

A Concise Rebuttal

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I read with interest Arthur Derse's eloquent commentary and found myself in agreement with most of his observations and arguments. Having said that, I wish to make three counter-contentions.

First, I challenge Derse's argument that there is an ethical consensus about the terms "brain death" and "persistent vegetative state." While both terms are widely in use and do receive legal recognition, many ethicists are uncomfortable with them. They are uncomfortable with the "brain death" concept either because they think we should insist on the concept of whole brain death or because they think the concept is often used in order to facilitate the procurement of organs.

Similarly, many ethicists consciously avoid resorting to the term "persistent vegetative state" because they realize how easily the slide might be from "vegetative state" to "vegetable," with demeaning and grave consequences to the patient in question. I never argued, as Derse contends, that the designation of persistent vegetative state (PVS) would necessarily lead to a stripping of moral characteristics from the patient. I agree with him that the designation does not necessarily lead to such a consequence. I think, however, it might bring about the dehumanization of patients.

I recall a conversation I had in 1995 with a deputy manager and chair of an ethics committee at a major general hospital in North America. We discussed, among other things, the hospital's policy with regard to post-coma unawareness patients. He said that his hospital usually maintains "PVS patients" for four to six months and then relocates them to other institutions. In response, I told him that research has shown that post-coma unawareness patients might regain awareness and cognitive functions even after

18 months, and he looked at me with complete disbelief. Evidently, this policy maker was absolutely unaware (in a state of prolonged unawareness, so to speak) of research conducted in Great Britain, Japan, and Israel, among other places, in this sphere. His attitude, quite commonplace in North America, creates a vicious circle: Post-coma unawareness patients do not receive adequate care, they are designated as "vegetables," and then it is said that it is "futile" to maintain them, especially when the costs are high. PCU patients deserve a fair chance to regain consciousness. In this context, Dr. Keith Andrews, Director of the Royal Hospital for Neurodisability in Putney, London, argues that life expectancy of PCU patients depends very much on the attitude of the family and clinicians, i.e., how long the patient is allowed to live rather than how long he or she can live.¹

In 1994, I had a conversation with a world-renowned American philosopher, one of the forefathers of medical ethics. I asked him what we should do with patients in prolonged unawareness. His answer wasn't verbal. Instead, he waved his arm in a dismissive mode as if he wished to scare off a fly. I insisted on an answer. Finally, he told me that, for him, their maintenance simply cost too much. This dismissive mode of thinking by an influential figure such as this gentleman creates an unhealthy atmosphere for post-coma unawareness patients.

Second, Derse's example of CPR for the affluent elderly person is sound but not very convincing. There can be numerous real-life situations in which the shortage of resources might sway doctors to describe a certain treatment as "futile," so to free beds and admit waiting patients. Some examples are shown in the Zipporah Film's excellent documentary, *Near Death*. I agree with Derse that patients are ill-served by physicians' unwillingness to give straightforward information about a poor prognosis when it is known.

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We need to strive for more extensive and candid communication between medical staff and patients and their loved ones.

Third, the double effect doctrine may not have been coined by physicians, but it has been incorporated into their profession and utilized for their own purposes, giving them some ground to maneuver in the absence of explicit laws that permit termination of life under certain circumstances. Derse thinks that “double effect” seems the least likely (among the terms I surveyed) to cause offense; however, it is unhealthy for patients to remain in gray zones dependent

on doctors’ intentions. Derse fails to recognize that some patients and their beloved people want sincerity in their relationships with doctors and are offended by an attitude that beats around the bush without directly addressing their wishes.

References

1. Keith Andrews, “Vegetative State - Background and Ethics,” *Journal of the Royal Society of Medicine*, 90 (November 1997): 594. Discussion with Dr. Andrews (23 September 1997).