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On Ending Life-Support

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Two recent cases illustrate the difficulty—and often the agony—experienced by family members and medical teams when they have to decide whether or not to remove life-support from an apparently dying patient.

This past July a twenty-six year old man was reportedly placed on life-support following an automobile accident. He was in a coma for two weeks and remains so at this writing. Physicians treating him at the University of Virginia Medical Center wanted to remove him from life-support, deeming the case hopeless. The young man's father, however, secured a court order prohibiting the medical team from doing so, in the hope that his son would recover.

The case raises issues regarding the allocation of available resources, as well as the so-called burden-benefit calculus: can the life-support technology be better used elsewhere, and is the man's prognosis so poor that continued support would be futile, merely drawing out the dying process with no chance of restoring life?

On both counts the father certainly didn't think so. Was he acting out of responsible conviction (and perhaps faith)? Or was his opposition to the doctors' decision based on empty hope that merely reflected his grief at the prospect of losing his son?

A second case is far more striking. For nineteen years following a truck crash in 1984, Terry Wallis was paralyzed. At first comatose, he drifted into what is termed a "persistent vegetative state" (PVS). This is characterized by periods of apparent wakefulness, with open eyes and emitted sounds, although the person is unresponsive to stimuli, such as the voice of a family member. Very few

people survive PVS. So the question arises: should such patients be maintained—often for years—on life-support, including food and hydration, or should they be removed and allowed (i.e., compelled) to die?

The question was answered when Terry Wallis, on June 11 of this year, emerged from his inner imprisonment and spoke to his mother. A simple regimen of anti-depressants seems to have improved his condition dramatically, to the point that he is now on the way to full recovery.

In today's atmosphere, aptly characterized as "a culture of death," there is increasing pressure on families and on medical professionals to remove life-support in such cases. On the other hand, fear of a lawsuit for "unlawful death" prompts some medical teams to continue life-support where it is clearly not in the best interest of the patient. It has been shown, for example, that when a person is in a truly terminal state—that is, when "the soul is struggling to leave the body," and death is imminent—removing a feeding tube and even withholding hydration can be beneficial. (Artificially introducing food and water into the patient's system prevents the build-up of natural analgesics. It keeps the cellular system "alive" and merely draws out the terminal phase, thus hindering the "peaceful separation of soul and body" that we request in the Church's prayer.)

How do we discern the just, appropriate and good decision in this regard? That is, how do we discern the will of God in cases where someone close to us is on life-support and judged to be "terminally" ill?

As so often in the moral life, there is no pat answer, no simple reply that fits every case. A rule of thumb should be obvious, however. Where the patient is comatose or in PVS, the diagnosis should never be "terminal." There is a vast difference between withdrawing or withholding life-support from such a person on the one hand, and on the other, from someone who, in the judgment of the medical team, is irreversibly engaged in the "dying process." While the dying person might well benefit from no treatment, thereby allowing death to occur naturally, withholding life-support from a comatose or PVS patient amounts to a death sentence. Terry Wallis' mother was certain she could convey love to her son and evoke a similar response on his part. Her conviction was confirmed, as he spoke his first word in nineteen years: "Mom."

As for those who are truly "terminal," any decision to withhold or withdraw life-support needs to be made between family members (or other proxies) and the medical staff. This may require seeking the counsel of local clergy, the hospital

chaplain or ethics advisor, particularly where the patient has not left advance directives. And, as many of us have experienced, it may also lead to disagreements and bitter disappointment, compounded by the weight of guilt and grief.

This likelihood underscores the most basic need, which is to place the dying person in the hands of God through our ongoing intercession. Death is not a private matter. It involves family, Church and other forms of community that have engaged and sustained the person over the years. Insofar as it does involve the Church, it is our responsibility and our privilege to journey with the dying person and his or her loved ones, to pray God's healing grace and mercy upon them all, and finally to surrender the person into His care.

As Christian people, any decision on our part to end life-support measures can only be justified—can only be considered good, right and appropriate—insofar as together, as the Church, we intend to accompany the dying person step by step through the terminal stage, and entrust that person, through our prayer and gestures of compassion, into the loving embrace of the Author of Life.