Julie Grimstad is the director of Life is Worth Living, Inc. and chair of the Pro-life Healthcare Alliance (PHA), a program of Human Life Alliance (HLA). She also serves on the HLA Board of Advisors. A speaker and writer, Julie addresses all aspects of medical decision-making and patient advocacy. She has served as a volunteer patient advocate for 28 years.

**MISSION STATEMENT**

Our mission is to strive to affirm – in thought, word, and deed – the infinite preciousness of human life; to encourage service to others rather than radical self-interest; and to promote a climate of public opinion that recognizes the right of all human beings to life, respect, compassionate care, appropriate medical treatment, and equality under the law.

**PROTECT YOURSELF: Advance Directive** (Living Will and Power of Attorney for Health Care) documents provided by the state and your hospital permit euthanasia by omission. To meet this problem, Pro-Life Wisconsin (PLW) provides a life-protective document, the Protective Power of Attorney for Health Care (PPAHC). This document is available for FREE download in PDF format at www.prolifewi.org. Or, you may call PLW at 262-796-1111 to request a PPAHC packet.

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**MEDICAL DECISION MAKING**

“PERSISTENT VEGETATIVE STATE”

by Julie Grimstad
H

uman beings are not “vegetables.” The
dehumanizing term “persistent vegeta-
tive state” (PVS), crafted in 1972, became
more familiar in the 1980s as “right to die”
activists, courts, state legislatures, physicians
and bioethicists1 began to use the PVS label as
justification for withdrawing food and fluids
from persistently unresponsive patients. PVS is a
diagnosis that kills people.

What is a “Persistent Vegetative State?”

Many people have blind faith in medical label-
ing. Most probably think that PVS is a reliable
diagnosis. However, experts disagree about what
it is and methods for diagnostic testing are dis-
pputed. PVS is grouped in the International
Classification of Diseases with “Symptoms, Signs
and Ill-Defined Conditions.”

A vegetative state is not a coma. According to the
1994 Multi-Society Task Force (MSTF) on the
medical aspects of PVS, a person in a coma is
neither awake nor aware; a person in a vegetative
state is awake but not aware. The MSTF defined
a “persistent vegetative state” as a vegetative state
that lasts more than one month.2

The person in PVS has sleep-wake cycles, eye
movement, and normal respiratory, circulatory
and digestive functions. Individuals in PVS are
seldom on any life-sustaining equipment other
than a feeding tube. Some can swallow, others
cannot. Some have random movement, some do
not. Some have been physically injured; others
suffer from stroke or dementia. In some cases,
the brain itself appears to change; in others it
remains unchanged.

In simple terms, the diagnosis of PVS is based on
lack of evidence of awareness of self or environ-
ment. However, it is not that simple.

Some patients who are misdiagnosed to be in
PVS do exhibit evidence of awareness, but the
diagnostician misses (or dismisses) the evidence.
These patients may be mute and immobile
(“locked-in”), but mentally alert and able to
communicate by blinking or through aids such as
computers—if someone gives them the

opportunity. Other patients retain some meas-
ure of awareness even though they do not exhib-

it any evidence of it. Patients who have recovered
from such a state can recall things that were said
or done to them while no one knew they were

aware.

Kate Adamson was diagnosed as PVS after a
brain stem stroke. Actually aware, she under-
went surgery with inadequate anesthesia. That
pain was nothing compared with the agony of
starvation and dehydration. Interviewed by Bill
O’Reilly in 2003, Ms. Adamson said, “When the
feeding tube was turned off for eight days, I
thought I was going insane. I was screaming out
in my mind, ‘Don’t you know I need to eat?’ ...It
was sheer torture.”

The Washington Post, 9/8/2006, reported a case
that astounded neurologists. A sophisticated
brain scan upon a woman supposedly in a vege-
tative state, when they in fact registered
light up” exactly as an uninjured person’s would.
The researchers told her to imagine she was play-
ing tennis. They were shocked to see her brain
“light up” exactly as an uninjured person’s would.
They repeated the test again and again with the
same result.

Misdiagnosis of PVS is not uncommon.

• In 2002, a study of mistaken diagnoses of
PVS revealed a 15% error rate.3

• Data gathered by the MSTF on a group of
434 adult patients who were in PVS as a
result of traumatic injury showed that three
months after injury, 33% had regained con-
sciousness; by six months, 46% had; and at
12 months, 52% had.4

• Out of 40 patients diagnosed as being in
PVS, 17 (43%) were later found to be alert,
aware, and often able to express a simple
wish. The author, London neurologist Dr.
Keith Andrews, said, “It is disturbing to
think that some patients who were aware
had for several years been treated as being
vegetative.”5

• "Another study shows that around 40% of
patients were wrongly diagnosed as in a vege-
tative state, when they in fact registered
the awareness levels of minimal conscious-
ness. Comparing past studies on this issue
shows that the level of misdiagnosis has not
decreased in the last 15 years."6

Using functional magnetic resonance imaging
(MRI), Dr. Haggai Sharon and Dr. Yotam
Paternak of Tel Aviv University’s Functional
Brain Center have shown that some patients in
PVS emotionally react to photographs of people
they know. Their findings offer hope for better
care and the development of novel treatments.7

What now?

Objections to deliberately ending the lives of
patients in PVS often rest on the hope that “they
might recover.” Let’s face it: many people with
disabilities will not recover. But killing them is
not a cure.

It is common for persistently unresponsive
patients who are not dispatched by dehydration
to wind up warehoused in nursing homes,
deprived of rehabilitation and beneficial med-
ical treatment. Their world is far more complex
than most of us can imagine. Those who have
severe brain damage may still enjoy touch, scent,
taste, and sound; they may also feel pain, loneli-
sness, fear, and despair.

A person’s inability to satisfy our longing for
response does not justify abandonment or
imposed death. Patients labeled PVS are our
brothers and sisters, human beings created in
the image and likeness of God. We must treat
them with respect and compassion.

1 Bioethicists often determine who should die. The core
principle of modern bioethics is “quality of life.” The core
principle of traditional medical ethics is “sanctity of life.”
2 Mappes, Thomas A., “Persistent Vegetative State,
Prospective Thinking and Advance Directives,” Kennedy
3-4 Ibid
5 British Medical Journal, 7/6/96
6 Quote from http://www.news-medical.net/news/
2007/06/20/26672.aspx
7 http://www.aftau.org/site/News2?page=NewsArticle&
id=19561, 12/16/2013