

Frequently Asked Questions on Persistent Vegetative State

WHAT IS PERSISTENT VEGETATIVE STATE [PVS]?

PVS is a form of "Eyes open unconsciousness" which manifests as an apparent lack of awareness while awake. It results from trauma, disease, or injury causing oxygen deprivation to the brain. This was the condition of Karen Anne Quinlan, Nancy Cruzan, and Terri Schiavo. Sleep-wake cycles exist with a putative lack of awareness of self or others while awake. These patients also lack comprehension or expression of language, and they exhibit no reproducible voluntary responses to external stimuli. Scientists admit there is much that remains unknown about PVS.

The word 'vegetative' does not mean that the person has become less than human, but rather has lost, at least temporarily, the sort of awareness that characterizes normal adult human life. The prognosis for recovery is determined by the cause of the injury, co-morbid conditions, and length of time one has been vegetative. When the duration is greater than 1 month, one is said to be "persistent." Duration greater than 3 months when the cause is non-traumatic, such as lack of oxygen to the brain after the heart has stopped, is said to be "permanent." Duration greater than 12 months, when the cause is traumatic brain injury, is also said to be "permanent."

CAN PATIENTS IN A PERSISTENT VEGETATIVE STATE REGAIN CONSCIOUSNESS?

Yes, in some cases. Chances for recovery are better early in the condition and diminish over time. Medical literature documents rare cases of at least partial recovery after many years, and medical science remains generally unable to predict with certainty which PVS patients will recover. Some medical authorities, such as the British Medical Association, deny the possibility for recovery from the PVS and attribute the appearance of recovery to an original misdiagnosis.

ARE PVS PATIENTS IN A PERSISTENT VEGETATIVE STATE COMPLETELY UNRESPONSIVE TO THEIR ENVIRONMENT?

The answer to this question is controversial, and the situation is complex. It has been widely assumed that PVS patients cannot consciously respond to their environment, but recent studies using brains scanning techniques indicate that some PVS patients exhibit the same cerebral responses to verbal commands as healthy adults. This phenomenon suggests that some PVS patients may in fact have conscious awareness, despite an inability to act upon it or manifest it outwardly.

WHAT OBLIGATIONS DO CAREGIVERS HAVE TOWARDS PVS PATIENTS?

Like all human beings, PVS patients are entitled to basic health care, including nutrition, hydration, cleanliness, and warmth, and to ordinary treatments preventing complications due to hospitalization. In other words, there should be a presumption in favor of providing nutrition and hydration to all patients, including those in a PVS who need medically assisted nutrition and hydration. In addition, the patient should be monitored for eventual signs of recovery, and should receive appropriate rehabilitative care.

WHEN IS IT LEGITIMATE TO DISCONTINUE A PARTICULAR TREATMENT?

When the treatment becomes 'disproportionate,' meaning that the burden of treatment becomes so great that discontinuing it becomes an option, there is not a moral obligation to make use of disproportionate means. Those means are optional. Treatment, however, should be distinguished from basic care, such as feeding, bathing, and preventing infection in the patient.

WHAT ABOUT THE 'QUALITY OF LIFE' OF THE PATIENT?

Quality of life is important, but the concept must be understood correctly. If an individual's quality of life is poor, we should take steps to improve that quality by the care we provide, and by making every effort to love those whose condition is compromised and quality of life is poor or declining. One never improves the quality of life by taking a life, and an example of a poor quality of life judgment would be to say, "This person does not have a life worth living." Life is always worth living until the day that God calls us home. Quality of life refers to the social, economic and especially the psychological aspects of the person's life. Valuable as they are, these qualities of life all serve a greater value, the person's very existence. It is not the quality that makes life valuable, but it is the life that makes every quality it has valuable. To rid society of certain people with unwanted characteristics is a form of eugenics.

SHOULD A CATHOLIC HOSPITAL HONOR A DIRECTIVE TO WITHDRAW NUTRITION AND HYDRATION?

It will depend on the particulars of the case. A Catholic hospital should not honor a directive to withdraw nutrition and hydration while one's body continues to be effectively nourished by those means, and where those means are not otherwise disproportionate to the needs of the patient. A decision to withdraw nutrition and hydration under such circumstances could have no other purpose than to cause death and is therefore assisted suicide rather than "allowing to die."

WHAT IS THE SIGNIFICANCE OF POPE JOHN PAUL II'S ALLOCUTION ON ARTIFICIAL NUTRITION AND HYDRATION?

