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An Evaluation of Faith-Based Perspectives on the Withdrawal of Life-Sustaining Treatment from Patients in a Permanent Vegetative State

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I. Introduction

For the last quarter of a century, English law has consistently countenanced the withdrawal of life-sustaining treatment (LST) from patients diagnosed as being in a permanent vegetative state (PVS). Continuing with interventions that are not conferring any medical benefit is considered not to be in those patients' best interests, thus doctors are released from any further duty to provide medical care,

including clinically assisted nutrition and hydration (CANH). In 2013, we published an article which examined the compatibility between, on the one hand, the conceptual matrix and value base of the secular legal framework that medical professionals in England and Wales are guided by, and, on the other hand, the Islamic worldview [1]. This article is an extension of that previous mono-faith effort. It is the summative critical analysis of a multi-faith symposium that we hosted at our institution, the University of Central Lancashire, on 29 April 2015.

In essence, a key question of this work is to explore how secular legal understandings challenge Abrahamic faith teachings, and what collective or individual epistemology the Abrahamic Faiths offer alongside faith-based legal strategems or understandings (e.g. Talmudic Law, Canon Law, Sharia Law) to balance patient care and religious values, whereby medical practicalities are reasonably considered and religious values are also honoured. The discussion is contextualised, in the next section, with an exploration of the medical understandings of PVS and its legal implications. This is followed, in the subsequent section, by an analysis of the viewpoints of the three Abrahamic faiths regarding the management of this patient group from a religious perspective. Through a comparative analysis of the three Abrahamic faith traditions, namely Judaism, Christianity and Islam, this section aims to identify the similarities, and particularly the differences and challenges that the secular legal approach holds for patients from these respective faiths. The article concludes with reflections on some of the questions which need to be considered in negotiating religious sensitivities within the existing legal framework.

II. The Permanent Vegetative State

When patients are diagnosed with serious brain injury, intervention by healthcare professionals is most often on the side of life preservation. In England and Wales, patients are afforded the benefit of sophisticated medical technology which can save their lives [2]. If the patient is subsequently diagnosed as brain-stem dead, the LST will be removed, as patients with this diagnosis are recognised as dead from medical and legal perspectives [3]. If the brain-stem is still alive but wakefulness and awareness are compromised, the patient would be diagnosed as having a "disorder of consciousness" [4]. One of the main conditions which fall under this umbrella term is the vegetative state.

Patients in a vegetative state may show signs of being awake. For example, they may open their eyes, have sleep-wake cycles and blink [5] (p. 163-164). They are also able to breathe and retain a heartbeat without mechanical assistance [4], although some may require ventilation. However, they do not show signs of environmental awareness or purposeful movement. For example, they do not respond to instructions and voice, do not follow objects with their eyes, nor display any emotional responses [4, 6]. Furthermore, they do not demonstrate any flinching reaction to pain stimuli, thus prompting the generally accepted medical viewpoint that they do not experience pain [7] (p. 96). Notwithstanding this, a number of studies have now challenged this understanding by claiming that such patients do retain some residual awareness, and are therefore able to perceive and experience painful stimuli [8] (p. 336; p. 3).

Vegetative patients who have been in this condition for over 6 months following anoxic or other metabolic brain injury, or over one year after traumatic brain injury, would be classified as being in a permanent vegetative state [9] (p. 10). Inasmuch as they are medically and legally recognised as still being alive, they are also not believed to be imminently dying [10] (p. 328). If LST is provided, they could live for many years but doctors are generally of the opinion that recovery of consciousness is "extremely unlikely" [4]. Thus, is its continuation in the patients' best interests in view of the poor medical prognosis?

It is necessary to highlight that English Law has taken a consistent approach since 1993 [11]. A diagnosis of this condition has led, and still leads, to the automatic conclusion that the continuation of LST is not in the patients' best interests on the grounds that it is futile [11]. Consequently, it is lawful for it to be withdrawn and the patients be allowed to die. This includes CANH, which is classified as medical treatment. It is pertinent to observe that whilst suspension of CANH should always be preceded by court approval, the Supreme Court ruled in July 2018 that this is no longer necessary in situations where there is agreement between the medical team and the patients' family that this would be in the best interests of the patients [12].

The retraction of LST and CANH is considered as an omission rather than an action, and doctors would not be in breach of their duty of care to the patients as it is deemed not to be in those patients' best interests to be in receipt of those interventions [13] (p. 14-18).

