

**What Is Man, That The Judges Are Mindful Of Him?:  
Lessons From The PVS Cases**

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**INTRODUCTION**

“What is man, that thou are mindful of him?”, asked the Psalmist<sup>i</sup>. And the same question should be asked whenever judges ponder whether or not the life of a medically compromised patient should be ended. The classic situation in which this issue arises is on an application to withdraw feeding and nutrition from a patient in persistent vegetative state (“PVS”).

If the diagnosis of PVS is right, said the House of Lords in *Airedale NHS Trust v Bland*<sup>ii</sup>, treatment is, by definition, futile. Not only do doctors have no duty to undertake futile treatment, they have a duty not to undertake treatment unless it is in the best interests of the patient, and where there is PVS it is, as a matter of law, not in the best interests of the patient to continue feeding and hydration. Accordingly it is lawful and, probably, mandatory, to bring about that patient’s death. In coming to this conclusion, English judges and those in other jurisdictions have inevitably said something (although it generally has to be read between the lines of their judgments), about what they think the essence of a human being is. Sometimes these thoughts are presumptions: sometimes they are reasoned conclusions. But whatever they are, they impinge significantly, but less demonstrably, on most other areas of judicial activity. It is important to identify them. Most judges think that they have a well-reasoned set of jurisprudential fundamentals. But there is nothing more fundamental than what one thinks man, the only real subject of judicial activity, is. There is an alarming poverty of judicial thought about that. The PVS cases show judicial philosophy in the raw, stripped of all the devices which usually allow judges to hide their emotional and theological colours. It may be that some of our forensic emperors have no clothes.

All judges say that they believe in the “sanctity” of human life.<sup>iii</sup> Although it is reassuring that they say this, it is an easy thing to say. It is less easy to say what the expression means. The judges have been more coy about that. This article examines the four possible meanings of the expression which emerge from PVS cases, and comments on how intellectually consistent the judges who have

embraced each meaning have been. It concentrates on decisions of the English courts. But first, some context is necessary.

### **WHAT IS PVS?**

PVS is a state in which there is generally extensive damage to the cerebral neocortex. The brain stem, which is responsible for the vegetative functions such as respiratory movement and the regulation of heart rate and rhythm, is more or less intact. Patients therefore breathe spontaneously, have normally functioning hearts, and require no support other than nursing care (turning, toileting etc), feeding and the provision of fluids. Feeding and hydration are generally done through nasogastric tubes, intravenous lines or stomas going directly into the stomach.

The neocortex is responsible for most of the “higher” functions of human beings. When it is destroyed: “Personality, memory, purposive action, social interaction, sentience, thought, and even emotional states are gone. Only vegetative functions and reflexes persist.”<sup>iv</sup> Dame Elizabeth Butler-Sloss P found it helpful to think of the state as one in which there was no “evidence of a working mind.”<sup>v</sup>

Diagnosis is difficult and controversial. There are a number of different codes embodying slightly different diagnostic criteria<sup>vi</sup> The failure of some patients to fit neatly into the diagnostic boxes has created problems for the courts.<sup>vii</sup>

Perhaps most definitively, properly diagnosed PVS patients do not have any potential to do anything except age, get ill, and die.

Caring for a patient with PVS, either as a family member or friend or as a professional carer, is inevitably harrowing. Some family members feel that the patient is already, for all practical purposes, dead, but that they cannot grieve properly. Some, conversely, feel that the essence of the person is still present, and make faithful journeys to the patient’s bedside each day, or indeed care for the patient at home. Some PVS patients are, although they may not be able to realize it, the hub of their communities.

To a large extent, PVS is a creature of medical technology. It generally occurs in people who have been heroically resuscitated. Although no advanced technology is necessary to allow PVS patients to survive in PVS, in a less technologically advanced age, most of them would have died before they entered PVS.

When nutrition and hydration are withdrawn, the patient will generally die within about 14 days. It is not a nice process to watch or to think about, but all the authorities are agreed that the patient is not in pain.

