who do not share their moral position. In the United States a number of decisions by the courts to allow withdrawal of treatment have been resisted by pro-life institutions which have refused to carry out court orders. The courts have ordered them to transfer the patient to the care of doctors and nurses willing to give priority to the patients' interests and the court's order rather than to their privately held principles. In the words of the *Guardian* this week, 'No-one wants to deny those who believe in the sanctity of life a prolonged and agonised death if that is their wish. A humane society, however, should seek to ensure that those who want to avoid such an end are able to do so.'

There are those who maintain that the issue of resources should not come into this debate. I cannot agree with that. This matter was raised in respect of the Bland case by Dr Gillon, the Editor of the *Journal of Medical Ethics*, acknowledging that the fourth principle of medical ethics is to consider justice in the distribution of health care resources. The Appleton International Conference on Foregoing Life Sustaining Treatment included health economists and it noted 'It is unfair to allow the prolonged consumption of societal resources in support of vegetative patients beyond the period of education and adjustment for the family'. Moreover Archbishop Coggan devoted a good deal of his 1976 lecture to doctors to this issue. He said, 'The prolongation of the life of one patient may entail the deprivation of aid to others and even the shortening of their lives. Extension of life for a terminal patient may necessarily involve the suffering and even death of those who if they could get treatment might have had many years of useful life ahead of them.' Father Paris, the Jesuit, entitled his comment on the Connecticut woman who lived 18 years in PVS, 'The six million dollar woman'. Moreover cost frequently appears in the definition of extraordinary or disproportionate treatment. Daniel Callahan of the Hastings Center has written that,

along with the patient's right to survive, 'physicians must be aware of, and responsive to, social and communal values—the treatment of any patient must be considered in the light of an awareness of the cost, the utilisation of medical resources, and the limits of tax payers' tolerance for health care expenditure'. Indeed the failure to decide to withdraw treatment from a hopeless patient is in effect often a decision to deny treatment to a patient who could benefit.

I conclude that the withdrawal of tube feeding from vegetative patients is in line with other decisions to withhold or withdraw futile treatment from the hopelessly ill—compatible with good medicine, good ethics and good economics. Arguments that tube feeding is not medical treatment have been rejected by the US President's Commission, the American Medical Association, numerous courts in the USA as well as in South Africa and New Zealand, the Appleton International Conference and, in the UK, committees of the Institute of Medical Ethics and the BMA. It is spurious to argue that tube feeding is not treatment because it does not therapeutically benefit the brain damage—neither does a ventilator, which no one would deny is medical treatment. One substitutes the lost function of swallowing, the other breathing. Each is applied in the hope that temporary substitution of function will allow an acceptable degree of recovery to occur. Allegations that death following withdrawal of tube feeding is unpleasant for carers are rejected by many with experience, as summarized in a recent *Lancet* paper under the title 'The Sloganism of Starvation'.

No-one can say that doctors have rushed to resolve the problem of the vegetative patient with undue haste. It is 20 years since the condition was defined and the year before that an account of neocortical death from hypoxia provoked an editorial in the *Lancet* entitled 'The death of a human being'. This concluded 'we may ask whether anyone would want his own vegetative existence to be prolonged with cortical death. Equally who, that knows the facts, would want a close relative so supported. It is a dreadful decision but the answer can hardly be in doubt.' Even before that, in 1969, a physicist from Cambridge wrote in the *Lancet* under the title 'An appeal to doctors', 'It adds fresh terror to traffic to know that an accident may make you an unconscious hulk lasting for years, a sorrow to any who love you and a trouble to all concerned, wasting valuable nurses and resources which should be used where they can do good. At best you could die in the end unconscious, at worst recover some degree of awareness and live indefinitely, deprived of those powers that distinguish us from the lower animals. The ability to prolong life may be a curse instead of a blessing.' He and many others will welcome the judgment in the Bland case.

REFERENCES

- Ahronheim, J. C., Gasner, M. R. The sloganism of starvation. *Lancet* 1990; 335: 278–79.
- Campbell-Taylor, I., Fisher, R. H. The clinical case against tube feeding in palliative care of the elderly. *JAGS* 1987; 35: 1100–14.
- Coggan, D. On dying and dying well: moral and spiritual aspects. *J Roy Soc Med* 1977; 70: 75–76.