Table 1: Medical terminology and definitions

Terminology	Medical Definition
Vegetative State	A state of wakefulness without awareness where there is preserved capacity for spontaneous or stimulus-induced arousal, evidenced by sleep-wake cycles and a range of reflexive and spontaneous behaviours. It is characterised by complete absence of behavioural evidence for self- or environmental awareness [9] (p. 3).
Permanent Vegetative State	When a vegetative state has persisted for over 6 months following anoxic or other metabolic brain injury; or more than 12 months following traumatic brain injury [9] (p. 10).
Brain-stem Death	Irreversible loss of the capacity for consciousness, combined with irreversible loss of the capacity to breathe, as produced by the irreversible cessation of the integrative function of the brain-stem [14] (p. 11).
Life-Sustaining Treatment	Treatment that replaces or supports ailing bodily functions (e.g. ventilation, cardiopulmonary resuscitation, antibiotics and dialysis) [15].
Clinically Assisted Nutrition and Hydration	All forms of tube-feeding (e.g. via nasograstric tube, percutaneous endoscopic gastronomy (PEG) or parenteral nutrition) [16] (p. 6).

In the next section, we turn to the important question of whether the secular legal framework and its underpinning concepts are congruent with religious values. For this purpose, we will explore whether the Abrahamic religions have at their disposal conceptual mechanisms that help their adherents determine how such patients should be managed. In other words, do religious values allow all medical interventions, including CANH, to be withdrawn and subsequently withheld from such patients when they are not expected to bring any medical benefit?

III. The perspectives of the Abrahamic Faiths on the management of PVS patients

The religious doctrines of the three Abrahamic faiths of Judaism, Christianity and Islam pre-date the development of modern life-support technology by many centuries. These doctrines are stipulated in their religious texts. Each faith community has its independent set of values, albeit some values are quite common, which influence how it approaches this phase of life. The following discussion offers an analysis of the variant positions they take on the notion of "futility."

A. Judaism

Our discussion begins with Judaism, the oldest of the three Abrahamic religions. In Jewish Law as in English law, a PVS patient is considered alive. The notion of life is defined by an ability to breathe based on the Book of Genesis: "Then the LORD formed a man from the dust of the ground and breathed into his nostrils the *breath of life,* and the man became a living being [17]." The word "breath" is understood as "soul" in this context [18] (p. 694). Therefore, the lack of an ability to breathe is considered to be tantamount to the removal of the soul, given that the removal of the soul is understood to be the definition of death [19] (p. 19-22). In light of this Judaic scriptural understanding, the question remains: if life is based on the ability to function, i.e. to breathe; then if a person's ability to breathe independently or to feed themselves are compromised, to what extent is there a need to provide such a person with treatment and sustenance?

In order to address this question, it is important to note that Orthodox Judaic legal thinking, which this article confines itself to, does not support the concept of "medical futility" nor letting the PVS patient die as being lawful [20] (p. 121). It argues that as long as the brain-stem is still alive, treatment should not be considered entirely futile [21] (p. 1267-1268). This understanding is underpinned by scriptural understandings. The starting scriptural reference point is the Book of Exodus, where it is recorded that killing any individual is forbidden [22]. Further, in accordance with the Book of Genesis: "Whoever sheds human blood, by humans shall their blood be shed; for in the image of God has God made mankind [23]." In light of this verse, the Judaic understanding is that human life is sacred since man is

in the image of God on the grounds that human life is the closest reflection of God [24] (p. 94). Given that human life is sacred, violating something sacred would be contra to Judaic teachings and will have severe consequences.

To the extent that Orthodox Judaism does not support the concept of "medical futility" nor the letting die of PVS patients as being lawful, it also maintains this position in the event of a competition for the same resources. In fact, Jewish Law states that no life is worth more than another [25, 29] (p. 1, p. 278). Therefore, if there is another person who requires the LST equipment, allocation would be based on a first come first served formula. The second person and subsequent people would be considered "pursuers" with not necessarily being primary claimants over resources, in the event of a constraint over resources [26] (p. 203-205). The implication of this is that an individual with a better chance of resumption of consciousness or survival could theoretically be overlooked in treatment, with preference given to an individual with a lesser chance of consciousness recovery or survival. The Jewish law understanding is that preservation of life is paramount, and anyone attempting to remove aid from a PVS patient would be considered as a pursuer and murderer. Indeed, there is a Jewish concept used in civil law, which can also apply here. Namely, if a person can prove ownership of something that is in the possession of someone else, then it can be removed from the second party and lawfully returned to the rightful owner [27] (p. 71). This argument is based on the premise that a court will recognise the right of a person to appropriate property unless conclusive evidence is presented to the court to show that it is the property of the disputant [28]. This analogy can also be applied in this case and the person receiving treatment would be considered as having lawful current possession and holding primary stake over resources.

