We are used to special interest groups requesting increased support, and we interpret such requests accordingly. However, to promote one intervention on ethical grounds must surely impose an ethical responsibility to consider the ramifications on others. This aspect seems to have been neglected in Weijer's analysis.

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Dr. Weijer argues eruditely for CPR when demanded by families as a matter of cultural and religious conscience. The force of his argument derives from his assertion that this is a contest of values between physicians who hold that such life is not worth living and family members who believe in its sanctity and require that all means be used to prolong it. While such conceptualization of a battle of beliefs may be forceful, it casts doubt on physicians' respect for life and advances a faulty construction of the rationale and motive supporting do-not-resuscitate (DNR) orders in such cases.

In Weijer's editorial, beneficence is correctly understood to be patient focused, subject to independent, verifiable clinical judgement and common sense, and applicable to a patient conceived as an intellectual, social and spiritual — and not merely physical — being. A patient irretrievably incapable of experience, such as a person in a PVS, cannot benefit. Just as the incapacity for conscious experience removes any burden of suffering that would proscribe CPR, so too it removes any hope of benefit that would prescribe it. Such patients are beyond benefit. Their physical existence is a necessary but insufficient ground for CPR. Prolonging unconscious life through aggressive medical treatment could be considered one definition of "bad medicine."

As physicians, we do not seek to judge the worth of a life but to judge all life worthy. Rather than the "smuggling in" of the premise that "a permanently unconscious life is not worth preserving," DNR orders in cases of PVS respectfully and ethically reflect a clear commitment to medicine's time-honoured mandate to mend and a humble understanding of its limitations. This is the wisdom behind the joint statement's position on DNR in cases involving a PVS.

Bruce W. Jespersen, MD
Calgary, Alta.

Dr. Weijer argues reasonably for accepting a family's refusal of a DNR order because of strong religious beliefs about the sanctity of life and therefore about the value of preserving the life of a family member even if that person is permanently unconscious. He argues that the joint statement[1] is "neither ethically nor legally defensible" and "ought to be amended," since treatment of a patient in a PVS is considered "futile" and, according to the joint statement, the patient would be "unable to experience any benefit."

An alternative view would be that the joint statement is valid, but, in the absence of outcome probabilities, it must be interpreted together with the patient's and the family's values. If the case is interpreted by hospital staff who understand and defend the values of the patient and the family, not their own personal values, the case would not be considered futile. The patient would be considered to experience benefit because in this value system an unconscious life is worth preserving.

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Reference

1. Joint statement on resuscitative interventions (update 1995). *CMAJ* 1995;153(11):1652A-C.

Two of the major issues addressed in this editorial are worth amplifying. The first is the concept of whether a life is worth living. We must never accept the concept that *any* life is not worth living. Once we do, we are on a slippery slope. There is very little difference between someone who is in a vegetative state for 2 years and someone who is in a vegetative state for 2 years less a day. Once the principle of the sanctity of human life is ignored, there may be no stopping the trend: the religion of death becomes accepted.

The second issue concerns the controversy surrounding euthanasia, exemplified in the editorial by the example of an Orthodox Jew who believes in God. Human beings are not only body and soul, but also spirit. Unless this conceptualization is accepted we will never understand that even for someone in a PVS, the spirit still exists. We do not know whether or not such a person is receiving input through some of the senses. There have been reports of patients later able to describe in detail every word spoken in their presence while they were in a comatose state. Let us not play God. Let us maintain our traditional values and concepts. These values work.

William D. Gutowski, MD
Chilliwack, BC

[The author responds]:

Patients and their families should be neither offered nor allowed to demand CPR in all situations. Empirical work has identified circumstances in which CPR cannot restore cardiopulmonary function.[1] CPR may be withheld legitimately in such cases, and without the need to invoke the notion of medical futility, because

it falls outside the standard of care for cardiac arrest.[2] The patient in a PVS illustrates well the problem of medical futility. For these patients, the issue is not whether CPR is effective but rather whether the life is worth preserving. In my editorial, I argue that the joint statement[3] errs in allowing a physician to override the religious or cultural beliefs of the patient and her family and to unilaterally withhold CPR from a patient in a PVS. Through my own work as a clinical bioethicist, I am aware of physicians and hospitals that have interpreted the joint statement as allowing such unilateral action. If, as the CMA Committee on Ethics claims, my criticism is based on a "serious misinterpretation," then they must agree that these physicians and hospitals are acting immorally. I am sorry they did not take the opportunity to state this more clearly.

When Dr. Turnbull wonders who will bear the cost of providing CPR to patients in a PVS, he confuses 2 logically distinct issues: futile treatments, by definition, ought not be provided even if there is a surplus of resources.[4] In addition, resource allocation calls for an entirely different process than determination of futility, including an examination of cost-effectiveness data — he provides none — and community consultation. In the absence of such a process, a physician risks legal sanction if she denies available treatment to a patient on grounds of cost containment.[5]

Dr. Jespersen does not think the provision of CPR to a patient in a PVS is consistent with the primary goal of medicine, which is to provide benefit for the patient. Since a patient in a PVS is "irretrievably incapable of experience," she cannot experience benefit from CPR and, hence, it is "bad medicine" to provide it. But even if one accepts the premises of his argument — and I do not — the argument applies equally to all treatment, not just CPR. Thus, it would be just as unethical for a physician to provide a patient in a PVS with fluids by intravenous line or food through a feeding tube as it would be to provide CPR. If this is, as I suspect, inconsistent with the moral intuitions of physicians, then a new moral justification for withholding CPR from all patients in a PVS must be sought.

I am grateful for the support offered in the letters of Drs. Walker and Gutowski. Respect for the religious and cultural beliefs of our patients and their families is an indispensable part of good medicine.

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2. Weijer C, Elliott C. Pulling the plug on futility. *BMJ* 1995;310:683-4.
3. Joint statement on resuscitative interventions (update 1995). *CMAJ* 1995;153(11): 1652A-C.
4. Jecker NS. Futility and rationing. *Am J Med* 1992;92:189-96.
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CMAJ index

The index for volume 158 (January–June 1998) of *CMAJ* will be mailed with the **Sept. 22** issue to paid subscribers and to CMA members who have requested it from the CMA Member Service Centre. Others may order single copies for $15 (within Canada; add 7% GST/15% HST as applicable) or US$15 (outside Canada).

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Thucydides' syndrome

The disease described by Dr. John Hoey in his article "Anthrax" (*CMAJ* 1998;158[5]:633) is indeed an old disease, appearing in chapter 9 of Exodus as the fifth and sixth plagues of Egypt and in Virgil's third Georgic as the murrain of Noricum.[1]

Epidemic inhalational anthrax on a scale unknown before or since may well have been the cause of one of medical history's greatest conundrums, the plague of Athens, also known as Thucydides' syndrome, a serious infectious disease that ravaged the Athenians during the Peloponnesian war between 430 and 427 BC.[2] Surprisingly, even though Thucydides left an excellent description of the disease's epidemiology and clinical features,[3] there has never been