Council on Ethical and Judicial Affairs of the American Medical Association. Persistent vegetative state and the decision to withdraw or withhold life support. *JAMA* 1990; 263: 426-30.

Emanuel, E. J. A review of the ethical and legal aspects of terminating medical care. *Am J Med* 1988; 84: 291-300.

Gillon, R. Patients in a persistent vegetative state: a response to Dr Andrews. *Br Med J* 1993; 306: 1602-3.

Gillon, R. Persistent vegetative state and withdrawal of nutrition and hydration. *J Med Ethics* 1993; 19: 67-69.

Institute of Medical Ethics: Working Party Report on withdrawing life supporting treatment from patients in a vegetative state after acute brain damage. *Lancet* 1991; 337: 96-98.

Jennett, B. Vegetative survival: the medical facts and ethical dilemmas. *Neuropsych Rehab* 1993; 3: 99-108.

Jennett, B., Plum, F. Persistent vegetative state after brain damage. A syndrome in search of a name. *Lancet* 1972; 1: 734-47.

Jennett, B., Boyd, K. M. Managing the persistent vegetative state. *Br Med J* 1992; 305: 886-7.

Lo, B., Steinbrook, R. Beyond the Cruzan case: the US Supreme Court and medical practice. *Am Coll Phys* 1991; 114: 895-901.

Mitchell, K. R., Kerridge, I. H., Lovat, T. J. Medical futility, treatment withdrawal and the persistent vegetative state. *J Med Ethics* 1993; 19: 71-76.

Paris, J. J., McCormick, R. A. The Catholic tradition on the use of nutrition and fluids. *America* May 2, 1987.

Stanley, J. The Appleton Consensus. Suggested international guidelines to forgo medical treatment. *J Med Ethics* 1992; 18: Supplement.

Steinbrook, R., Lo, B. Artificial feeding—solid ground, not a slippery slope. *N Engl J Med* 1988; 318: 286-90.

Weir, R. F., Gostin, L. Decisions to abate life-sustaining treatment for non-autonomous patients. *JAMA* 1990; 264: 1846-53.

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DEFINITIONS OF PERSONHOOD: IMPLICATIONS FOR THE CARE OF PVS PATIENTS¹

The title I was given—'Definitions of Personhood and Implications for Care of PVS Patients'—sounds esoteric. Nothing very obviously follows from a mere definition of 'personhood' for what particular duties of care may be owed to a patient diagnosed to be in a persistent vegetative state. However, people debating questions about what we owe in the way of respect and care to embryos, to pre-born children, to the handicapped newborn, to those with senile dementia, and to those in PVS, will often be found articulating their conflicting views in terms of one or another concept of what it is to be a human person, in terms of some concept of 'personhood'.

Broadly speaking two differing concepts of what it is to be a human Person are employed in these debates. One is a variant on the general concept of a person which was originally worked out in early Christian theological debates: a person is 'an individual substance of a rational nature'. A human person is, therefore, any individual member of the human race, any individual who shares in the nature which characterises our species, *homo sapiens*. By contrast, there is a body of philosophers who, since the English philosopher John Locke in the seventeenth century, have so defined what it is to be a person that persons are a subclass of human beings: they are those human beings who possess presently exercisable psycho-

logical abilities, and more particularly the abilities to understand, choose and communicate.

It would be a mistake to think that it is differing concepts of 'personhood' which just as such lead people to their differing conclusions about the proper treatment of PVS patients and certain other human beings. In order to understand what is at issue when people invoke contrasting concepts of 'personhood' in discussing duties to PVS patients we need to look at the arguments people deploy.

A short paper, such as this, does not offer scope for reviewing all the lines of argument which may be employed in discussing what is and is not owed in the way of respect and care to PVS patients. I think it would be helpful, however, in our present circumstances if I were to begin by looking at some of the considerations which have been given an airing by the Medical Ethics Committee of the BMA in their *Discussion Paper on Treatment of Patients in Persistent Vegetative State*.

Though a valiant effort at covering many aspects of its topic, the paper does seem to be confused and confusing in certain respects. It is to be hoped that the Committee will be able to identify a clearer and more coherent basis, and one consistent with the fundamental requirements of justice in the treatment of patients, before the BMA issues 'guidance on the ethical questions which arise in relation

to treatment of patients in the persistent vegetative state'.²

The starting point for much that is advanced in the Medical Ethics Committee's Discussion Paper is the 1988 BMA Working Party Report on *Euthanasia*, which represents the Association's policy.