Notwithstanding the above, one is not allowed to cause an ill person discomfort or pain [29] (p. 279). Therefore, it may also be necessary to provide any person with hydration and nutrition [30] (p. 5). However, if this causes them distress or pain and is only prolonging the dying process, it would be deemed forbidden. No doubt levels of pain would need to be considered with regard to this. The level of discomfort that is required for stopping CANH is one that has the potential to cause a damaging amount of pain [31] (p. 47). This dilemma must be resolved

by the application of an informed judgement undertaken by clinicians, applying their knowledge and experience, then coming to a professional judgement on behalf of the patient. However, clinicians would need to approach such decisions on a case by case scenario and in consultation with Jewish religious leaders [32] (p. 48). The latter equally cannot make the decision without clinical knowledge or consultation with clinicians [32] (p. 48). It would be anticipated from a Rabbi or a decider that a judgement is made after taking into consideration logical thinking, the minutiae of previous rulings (analogical thinking) and from meta-halakhic rulings [33]. It is anticipated that this cognitive clinical process is also creative but firmly underpinned by relevant principles that are related to the meta-halakhic rulings. Further, as mentioned previously, it is forbidden to carry out an intervention that would cause pain or suffering.

It should be noted, though, that there exists a plurality of opinions amongst Jewish legal deciders. There are strands of Judaism that may disagree with the Orthodox view on these issues. The change in opinion is normally governed by variations in extenuating circumstances i.e. there is a text and context relationship.

In essence, the Judaic epistemology is based upon the application of scriptural wisdom and human reasoning. It has a set of higher aims, scriptural references and legal or halakhic processes of legal deduction. It is a structured process that aims to balance medical guidance with faith obligations. There are three key stakeholders in this process: the patient or his family, the team of clinicians (medical experts), and the Rabbi (Jewish law expert).

B. Christianity

Like Judaism, there are many Christian understandings or opinions on the topic. This study only comprises the view of the Church of England. The central point upon which its understanding is based, is how the intrinsic worth of every individual human being is understood. This is highly intertwined with the concept that each human being is created in the image of God in the context of the here and now, and eternity [34]. By extension, all human life is therefore sacred from birth to death [35]. Further, the human body itself is regarded as a sacred temple of the Spirit of God i.e. God's breath is breathed into the human being [36] (p. 99). Given this understanding, since PVS patients

are still breathing whether naturally or with technological assistance, it is accepted that they are alive and are to be treated accordingly [37].

This perspective is further underpinned by the understanding that the aim of all human relations centres around the Christian commandment to love God and to love one's neighbour as oneself [38] (p. 50). However, this can attract a diversity of approaches in pastoral care depending on how those involved interpret the call to love in all circumstances. The pastor may support a decision to allow a patient to die in limited cases, whereas in other situations the pastor may support continued preservation of life, given the possibility of variant understandings of the "call to love" [39] (p. 4). Nevertheless, the service provided to PVS patients and their relatives will be customised to their needs while the general principle (the "call to love") will be the same. The adherents of the Church of England believe that there is a life after this one and an individual needs to hope that there is a better life beyond the suffering and physical incapacity [40]. The merciful or "call to love" approach in such a circumstance would be not to prolong the patient's suffering beyond necessity, as any meaningful life has seemingly ended [41]. Further, at all times, the wishes of the patient would be respected in compliance with the law. The Church of England would support such patients by prioritising the need to respect their dignity. Since the merciful approach would be *not* to prolong patient suffering; in such circumstances all medical, legal and religious considerations would become more patient-centred and be considered for what is in the best interests of the patient [42]. The understanding is that it is better for these to coincide rather than conflict with one another.

The Church of England is therefore comfortable with how the law determines the best interests of the PVS patient [42]. It further argues that it is right and proper to allow the patient to die. As human beings, we have no right to hold on to such patients [42]. However, there is no broad line opinion on what is right and what is wrong in this type of situation [42]. Equally, there is no generic perspective that can be applied for the decision-making process other than the "call to love" complemented with patient-related understanding of the notion of suffering.

This Christian denomination (like other denominations) holds the view that suffering is part of a soul-enrichment process [43] (p. 14).

Humans have to live, it argues, in a challenging and uncertain environment where little is assured, and the enhancement and denial of life, individual prosperity and catastrophe happen almost randomly [43] (p. 11). So, suffering is seen as a test of faith and an opportunity for spiritual growth. The sufferer is not alone. Rather, he is supported by God whilst being in the process of being drawn to Him [44] (p. 145-146).