### **WHAT IS MEANT BY THE SANCTITY OF HUMAN LIFE? THE FOUR VIEWS**

Broadly, four entirely different meanings of the expression “the sanctity of life” can be detected in the authorities. They are as follows: First, that any human who is biologically alive is sacred. Second, that there is no magic in biological life per se: what is sacrosanct is the conglomeration of those characteristics of human life which constitute the quintessence of a human being. Third: it is not human life itself which is to be revered, but the rights which a human being possesses by reason of his humanity. And fourth: it is not the individual, or his characteristics, or his rights which are sanctified, but his status as a member of the wider community.

These propositions are examined in turn.

### **PROPOSITION (1): IT IS BIOLOGICAL LIFE THAT IS SANCTIFIED**

In English law, PVS patients are alive. In *Bland* Lord Goff said:

*I start with the simple fact that, in law, Anthony is still alive. It is true that his condition is such that it can be described as a living death, but he is nonetheless still alive....The evidence is that [his] brain stem is still alive and functioning and it follows that, in the present state of medical science, he is still alive and should be so regarded as a matter of law.*<sup>xviii</sup>

The criterion of brain stem death has been applied to define death in all the cases.<sup>ix, x</sup>

Because PVS patients are alive they have (or at least the judges say that they have) all the legal rights of anyone else, including the right to life embodied in Article 2 of the European Convention on Human Rights (ECHR)<sup>xi</sup>, but they can still be starved to death. They have, it might be said, nothing but biological life, and that can be, and indeed arguably must be, taken away. It seems, then, that in English law, the essence of a man is not regarded as identical with, or even significantly co-extensive, with, the biological fact of his existence.

The position is more or less the same in other common law jurisdictions.<sup>xii</sup> Cases sometimes cited as exceptions tend not to be true exceptions at all.<sup>xiii</sup>

### **PROPOSITION (2): IT IS VARIOUS CHARACTERISTICS OF HUMAN LIFE THAT ARE SANCTIFIED**

Judges have often expressed themselves in ways which suggest that this is what they mean by the sanctity of life. Indeed it could be said that the ratio of *Bland* was that the faculties possessed by PVS patients are not faculties which the court thinks are sufficiently characteristically constitutive of human beings for it to be supposed that the patient would want to continue to possess them. The

assumption is that there is that there is a bare minimum of faculties which need to be present in order for a person (a) to continue to be properly human, or (b) have an interest in continued existence, or (c) deserve the full protection of the law. The cases have generally expressed themselves in terms similar to (b), but only for reasons of taste<sup>xiv</sup>.

The faculties which PVS takes away have been noted above. One could cite ad nauseam the comments of the judges of the world about the significance of the absence of those faculties. They are broadly agreed that consciousness, with all its corollaries (the capacity for self-awareness, for pain, pleasure and relationship) are necessary defining characteristics of humanity and therefore necessary for continued worthwhile human existence. Two forthright but typical examples, both from *Bland*, make the point:

*Anthony Bland cannot see, hear or feel anything. He cannot communicate in any way. The consciousness which is the essential feature of individual personality has departed for ever.*<sup>xv</sup>

*The parts of [Bland's] brain which provided him with consciousness have turned to fluid. The darkness and oblivion which descended at Hillsborough will never depart. His body is alive, but he has no life in the sense that even the most pitifully handicapped but conscious human being has a life.....The continuation of artificial sustenance and medical treatment will keep him alive but will not restore him to having a life in any sense at all....We all know and admire people who suffer pain and disability, of whom many would think that in their position they would rather be dead, and yet who endure their lives and derive meaning and satisfaction from living. But the very concept of having a life has no meaning in relation to Anthony Bland. He is alive, but has no life at all....There is no question of his life being worth living or not worth living, because the stark reality is that Anthony Bland is not living a life at all. None of the things that one says about the way people live their lives - well or ill, with courage or fortitude, happily or sadly - have any meaning in relation to him.*<sup>xvi</sup>

Because the spectre of misdiagnosis is so appalling, all judgments emphasise the importance of the permanence of the condition. In doing so they highlight another human characteristic: potential - the capacity to move from one state to another. But it is a limited class of translations between states which is valued. Bland, for example, did have the capacity to change from being a young man to an old man, or from being a poor man to a rich man. The changes which are valued are evidently those changes which are either willed or capable of being appreciated by the subject.