A central contention of that Report is that '... human life is of inestimable value and ought to be protected and cherished' (para. 72). At first sight this might be taken to mean that any human life is of inestimable value. However, a reading of the sections of the Report on 'brain death' (paras. 29–33) and the persistent vegetative state (paras. 34–39) undermines this interpretation. For it becomes clear that it is the continuing capacity for a certain level of psychological activity which is held to be of 'inestimable value'.

This view led the Working Party in two directions in their discussion of the persistent vegetative state. On the one hand they are tempted to say that human beings incapable of psychological activity are *dead*. Thus at para. 32 we read: 'where an individual can no longer have the experiences of a human being and never will have again we think that the functions that remain are of no further value to the individual. *This is why controversy over whether the brain stem is completely and in every part dead and whether the whole brain can be said to be not functioning just on the basis of the accepted battery of tests are beside the point.*' And at para. 34 we read: 'Our justification for brain death as the end of life has relevance for the persistent vegetative state where the neocortex is extensively and irreversibly destroyed and we are left with a biologically persistent human life in which only certain reflex and automatic responses persist. *At present we cannot move from brain death to neocortical death because there is no way to establish that irreversible and complete loss of all neocortical function has occurred.*' [Emphases added.] In other words, the BMA position is that it is only a technical problem of diagnosis that stands in the way of our declaring PVS patients to be dead.

In face of the difficulty so identified, the other direction in which the BMA Working Party was bound to look was towards an adverse judgement on the *worth* of the PVS patient's existence. In doing so the Working Party certainly takes account of what, on their understanding, are the legal constraints on embracing wholeheartedly the logic of such a judgement.

It is clear that human beings incapable of the level of psychological activity which confers 'inestimable value' on a life in principle lack the entitlements which are conferred by that 'inestimable value': entitlements to respect, protection and care. And so when considering the case for killing a patient 'in a state that can no longer be called human life' (para. 98), in which 'there is no prospect of restoring the patient to sentient life', the Report observes: 'The situation is not the same as one in which a sentient person is killed.' It immediately adds, however, that 'a patient in the UK who is in a persistent vegetative state, and, consequently, who is non-sentient, is not killed' (para. 101). This has somewhat the force of a detached ethnographic observation rather than a report on practice which the Working Party has given convincing reasons for maintaining. Indeed, when they say

... some patients have permanently lost all capacity for the conscious quality of life that constitutes being fully human ... we have stopped short of saying that such a state of affairs ought to be terminated by a positive act (para. 131:1; emphasis added)

the position stated sounds little better than a pragmatic recognition of existing legal limits for which no sound basis has been found. Indeed, it is notable that the Working Party merely stops short of recommending that these patients be killed by a *positive* act. But it does not oppose killing them by a planned course of omissions intended to bring about death.

The two positions which I have identified in the 1988 BMA Working Party Report, and which have decisively influenced the Medical Ethics Committee's Discussion Paper, can be given concise expression in terms of the Lockean concept of the 'person': we can say that PVS patients are as '*persons*' dead; or we can say that PVS patients, being no longer '*persons*', have no distinctive value and therefore no basic human rights. In particular, they do not have the right not to be intentionally killed. As I remarked earlier, this conclusion does not follow in any direct way from a Lockean understanding of the concept of a 'human person'. Rather, the Lockean concept of 'person' has been coopted to express a particular understanding of what makes human life valuable.

One writer who uses the word 'person' in this way is Dr Grant Gillett, a New Zealand neurosurgeon who in the mid-1980's held a fellowship in philosophy at Magdalen College, Oxford. During this period Gillett is described³ as being an 'observer' on the BMA's Working Party on Euthanasia, but he was in fact engaged as a rapporteur to it and played a considerable role in drafting its Report. I do not know to what extent the doctors who were formally members of that Working Party were conscious of the fact that the Report's sections on 'brain death' and PVS reflect Grant Gillett's views on these topics. This is of very considerable significance in coming to understand the BMA's views on the proper treatment of PVS patients. So I will say something briefly about an important element in Gillett's thoughts on these matters.⁴

Gillett's starting-point is similar to Peter Singer's. He believes that the mere fact that someone is human gives no distinctive value to his or her life. To believe that it does is an expression of mere irrational prejudice, which Singer calls 'speciesism'.