In the belief that life is fast-approaching an end, appropriate pastoral support is more focused on the holiness of death. Death is viewed as the final healing from the suffering and sorrows of this world [45]. Further, the teachings of Jesus Christ, it is argued, indicate that it is the Will of God that humans take responsibility for their own lives and acknowledge that God gives life and God receives life [46]. The Church of England also considers that as humans, relatives and doctors may not be sure whether the right thing was administered but can be assured that they have made the best decision possible and assign the rest to the Grace of God, with an emphasis on redeeming love rather than Divine Judgement [47]. The belief is that judgement has already been passed and Christians are not judged twice [48]. Given this, Christians are prepared for death as the beginning of a new eternal life. In the final extension, for the Christian in PVS, death leads inevitably to life; eternal life [45].

The post-death situation is approached in a similar manner. Prayers following the patient's death will focus on reconciliation and the long-term peace of the patient in affirming a Godly grace that is already in operation [49] (p. 6-14). Consequently, the patient can move on to the next life and the relatives can move on with the rest of their earthly lives. Therefore, the withdrawing of all medical support from a patient is in line with Christian values or at least Church of England values to allow the person to die.

The Church of England Christian perspective is based upon the Christian commandment of "call to love." The application of this notion can manifest a diversity of approaches to individual cases since the application of this commandment can be customised on a case by case scenario. The outcome of this application is subject to the condition and prognosis of the patient. The approach seems patient-orientated and comprises an asset of values: any suffering should not be prolonged; the wishes of the patient should be respected and illness is

an opportunity for spiritual growth. There are three prominent stakeholders in this process: the patient or his family; the team of clinicians (medical experts), and the pastor (who assists in the application of the "call to love").

C. Islam

In Islam, a key notion that underpins all human life actions is that the main purpose of human creation is the worship of God [50]. Although PVS patients are physically unable to carry out any acts of devotional worship, and also do not even possess the ability to smile, which is in itself an act of virtue [51] (p. 1383), it is believed that their state of being ill is itself a source of Divine mercy and being patient upon this is meritorious and worthy of reward in the Hereafter [52] (p. 395). In light of this belief, such patients are considered alive in Islam and subject to its commands according to their mental and physical states [53].

In Islam, similar to Judaism and Christianity, life *per se* is valuable [54] (p. 95). Therefore, there should always be an ardent attempt to seek a treatment given that the primary goal of medical intervention is the preservation of life [55] (p. 432). Nevertheless, to what extent the sanctity is maintained through the indefinite provision of life support, is a debated issue. This is approached in different ways. A range of issues (e.g. status of seeking medical treatment in Islam, potential outcomes of treatment, condition of the patient, etc.), and a set of variables are considered. The more embracive question with regard to a PVS patient is whether administration of medical treatment is mandatory or less in Islam. This would be adjudicated by Islamic legal consults. In Islamic law, the opinions of the classical Sunni scholars are considered to be authentic and followed across the globe on the proviso that they are not compromising fundamental Islamic principles (i.e. those that contravene the primary scriptures: the Quran and the main Hadith collections) [56] (p. 3-6). There are a number of viewpoints from the classical Sunni schools of Islamic law that range from the "literal" opinion that advocates total reliance on the Will of God and contra behaviour potentially being reprehensible [57] (p. 213), to the majority view of the four established schools of legal thought (Hanafi, Hanbali, Maliki and Shafi'i) who collectively deem it permissible [58] (p. 238), whilst some scholars from the latter three schools advocate treatment as being preferable [1]. This structured approach and thinking is at the

disposal of the family, patient and the scholar to care for their PVS relative. It is very much related to the clinical condition of the PVS patient and takes into consideration practicalities. Each Sunni school of legal thought has an informed position subject to its mode of engagement with the primary sources [59] (p. 1-35; p. 1-8).

The preservation and sustenance of life is the *key* notion for treatment being mandatory [60] (p. 267; p. 965). Where this outcome is not anticipated, the case of medical treatment would be graded as preferable or permissible, subject to the presumption of cure [61] (p. 433; p. 163; p. 530). Members of the Sunni Muslim community of different regions follow different schools of legal thought. Each respects the view of the other schools [62] (p. 2). Whilst it could be difficult for a medic to navigate through the maze of Islamic legal formulations, without a doubt, collaboration between clinicians, scholars, and the family would enrich patient care and comfort.

The generic underpinning is that even when medical intervention is considered futile or even harmful for the body, CANH must be continued, regardless of the futility of the medical treatment [63] (p. 203). This would be maintained up to the point that the harm outweighs the benefit. However, medical intervention can be stopped if the treatment is considered futile for a PVS patient. Omission then becomes necessary and the provision of medical intervention would be understood as significantly compromising the efficient use of resources [64]. This factor would need to be determined by analogical deduction by taking into account past experiences in similar cases, with a view to preserve medical resources for a patient with a better prognosis [65].