On March 24, 2004, Pope John Paul II addressed an international congress on life-sustaining treatments and the vegetative state. Without changing any Catholic teaching, the pope clarified that assisted nutrition and hydration [ANH, that is, administered artificially] is *basic care* that should always be provided, so long as it is achieving its "proper finality, which in the present case consists in providing nutrition to the patient and alleviation of his suffering." Some Catholic ethicists had argued that nutrition and hydration are 'medical acts' that could be refused as too burdensome and even presumed extraordinary, and thus optional. John Paul II decides against this position, explaining that since the purpose of food and drink is nourishment, it must be provided to patients. To refuse or deny nutrition and hydration amounts to euthanasia by starvation. The pope's address does not teach anything about *when* nutrition and hydration cease to nourish the patient and for that reason can be withdrawn, which is a judgment rightly left to medical professionals. Neither does the pope address related questions such as the ethical significance of the modes of delivery of ANH, types of coma, the significance of the imminence of death, nor who should bear the costs of the continued provision of ANH. Ethicists and theologians continue to offer arguments about these and other questions. There is no departure from tradition in the pope's remarks, and the customary moral categories used in Catholic health care apply. The pope has articulated a general principle for providing nutrition and hydration to those in a persistent vegetative state. The allocution allows for prudential case-specific judgments.

TO WHAT DOES THE EXPRESSION "BRAIN DEATH" REFER?

"Brain death" refers to the medical judgment that a person is dead by using "neurological criteria". Properly diagnosed, "brain death" refers to the complete cessation of all organized neurological activity throughout the entire brain, including the cerebrum, cerebellum, and brain stem. At this point, the body irrevocably ceases to function as a unified whole. The appropriate phraseology here is "the determination of death using neurological criteria."

IS IT APPROPRIATE TO USE NEUROLOGICAL CRITERIA TO DETERMINE DEATH?

The customary criteria for determining death are "cardio-pulmonary," i.e., death is declared after breathing and heart-beat cease. Technological advancements in critical care, however, have made continued circulation and respiration possible through mechanical means even after brain function has ceased.

The use of neurological criteria for the determination of death is legitimate according to the Catholic Church. Pope John Paul II approved this approach in an [address he gave to the 18th International Conference of Organ](#)

[Transplant Specialists in August 2000](#). Neurological criteria consist of four key signs: coma or unresponsiveness, absence of cerebral motor responses to pain in all extremities, absence of brain stem reflexes, and apnea. Pope Pius XII and Pope John Paul II both said the Church has no competency in determining death; this properly belongs to medical science.

MAY I RECEIVE ORGANS FOR TRANSPLANT FROM THOSE DECLARED DEAD USING NEUROLOGICAL CRITERIA?

Yes, a faithful Catholic may receive organs from a donor who is declared dead by neurological criteria. A faithful Catholic may also make provisions for the donation of his own organs in the event of his death whether it is determined by cardio-pulmonary or neurological criteria.

WHY DOES THE USE OF NEUROLOGICAL CRITERIA REMAIN CONTROVERSIAL?

As mentioned above, when a person suffers total loss of brain function, the heart may continue to beat with the assistance of mechanical ventilatory support. In such cases, this artificial support may cause the victim to appear alive visually and to the touch. Medical evidence, indicated by the four signs listed above, shows that this is not the case. In short, there is no reason for controversy. The use of neurological criteria makes certain that life has ceased.

WHY DOES THE CHURCH ACCEPT THIS DEFINITION OF DEATH?

This is not a new definition of death but rather of the use of new signs to determine that death has occurred. The Christian understanding of death has always been that it is the separation of the soul from the body. The Catholic Church looks to the medical community to determine the biological signs that indicate with moral certainty that this event has already occurred. In recent years, medical research has indicated that the irreversible loss of brain function provides a firm indicator that death has already occurred.

WHAT DOES CATHOLIC THEOLOGY SAY ABOUT THIS DEFINITION OF DEATH?

Neurological criteria are compatible with Catholic teaching that a human being is a substantial union of body and rational soul. When all brain function is completely and irreversibly lost, this may be taken as a reasonable indicator that the rational soul is no longer present.

DOES THE USE OF "BRAIN DEATH" CRITERIA CAUSE THE DEATH OF THE PATIENT?

The use of brain death criteria does not cause the death of the patient, but only assesses whether that death has already occurred. This is analogous to the way that cessation of heartbeat and respiration have traditionally been used to make that assessment.

WHY DO SOME SAY THAT TAKING ORGANS FROM THOSE DECLARED DEAD BY NEUROLOGICAL CRITERIA IS A FORM OF HOMICIDE?

Such comments are irresponsible. Those who make such statements wrongly believe that a person is still alive because the corpse appears to be alive from the effect of oxygenated blood continuing to be pumped through the body by mechanical means. Those who reject the use of neurological criteria for the determination of death claim that a patient declared dead by this method is killed for his organs. Such comments overlook the important distinctions mentioned above, and are in tension with sound Catholic teaching. In medical practice, a physician who is not on the organ transplant team must declare death to avoid any potential conflict of interest. However, it must be emphasized, that the neurological criteria must be rigorously and consistently applied and a judgment made of total brain death before a person is declared dead.

HOW DOES THE MEDIA ADD TO THE CONFUSION OVER THIS MATTER?

The media is often imprecise in the way that they say that a patient who is brain dead "had life support removed, and died." Obviously, one who is dead cannot die again. Reporting such as this shows a careless imprecision in the use of language and a general ignorance about neurological criteria for ascertaining death.