So what does give value to an individual human life? Gillett's answer goes roughly as follows: your life has value in so far as you are in a position to value things and projects and activities and you *do* value them. This means that if you do not possess the developed mental equipment which makes it possible for things to seem valuable to you then there is no account one can give of the inherent value of your life. Human beings who do not possess the mental capacities to make things matter *to them* do not *in themselves* matter.

On this account a human being can *give* worth and dignity to his life in so far as he is able to maintain a sense of things and projects being worthwhile and valuable. The corollary to this account of what it is for a human life to have value is that those lacking the mental equipment

to confer value on their own lives must depend on others to attach value to their lives. This means in practice that if those one would normally expect to value the life of an unborn child (the child's parents) or the life of a senile parent (his or her children) do not themselves reckon that life valuable, then not only is there unlikely to be a social basis for treating that life as valuable, but there is no account to be given of its value. The same applies, evidently, to PVS patients. Their lives cannot matter to themselves and if they matter to no one else then they just don't matter.

If this is all that can be said about the value of human lives there is a very powerful case to be made for non-voluntary euthanasia. It is startling to reflect on the extent to which the BMA has taken this case on board, contrary, I suspect, to the intentions of many of those who were signatories of the 1988 Report.

I turn now to explaining why I think it is untenable to treat someone in PVS as as good as dead or to regard the life of the PVS patient as so little worth living that he or she may be thought better off dead.

Living human beings are organisms. On a non-dualistic view of human life the human organism is *human*. It is not a material substrate to which psychological attributes are mysteriously attached and from which they may be detached. The discussion document on PVS, following the BMA's 1988 Report on *Euthanasia*, talks as if there is a living *human* body only to the extent that that body is capable of exhibiting psychological abilities. But this is to consign a very large number of living human beings to a non-human or sub human status. It is obviously false to say those bodies are not living. So what sense is there in allowing oneself to be tempted to say that they are dead? Perhaps the claim amounts to saying that these bodies have lost the *kind* of life that made them human. But their life is a unified life: the life that is exhibited in thinking is the *very same life* that is manifested in respiration and heartbeat. To cease to be able to think is to lose an *ability*, not to lose one's life.

In the diagnosis of human death there is no alternative to employing criteria analogous to the criteria we employ in diagnosing death in other kinds of animals. Living human beings are living animal organisms. And they cease to be living animal organisms when they irreversibly lose the capacity for the integrated organic functioning characteristic of organisms.

In the days before artificial ventilation, cessation of heart and lung function was an unambiguous indicator of the loss of the capacity for integrated organic functioning. If there is validity in taking 'brain stem death' as an indicator of death, then it can only be because a functioning brain stem is a necessary condition of integrated organic functioning.

Hence the BMA is mistaken in allowing itself to say '... controversy over whether the brain stem is completely and in every part dead and whether the whole brain can be said to be not functioning ... are beside the point'. In so far as controversy over these questions is relevant to establishing appropriate tests for the loss of the capacity for integrated organic functioning then the controversy is pertinent. What seems clear is that so called 'neo-cortical death' (such as one finds in PVS patients) does not

demonstrate loss of the capacity for organic functioning. These are living human beings, albeit gravely impaired.

When people say PVS patients are 'dead as persons' they are not making a statement about a living animal organism ceasing to exist. They are perhaps better interpreted as saying—metaphorically—that certain living human bodies have *ceased* to make the moral claims upon us that human beings characteristically make upon us. We no longer, as a matter of justice, have certain duties towards them. We no longer have those duties because human beings possess the correlative basic rights *only* if they possess certain developed and exercisable psychological abilities.

Let us reflect on this thesis, a thesis which underpins not only certain claims about the appropriate treatment of PVS patients, but analogous claims about the appropriate treatment of preborn children, the handicapped newborn, the mentally handicapped, and those with senile dementia.