The capacity for relationship (which is implicit in the capacity for communication), is also repeatedly emphasised as important. Anthony Bland, however, was involved in plenty of relationships: he was loved and valued by his family and

carers, for example, (although it might be countered that the quality of those relationships was not dependent on the continued physical existence of his body). It does seem as if what was really valued was not Bland's capacity for relationship, but his ability to perceive that he was in relationship. Awareness – and particularly its apotheosis, self-awareness - is again the real defining characteristic of humanity identified and rated as important by the judges.<sup>xvii</sup>

What we seem to have here is a definition of humanity (or worthwhile human existence - they come to the same thing) in terms of function. The cells in Anthony Bland's cerebral cortex did not function properly. That malfunction effectively disqualified him from sufficient identification with other humans, or sufficient participation in the human enterprise, for the support mechanisms which kept him vegetatively alive to be worth maintaining. Either Bland's intrinsic human worth resided in his cortex, and died with it, or he had no intrinsic human worth which it was imperative to maintain<sup>xviii</sup>.

### **PROPOSITION (3): IT IS THE RIGHTS WHICH A HUMAN BEING POSSESSES THAT ARE SANCTIFIED**

This is a popular way of looking at the issue. It seems that for most judges, the important thing is not to refrain from destroying a life, but to refrain from infringing a right which the patient in question has. This analysis defines human beings as bundles of rights. It is a view which has a high regard for the law (human rights are, after all, artificial legal creatures), but a low or no view of humanity itself.

The proposition is philosophically unsatisfactory: It begs the question of whether a human being is a human being because he has rights, or whether he has rights because he is a human being.

Rights are posited on the existence of interests, and are their corollaries. In *Bland*, most of the judges thought that Tony Bland did have interests, and indeed said that the important question was not whether it was in his best interests of the patient to die but whether it was in his best interests to continue life-prolonging treatment<sup>xix</sup>. Hoffmann LJ thought that Bland had a positive interest in his life being terminated, saying that “.....*Counsel.....offers a seriously incomplete picture of Anthony Bland's interests when he confines them to animal feelings of pain or pleasure. It is demeaning to the human spirit to say that, being unconscious, he can have no interest in his personal privacy and dignity, in how he lives or dies....*”<sup>xx</sup> It was a fallacy, he said, to assume that humans have no interests except in those things which they have the capacity to experience. One could have an interest in how one's property was distributed after one's death, for example, or in the dignity with which one's unconscious body died, or in respect being paid to what are most likely to have been one's own views on the cessation of treatment.<sup>xxi,xxii</sup> ..

Only Lord Mustill said that it was a nonsense to speak of Bland having any interests at all. After noting the arguments that Tony Bland's interest in maintaining his personal dignity was being infringed by continued treatments, and that his interest in being remembered well by his family was being compromised by his family having to see him in distressing circumstances, he said that it was:

*...stretching the concept of personal rights beyond breaking point to say that Anthony Bland has an interest in ending these sources of others' distress. Unlike the conscious patient he does not know what is happening to his body, and cannot be affronted by it; he does not know of his family's continuing sorrow. By ending his life the doctors will not relieve him of a burden become intolerable, for others carry the burden and he has none. What other considerations could make it better for him to die now rather than later? None that we can measure, for of death we know nothing. The distressing truth which must not be shirked is that the proposed conduct is not in the best interests of Anthony Bland, for he has no best interests of any kind.*"<sup>xxiii, xxiv</sup>

All the judges approached the question of whether treatment should be continued as a balancing exercise - balancing Tony Bland's interests in treatment against his interests in non-treatment. Lord Mustill was forthright: for him the balancing exercise was easy, because there was nothing at all to put in the pan on the side of continuing treatment. But did the others judges really think that there was anything to put in that pan? If they did, it is difficult to see what it was.