Another consideration of the decision-making process is the severity of the illness and the certitude or the probability of intervention efficacy. If the ailment is tolerable with patience and forbearance, then it would not be mandatory to seek treatment. However, if the illness is considered life-threatening or even intolerable, then treatment would be graded accordingly [66] (p. 98), for example:

- Mandatory: if treatment will definitely provide a cure
- Encouraged: if treatment is likely to provide a cure
- Permissible but not encouraged: if treatment may or may not provide a cure
- Necessary: if treatment is considered futile, then omission is necessary

There is nevertheless an argument that treatment and care should never be considered futile [60], i.e. that it may be definitively unknown what the outcome of treatment could be but there should still be an attempt to seek a treatment irrespective of the prognosis. Further, treatment is not considered mandatory for a conscious Muslim patient with diminished capacity who cannot regain accountability. However, this does not negate the permissibility of providing treatment [67] (p. 4).

Notwithstanding the above range of understandings, a non-cognisant person can still gain reward for the afterlife albeit in a vegetative state, as he is still a living individual [68] (p. 180). However, it is argued that reward is the providence of Divine Mercy, it can be manifold and not just a source of recompense [69]. In Islam, death is seen as a bridge to the Hereafter, and a natural journey to the eternal next life. The time of death has been Divinely fixed [70]. In this light, medical intervention or the lack of it should be understood as the Will of God. In essence, the opinions consider notions of *Taklif* (i.e. accountability) or *Hurma* (i.e. sanctity) [70]. The basis of the decision would be on the efficacy of treatment and severity of illness, and by extension perhaps on putting a value on life in regards to PVS.

In Islam, any discussion with regard to the care of the PVS patient must consider a set of concepts as part of a decision-making process. This includes a consideration of the concept of sanctity of human life, the concept of seeking treatment for illness, the concept of the human as a trustee of his body, and the definition of death and its determinants. The consideration of these values can greatly assist to determine the nature of treatment and care a PVS patient could be administered. The nature of such concepts implies that any determination of treatment would be considered on a case by case basis where medical views and Islamic scholarship views would need to be balanced. Further, it should be a collaborative exercise in order to minimise error [71] (p. 187-188). Ultimately, the wish of the patient and the family is that the patient dies honouring the faith. Islamic law has several precepts in any given scenario to facilitate this. It does not acknowledge that a PVS patient has clinically died but does have a range of tools to balance clinical medical care and costs, and patient welfare and spiritual care.

IV. Conclusion

The discussions regarding patients in a PVS are inextricably linked to the following question: is the patient to be considered alive or not? The three Abrahamic faiths share with English law the view that PVS patients are still alive. There is nevertheless, as explored above, a variation in the approach religions advocate for the withdrawal of LST. Further, even in situations where they believe that LST could or should be withdrawn, they are in agreement that CANH should be continued, and not stopped unless this is causing pain and suffering. Abrahamic Faith scholarship and followership represent understandings and practices that manifest a diverse range of scriptural interpretations and devotional practices that are all based on human engagement with revelation and post-revelation literature across time and space. It represents an effort to be loyal to faith whilst dying and being on the journey of meeting one's Creator. This diversity also demonstrates an effort to be loyal to scripture and to respective schools of interpretation. These two diachronic and synchronic principles represent the epistemology of the Abrahamic Faiths in determining a decision. They are applied to varying degrees across the Abrahamic Faiths to balance the spiritual and the temporal aspects with a view to provide religious-specific spiritual comfort for the patient. Abrahamic Faith scholarship has in broad terms considered faith values, medical assessment, and resources. They equally hold common perspectives and concerns which although diverge, are still subject to the patient's condition.

The implications of such a broad common perspective, albeit in principle rather than in detail, are that with a sizeable proportion of the UK population belonging to these faith groups [72], it is important that religious values on this issue be accommodated, as part of the medico-legal decision-making process. But as healthcare in the UK is publicly funded, the findings give rise to two other questions which merit further reflection. One, how could these faith-based values be synthesised and accommodated within the secular legal framework? Two, how should the potentially disproportionate use of resources such an accommodation may entail be addressed, seeing as public health resources are finite? Should it still be funded by the National Health Service (NHS) in furtherance of the equality and diversity agenda [73]? Or should it be financed by the faith communities themselves, the

patient or the patient's family? Or will the advancement of technology have an impact on faith understandings? These questions require public debate.

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