Which are the developed, exercisable abilities we need if we are to possess basic human rights and a claim to be treated justly? The BMA is wholly implausible in making possession of 'sentience' the basis of the unique ethical importance of human beings. All forms of animal life possess sentience. It is the exercise of the capacities to understand and know the truth and to make free choices which *exhibit* the distinctive dignity and worth of human beings, a dignity and worth which are the foundation of their claim to be treated justly.

But if *actual possession* of these abilities is a necessary condition of the claim to be treated justly, questions will have to be faced about precisely *which* abilities must be possessed, and how developed they must be, before one enjoys this claim to be treated justly. Abilities, such as abilities to understand, reflect, choose, relate to others, communicate, come in differing degrees, and are not correlated with each other nor with age, state of mental health, or other attributes. So it becomes a matter of *choice* *what* degree of *which* abilities are required in someone if he is to have a claim to be treated justly. But to base one's behaviour towards other human beings on such choices is to act in an unavoidably *arbitrary* fashion: one cannot avoid being arbitrary about where to draw the line between those one recognises as possessing rights and those one reckons not to possess basic human rights. But if the basis of one's understanding of rights commits one to being arbitrary about who are to be treated justly (i.e. who are the very subjects of justice) it is clear that one lacks what is recognisable as a framework of justice. A non-arbitrary understanding of who are the subjects of justice requires us to *assume* that *just treatment* is owing to *all human beings in virtue of their humanity*.

But this indispensable assumption is also intrinsically reasonable. It is true that the distinctive dignity and value of human life are *manifested* in those specific exercises of developed rational abilities in which human beings come to participate in such goods as truth, beauty, justice, friendship and integrity. But we come to acquire the relevant (first-order) rational abilities in virtue of a (second-order) capacity in our nature for developing precisely such abilities. Our human nature, however, is not directed to the development of rational abilities to be exercised in just any fashion. Our abilities to know and

choose are not properly exercised by believing falsehood or by choosing to act unjustly. The nature in virtue of which we come to acquire rational abilities is itself intrinsically directed to human good. And that is why it is reasonable to hold that there is a fundamental dignity or value inherent in our common humanity, and seriously unreasonable (and radically subversive of justice) to judge that the lives of some human beings lack inherent value because those human beings lack presently exercisable psychological abilities.

I have here articulated two counterpositions by way of criticising the BMA positions on 'death' and the value of human life. They can be expressed in terms of the classical concept of the human person. That concept, you will remember, is applicable to *every* living human being.

1. You can cease to be a person only by ceasing to be a living human being, and you can cease to be a living human being only by ceasing to be a living human organism.
2. Since every person possesses an ineliminable dignity and value just in virtue of being human, in saying justice is owing to every person one is saying that justice is owing to every human being.

What follows from these general counterpositions in regard to what is owing by way of care of PVS patients?

First, PVS patients are persons, and in virtue of their humanity that they possess the same fundamental dignity and value as any other human being. Unless we regard this dignity and value as an *ineliminable* attribute of every human being then we lapse back into the arbitrariness of choosing which human beings we shall treat justly.

Secondly, it is incompatible with recognition of the ineliminable dignity and value of PVS patients to judge that their lives are without value or not 'worthwhile'. If a person's life is judged not worthwhile then it will indeed seem reasonable to conclude that the person would be better off dead. And if that is so, then it will also seem reasonable to make the death of that person the *object* of clinical management.

Thirdly, one may aim to kill a patient by deliberate omission of treatment or care, which one decides upon precisely to bring about death. Intentional killing of the innocent by planned omission is as gravely wrong as intentional killing by positive act.

Fourthly, PVS patients are entitled to the ordinary care to which any impaired and vulnerable person is entitled.

Fifthly, I have not seen a convincing argument for the claim that enteral feeding of a PVS patient (i.e. feeding by nasogastric tube or gastrostomy) is medical treatment. It will, of course, normally require a doctor's decision to first establish such feeding (though it will not require specifically medical skills to maintain feeding by nasogastric tube). And the doctor's purpose in so deciding will normally be to sustain the patient while diagnostic investigations are carried out and an attempt is made to establish an appropriate therapeutic regimen. But the tube-feeding itself is not therapy. Many PVS patients retain some degree of swallowing reflex, and they standardly possess a capacity to digest food in the normal way. Enteral feeding is an expeditious way of delivering

to the PVS patient the food any human being needs, and it serves the same purpose that eating and drinking do. Why should failure to achieve the therapeutic goals of medicine (see next point) be thought to justify withdrawing tube feeding?⁵

The reason why it is often suggested tube feeding should be withdrawn is because it is deemed a 'benefit' to put an end to what is judged to be an existence without dignity and value. But withdrawal on those grounds has to be characterised as a choice to kill someone by starvation.