Whatever it means to be human, there was no doubt that stopping treatment would lead to Tony Bland ceasing to be human (if he had not already lost all quintessential human faculties) except insofar as the essence of human existence consists in existence in the memories of others. Yet for most of the judges to cease to exist (and therefore to cease to be human) was better for him than continuing to exist in the condition that he would otherwise have continued to exist in. For Lord Mustill it was meaningless to make assertions like that. The majority view was that an ability to exist in a state in which certain interests (broadly the interest in maintaining one's own dignity) can be protected, is so central to the definition of human life that when the ability is removed life has either come to an end or can be brought to an end<sup>xxv, xxvi</sup>.

Some of this is flatly contradicted by *An NHS Trust v M*<sup>xxvii, xxviii</sup>. The contradiction is ironic: Dame Butler-Sloss P evidently thought that she was saving *Bland* from the potential deprivations of the European Convention on Human Rights. But her judgment essentially said that the only right possessed by a PVS patient was the right not to be killed by active criminality. Put another way, the only interest possessed by such a patient was an interest in not being murdered by a commission. She thought, therefore, that PVS patients possessed less than the judges in *Bland* thought they possessed. She thought that there was less to reverse. Although the reasoning in *M* is confusing, it is unsurprising that Butler-

Sloss P decided, like the court in *Bland*, that it was justifiable to deprive such patients of their biological life.

She held that in a PVS case, Article 3 of the ECHR was not engaged. Article 3 provides that “No one shall be subjected to torture or to inhuman or degrading treatment.” The NHS Trusts concerned had submitted that Article 3 could be invoked to protect a PVS patient’s right to die with dignity, and that it was degrading to enforce the continuation of life in the circumstances of PVS. It was submitted against them, on behalf of the patients, that for treatment to be degrading in an Article 3 sense the patient had to be aware of the treatment (and presumably at least its degrading nature, if not feel actually degraded by it), and further that administration of medical treatment in good faith is unlikely to be a violation of Article 3.<sup>xxxix</sup>

Butler-Sloss P appeared to accept both of the patients’ submissions, although her acceptance of the “good faith means no Article 3 breach” argument was rather mistily equivocal. In relation to the requirement of awareness, she said:

*I am.....satisfied that Article 3 requires the victim to be aware of the inhuman and degrading treatment which he or she is experiencing or at least to be in a state of physical or mental suffering. An insensate patient suffering from [PVS] has no feelings and no comprehension of the treatment accorded to him or her. Article 3 does not in my judgment apply to these two cases...*<sup>xxx</sup>

There was a blistering dissent from this position by Munby J in *R v General Medical Council ex p Burke*<sup>xxxix</sup>. He thought that Article 3 would be engaged. Probably Strasbourg would be on his side<sup>xxxix</sup>. The point for present purposes is that these patients were being bothered about by the lawyers primarily because of the rights which they may or may not have had.

Article 8 (“Everyone has the right to respect for his private and family life, his home and correspondence”) protects “the right to personal autonomy, otherwise described as the right to physical and bodily integrity”<sup>xxxix</sup>, but, per Butler-Sloss P, does not, in the case of PVS patients, confer a right independent of the patients’ Article 2 right. Its primary value in such cases is not as a guarantor of a fundamental right, but as a canon of construction:

*....[Counsel for the Trust] suggested that Article 8 may be in conflict with Article 2 and is to be balanced against Article 2. I prefer however the submission of [Counsel for the patients] that, in seeking to determine the scope of the positive obligation in Article 2, assistance can be derived from the provisions of Article 8....*<sup>xxxix</sup>

It is true that she did say that “....the fundamental principle....that every person’s body is inviolate”<sup>xxxix</sup> was also to be found in Article 8<sup>xxxix</sup>, but treated this principle as subsumed invisibly into Article 2.