There may be certain limited circumstances in which it is reasonable to discontinue enteral feeding of a patient, as when the patient is in the final phase of dying or when the only available method of delivering the food has become a grave burden on the patient. Then one's precise intention in discontinuing feeding is to terminate *not* the life of the patient, but a form of care which has become incapable of serving its normal purpose or which, in seeking to serve that purpose, has become gravely burdensome.

Sixthly, the basis of the obligation to give specifically medical care is distinct from the basis of the obligation to give ordinary care. The proper objectives of medicine are the maintenance and restoration of health (i.e. the well-functioning of the organism as a *whole*⁶) or of some approximation to health, and, when this cannot be achieved, the palliation of symptoms. The condition of a PVS patient is, however, so seriously defective (organically) that the good of human bodily health, or of some desirable approximation to it, are no longer achievable in the patient. And given the supposition that such patients are insensate, palliative treatment has no role in their care. If the proper goals of medicine are not achievable in a patient then doctors do not have an obligation to provide medical treatment the rationale of which is the achievement of one or other of those goals. It is not a distinct end of *medical* treatment to seek to prolong life or to keep certain bodily capacities functional irrespective of whether the relevant medical goals are achievable.

If that view is correct, it is reasonable, subsequent to a duly cautious diagnosis of PVS, to withdraw *medical* therapy, including antibiotic therapy. In doing so one's precise purpose is not to put an end to the life of the patient but to put an end to therapeutic measures which can no longer achieve their proper goal. It matters not that a foreseen consequence of acting in this fashion is that the patient is likely to die earlier than he might otherwise have done. For the patient's death is neither the object for which one is acting nor is it a means to achieving one's object. And it would have to be one or other of those for the bringing about of death to be intentional.

The six points I have made state in very general terms some of the considerations that I believe should govern the care of PVS patients, with special reference to the decisions which are now controversial. I believe it is a matter of fundamental importance, especially for all vulnerable and impaired patients, that the courts should not deem lawful any choices in the management of PVS patients which are in effect based on the judgement that the lives of these patients are no longer worthwhile, and

hence that it is in their 'best interests' that an end should be put to their lives. To deem such choices lawful is to deem non-voluntary euthanasia lawful.

POSTSCRIPT: SIX MONTHS LATER

The above was written a little over five months ago. In the meantime, the Law Lords in the *Bland* case have in effect declared non-voluntary euthanasia lawful. Three of them were quite explicit in saying that the purpose of stopping the tube-feeding of Tony Bland was to bring about his death. As Lord Browne-Wilkinson put it: 'What is proposed in the present case is to adopt a course with the intention of bringing about Anthony Bland's death. As to the element of intention or *mens rea*, in my judgement there can be no real doubt that it is present in this case: the whole purpose of stopping artificial feeding is to bring about the death of Anthony Bland.'⁷

Why did their Lordships not consider that proceeding on such an intention would be murder? Because, like the authors of the BMA's 1988 Working Party Report on *Euthanasia* and 1992 *Discussion Paper on Treatment of Patients in PVS* they chose to attach decisive significance to a general distinction between bringing about death by an action (or 'positive action') and bringing it about by an omission. There is indeed a morally significant distinction to be made when what is omitted is something the agent did not have a duty to do and the resulting death is no part of what one intended in one's choice to omit (care, treatment, assistance, etc.). Their Lordships argued that Tony Bland's doctor was under no duty to continue feeding him since to do so was futile; and it was futile because a responsible body of medical opinion did not regard existence in Tony Bland's condition a benefit. But if the basis of the judgement of futility is an assessment of the worth or value of Tony Bland's existence then omission of tube feeding is made to be justified precisely by the desirability of putting an end to his existence. Lord Mustill described the basis of the courts' decision as 'morally and intellectually misshapen'. What is misshapen and intellectually indefensible is the law as we now have it, post *Bland*, which 'treats as criminal a harmful "act" while treating as lawful . . . an omission, with the very same intent, by one who has a duty to care for the person injured'.⁸