Thus Article 3 gives PVS patients nothing (if Butler-Sloss P's view prevails over that of Munby J), and Article 8 gives them nothing meaningful. In terms of an ECHR analysis, then (and it was not suggested in *M* that any other analysis would give patients anything else), the only right such patients possess is an Article 2 right. And that right is the most technical and least comforting of possessions.

Article 2, the "Right to life", states:

"1. *Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law....*"

Butler-Sloss P considered that the intention of withdrawal of treatment from a PVS patient was to bring about the patient's death or to shorten his life,<sup>xxxvii</sup> but that the phrase "deprivation of life":

*... must import a deliberate act, as opposed to an omission, by someone acting on behalf of the state, which results in death. A responsible decision by a medical team not to provide treatment....could not amount to intentional deprivation of life by the state. Such a decision based on clinical judgment is an omission to act. The death of the patient is the result of the illness or injury from which he suffered and that cannot be described as a deprivation....*<sup>xxxviii</sup>

This is the straightforward act/omission distinction which underlies *Bland*. It is open to many criticisms, but for present purposes it is enough to note rhetorically that whatever the right to life means in the context of a PVS patient, it does not mean the right not to be starved out of one's biological life. However it is wrapped up, a PVS patient has no meaningful Article 2 right except a right not to be killed by a medical or external act done with the intention of killing (or, presumably, causing grievous bodily harm). That, implied Butler-Sloss P, falls beneath the threshold criteria which have to be satisfied if life is to be considered worth preserving.

#### **PROPOSITION (4): IT IS THE HUMAN BEING'S STATUS AS A MEMBER OF THE COMMUNITY THAT IS SANCTIFIED**

It might often seem as if PVS is the ultimate isolation - a sort of permanent exile from all senses, and, because senses are generally perceived as necessary to participate in community, from community itself. But even PVS patients are not islands unto themselves. Quite apart from the rights flowing from their persisting status as legally human beings which have been discussed above, they continue to have the capacity to affect others in a number of respects.

The courts have been influenced by arguments which assume that the life of a PVS patient (or anyone else) is conditionally sanctified. Such a life is regarded as sacrosanct as long as, rationally balanced, its continuation is in the overall interests of the community. This is pure utilitarianism.

Two main arguments have been deployed:

**I. ARGUMENT (1): PVS PATIENTS CONSUME RESOURCES WHICH COULD OTHERWISE HELP OTHER PATIENTS. TO MAINTAIN A PVS PATIENT MIGHT THEREFORE BE TO KILL OTHER PATIENTS.**

The courts have been slow to acknowledge that financial considerations might be legitimately relevant to clinical decision making. It is not difficult to understand why. The rhetoric which says that doctors, not hospital accountants, should decide how treatment should be deployed has an obvious appeal. But of course if that argument is accepted it does not mean that finances are irrelevant: it simply means that the burden of deciding how resources should be allocated rests with clinicians rather than accountants. The English law has given little help as to the principles which should underlie decisions about resource allocation. It has been argued strenuously that a doctor who takes money into consideration takes an irrelevant criterion into consideration and has therefore made a decision in a reviewably defective way<sup>xxix</sup>. Arguments can and have been mounted that there is an absolute statutory duty to give the treatment which is the patient's best interests (under the National Health Services Acts), and an absolute duty under ECHR Article 2, and that the language of absolutism necessarily outlaws economic considerations. But that is not the real world. Demands for healthcare in patients' best interests are theoretically infinite: national healthcare budgets are not, and it is not unreasonable not to have an infinite healthcare budget. That was what the Court of Appeal finally said<sup>xi</sup>. But the courts have said little more. They tend to approach questions about funding (whether those questions are raised in a private or a public law context) wielding two analytically complementary tools: the private law *Bolam* test<sup>xii</sup> (which says that a doctor will not be negligent if what he has done would be endorsed by a responsible body of medical opinion in the relevant specialty) and the public law *Wednesbury* test<sup>xiii</sup> (which says that a decision will not be struck down unless it is frankly irrational).

In *Bland*, Lord Browne-Wilkinson said that "it is not legitimate for a judge in reaching a view as to what is for the benefit of the one individual whose life is in issue to take into account the wider practical issues as to allocation of limited financial resources or the impact on third parties of altering the time at which death occurs."<sup>xiiii</sup> It does not follow from this that questions of resource allocation are irrelevant to the question of whether treatment should be continued, unless one concludes that the narrow ratio of *Bland* is that the "best interests" test, determined by reference to the *Bolam* principle, is determinative of the legality of continued treatment. Lord Browne-Wilkinson himself did not seem to think that the ratio was this narrow, and was probably just cautioning against using economic criteria to help solve novel, ethically explosive questions.

Lord Mustill thought that the point about resource allocation, and other effects on third parties, was properly the business of Parliament. He said:

*Threaded through the technical arguments addressed to the House were the strands of a much wider position, that it is in the best interests of the community at large that Anthony Bland's life should now end. The doctors have done all they can. Nothing will be gained by going on and much will be lost....The large resources of skill, labour and money now being devoted to Anthony Bland might in the opinion of many be more fruitfully employed in improving the condition of other patients, who if treated may have useful, healthy and enjoyable lives for years to come.*

*This argument was never squarely put, although hinted at from time to time. In social terms it has great force, and it will have to be faced in the end. But this is not a task which the courts can possibly undertake. A social cost-benefit analysis of this kind, which would have to embrace "mercy killing" to which exactly the same considerations apply, must be for Parliament alone, and the outcome of it is at present quite impossible to foresee.<sup>xliv</sup>*

**II. ARGUMENT (2): A PVS PATIENT IS INVOLVED IN EMOTIONAL RELATIONSHIPS WITH OTHER PEOPLE. SINCE THE PATIENT HAS NO INTERESTS, HIS FUTURE SHOULD BE DECIDED BY CONSIDERING THE IMPACT OF HIS SURVIVAL ON THOSE OTHER PEOPLE.**

Although denuded of the ability to feel, the potential to develop, and many of the rights which the law recognises more competent people as possessing, the biological extinction or continued survival of a PVS patient matters to people other than the patient. Obvious examples are the patient's family (who might profoundly wish the patient to be allowed to die) and the clinical staff caring for the patient (who may have established a real relationship, however unilateral, with the patient, and who would be very distressed by the patient's death).

The common law, however, in its desire not to be seen to be acting in the interests of anyone but the patient, has given the interests of others little consideration. This includes the effect on carers etc of his death. A good example is *NHS Trust A v M* where Butler-Sloss P was urged to take into account under Article 8 the views and feelings of the patients' families. She said:

*[Those views and feelings] are, of course, important considerations for the hospitals treating these patients to take into account. It is not necessary for me in the present cases to come to a conclusion [as to] whether the wishes and feelings of the families form part of the patient's right to respect for family life under Article 8 in situations where the patient is insensate. If they are relevant they cannot outweigh any positive obligation on the state to maintain the patient's life. I rather doubt that the families*

*have rights under Article 8 separate from the rights of the patient, but a decision on that issue also is not a necessary part of my overall decision.*<sup>xlv, xlvii</sup>

These observations on families' Article 8 rights are highly dubious. Probably those rights are at least engaged. It is difficult to imagine anything which interferes more obviously with A's enjoyment of his family life with B than the death of B<sup>xlviii</sup>. This issue will no doubt be fully argued soon<sup>xlviii</sup>.

The codes of the various clinical professional organisations unsurprisingly insist that it is good practice to consult with relatives about any decision to withdraw treatment.<sup>xlix</sup> Anything else would be old-fashioned medical paternalism of an extreme kind. Probably the English courts will grope towards a pragmatic compromise: they will acknowledge that relatives have an Article 8 right to be consulted about treatment options, and indeed other Article 8 rights engaged in any decision about treatment which might affect the survival of the patient.