Lord Browne-Wilkinson in his judgement observed: 'the conclusion I have reached will appear to some to be almost irrational. How can it be lawful to allow a patient to die slowly, though painlessly, over a period of weeks from lack of food but unlawful to produce his immediate death by a lethal injection, thereby saving his family from yet another ordeal . . . ? I find it difficult to find a moral answer to that question.' The Law Lords' answer is certainly not intellectually tenable as it stands. We can either retrieve the antecedent position of the law⁹ 'that one who undertakes the charge of caring for a dependent person . . . and omits to supply necessary food or raiment with the intention of causing death or serious bodily injury is guilty of murder';¹⁰ or we shall find that the logic of declaring it lawful intentionally to cause a

patient's death by planned omission leaves opposition to the legalisation of active euthanasia hopelessly weak.

1. A paper given at St Thomas's Hospital Postgraduate Centre at a Conference organised by the Centre for Bioethics and Public Policy on Saturday 28 November 1992. The original text has been lightly edited, and some brief comments added in postscript on the Law Lords' judgements in *Bland*. I am grateful to Professor John Finnis and to my colleague Dr Helen Watt for criticism of the original text.

2. Quotation from the covering letter by the Secretary of the Medical Ethics Committee accompanying the Discussion Paper. Lord Goff in *Bland* (Transcript p. 17) treated this document as though it already offered authoritative guidance on, rather than canvassing a view about, responsible medical opinion.

3. In the published version of the Report, p. 2.

4. Perhaps the clearest exposition of his views is to be found in Grant Gillett, *Reasonable Care*, Bristol: The Bristol Press 1989. See especially pp. 15-19, 56-68, 93-94, 99-105, and 145. For earlier statements relevant to our topic see Grant Gillett, 'Why let people die?' *Journal of Medical Ethics* 12(1986):83-86, and 'Euthanasia, letting die and the pause', *Journal of Medical Ethics* 14 (1988):61-68. I do not pretend to describe all the elements in Gillett's thinking but focus on those which have influenced BMA positions on PVS, the logic of which is now being worked out in the Courts.

5. People sometimes wonder why, if it is morally acceptable to withdraw artificial ventilation from an irreversibly comatose patient it should not be morally acceptable to withdraw 'artificial feeding'. It is important to grasp the difference between the two activities. *Feeding* people (in a variety of ways, from setting dishes before them to spoonfeeding them) is part of our *ordinary care* of them. At various times in our lives, either because of under-development or decline or accident, we can be helpless in regard to obtaining or ingesting food. If a mother fails to set dishes before her young children she will starve them. If she had failed to spoonfeed them when they were still younger she would have starved them. Tube-feeding (once one has embarked upon it) is most naturally understood as the *extension* of an ordinary pattern of care, and as owed to someone in the way of such care. By contrast, 'making people breathe' is not a part of our ordinary care of people; 'oxygenating' others is not a standard part of what we do for each other. And the reason is obvious: at any normal stage of extra-uterine life we can spontaneously breathe and the air is there to be inhaled. Consequently, supplying for the inability to breathe is *not* an extension of an activity of ordinary care. It is an intervention which is more reasonably interpreted as having its justification in the achievability of properly medical goals (the restoration of health or of some approximation to health, or the palliation of symptoms). But if those goals are not achievable there can be no obligation to continue ventilation.

6. See Leon Kass, 'The End of Medicine and the Pursuit of Health' in his *Toward A More Natural Science. Biology and Human Affairs*, New York: The Free Press 1985, pp. 157-186.

7. Transcript p. 28. See also Lord Mustill at pp. 35 and 44, and Lord Lowry at p. 23.

8. J. M. Finnis, 'Bland: Crossing the Rubicon', forthcoming in *The Law Quarterly Review*. I am very grateful to Professor Finnis for supplying me with a copy of his article in advance of publication, as well as to Dr John Keown for a copy of his analysis of the judgements.

9. Stated in *R v Bubb* (1850) 4 Cox CC and *R v Gibbins and Proctor* (1918) 13 Cr. App. R. 134.

10. J. M. Finnis, *op. cit.*

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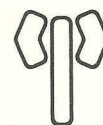
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