## **SUMMARY**

PVS cases force judges to be philosophers. They force them to say what they think human beings really are. All judges say that they believe in the sanctity of human life, and tend, unhelpfully, to define human life as that which is sanctified. What they mean by 'sanctity' emerges mistily in their judgments. Four views emerge: (1) That biological human life is sacred. (2) That what is sacred is the bundle of human characteristics which, if possessed, allows a being to be described as human. (3) That what are sacred are the rights that the law says a human possesses. (4) That what is sacred is the human's status as a member of the human community - with the implication that inability to participate in that community means loss of the status. There are obvious circularities in these definitions. This paper examines the way in which those four views govern judicial thinking, and notes that, judges being human themselves, there is a high degree of incoherence and inconsistency.

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i. Psalm 8 v 4 (AV)

ii. [1993] AC 789

iii. See, eg Lord Goff in *Bland* at 864: “To this extent, the principle of the sanctity of human life must yield to the principle of self-determination” (citing Hoffmann LJ in the Court of Appeal at pp. 826-827); Lord Browne-Wilkinson in *Bland* at 878: “What is meant now by “life” in the moral precept which requires respect for the sanctity of human life?” Taylor LJ in *Re J (a minor) (wardship: medical treatment)* [1991] Fam 33 at 52: “...the court’s high respect for the sanctity of human life imposes a strong presumption in favour of taking all steps capable of preserving it, save in exceptional circumstances....” It is accepted that simply to say that something (eg sentience) is relevant to a decision about withdrawal of treatment does not necessarily mean that (eg) sentience is being equated with the sanctity of life. But in fact an equation of each of the four listed characteristics with sanctity does emerge from the judgments.

iv. President’s Commission, *Deciding to forego*, 174-175

v. *NHS Trust A v H* [2001] 2 FLR 501 at 504

vi. *International working party report on the vegetative state*: Working Group of the Royal College of Physicians. London: Royal Hospital for Neurodisability, 1996. *The permanent vegetative state*. J.R. Coll Phys 1996; 30: 119-121 and addendum: 1997: 31: 260: MultiSociety Task Force on PVS. *Medical aspects of the persistent vegetative state*: Part 1: N. Engl J Med. 1994; 330: 1499-1507: Part 2: 330: 1572-1579; D.T. Wade and C. Johnston *The permanent vegetative state: practical guidance on diagnosis and management*. BMJ 1999: 841-844.

vii. Eg *Re D* (1997) 38 BMLR 1: [2001] 2 FLR 501.

viii. At 863

ix. All the judges in *Bland* agreed that Tony Bland was alive. Their conclusion was recently reconsidered and applied by Dame Elizabeth Butler-Sloss P in *An NHS Trust v M: An NHS Trust v H* [2001] 2 FLR 367 at 373.

x. It has been argued by some philosophers that permanently unconscious patients are really dead, because life consists in personhood and personhood consists in or necessarily involves consciousness: see, for example, R.M.Veatch, *The whole-brain-oriented concept of death: an outmoded philosophical foundation*. J. Thanatol. 1975; 3: 13-30 and K.G.Gervais *Redefining death*: New Haven, Yale University Press, 1997. Cited and discussed further in Jennett, B, *The Vegetative State*, Cambridge, Cambridge University Press, 2002: 81-82. This approach has not attracted the judges, and there are obvious practical and theoretical difficulties with it.

xi. See *An NHS Trust v M: An NHS Trust v H*, supra.

xii. Eg Scotland: *Law Hospital NHS Trust v Lord Advocate* [1996] 2 FLR 407: USA: *Finn v Governor of the Commonwealth of Virginia*, 527 SE 2d 426; New Zealand: *Auckland Area Health Board v Attorney General* [1993] 1 NZLR 235; South Africa: *Clarke v Hurst* [1994] 5 Med LR 177 : Canada: *Nancy B v Hotel-Dieu de Quebec* (1992) 86 DLR (4<sup>th</sup>) 385: Ireland *Re Ward of Court* [1995] 2 IRLM 901.

xiii. Eg *Cruzan v Director, Missouri Department of Health* (1990) 110 S.Ct. 2841, which is simply US Supreme Court authority for the proposition that it was not constitutionally offensive for Missouri to require clear and convincing evidence that a PVS patient would have wanted treatment to be discontinued, before discontinuing it.

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xiv. It is probably reasons of taste, too, which have inhibited judges from resorting to the philosophical language, beloved of Singer, Glover and Harris, of “persons” and “non-persons”.

xv. Per Lord Keith at 856

xvi. Per Hoffmann LJ at 825, 828 and 829

xvii. The judges’ talk about the capacity for relationship is curious. Philosophically it is something of a red herring. If there is no consciousness any relationship must be unilateral. A car has no consciousness but yet can be loved. The fact that it is loved does not make it human.

xviii. For a reasoned and concise defence of the position that “human beings possess an ineradicable value prior and subsequent to the possibility of exercising autonomy”, see Keown, J and Gormally, L: *Human Dignity, Autonomy and Mentally Incapacitated Patients: A critique of ‘Who Decides?’* [1999] 4 Web JCL

xix. Per Lord Goff at 868 and Lord Browne-Wilkinson at 884

xx. At 829

xxi. Ibid, and also 833. See comments to the same effect in the dissenting judgments of Handler J in *In re Conroy*, 486 A. 2d 1209 and Brennan and Stevens JJ in *Cruzan v Director, Missouri Department of Health*, 110 S.Ct. 2841.

xxii. Note the distinction drawn by Dworkin between experiential and critical interests: R. Dworkin, *Life’s Dominion* (London: Harper Collins, 1993, at 199-217, and the discussion of this distinction in the context of PVS patients by Andrew Grubb in *Incompetent Patient (PVS): Withdrawal of feeding (Scotland)*: Med. Law Rev. 4 (Autumn 1996), 300, at 309-311).

xxiii. At 897

xxiv. For a philosophical examination of the different approaches taken to ‘dying with dignity’ in the USA, Canada, Britain and Israel, see R. Cohen-Almagor: *Reflections on the intriguing issue of the right to die in dignity*. Israel Law Review: Vol. 29, No. 4 (Autumn 1995)

xxv. In *Cruzan* (supra), the US Supreme Court cited *Youngberg v Romeo*, 457 US 307 at 321: “...whether respondent’s constitutional rights have been violated must be determined by balancing his liberty interests against the relevant state interests”, and this balancing exercise was important in the decision in *Cruzan*. But the court there, faced with the limited question of the constitutionality of Missouri’s law, did not need to, and did not, ask what Nancy Cruzan’s persisting interests were, or whether they made her continued biological existence legally justifiable.

xxvi. In *re Conroy*, 486 A. 2d 1209 the New Jersey Supreme Court said that withdrawal of treatment could be justified only if continued treatment was going to inflict severe pain. The identified interests were therefore the (presumed) interest in continued existence and the interest in not suffering. Cited E.J.Emanuel, *What criteria should guide decision makers for incompetent patients?* Lancet 1988; 1, 170-171.

xxvii. [2001] 2 FLR 367

xxviii. For a discussion of human rights law issues in this and similar cases, see A. Maclean: *Crossing the Rubicon on the human rights ferry*. (2001) MLR Vol. 64 No. 5: 775-794

xxix. The submissions are summarised at 380.

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xxx. At 381

xxxi. [2004] EWHC 1879 (Admin). His comments in the context of insensate patients were technically obiter.

xxxii. See *Keenan v United Kingdom* (2001) 33 EHRR 913; *R v Broadmoor Special Hospital Authority ex p Wilkinson* [2002] 1 WLR 419

xxxiii. At 379

xxxiv. At 379

xxxv. *Re. F (Mental Patient: Sterilisation)* [1990] 2 AC 1, per Lord Goff at 72. Also see Lord Browne-Wilkinson in *Bland*, *supra*, at 884-885

xxxvi. See M at 375, para. 26

xxxvii. At 373

xxxviii. At 376

xxxix. See, for example, the judgment of Laws J in *R v Cambridge Health Authority ex p B* (1995) 25 BMLR 5

xl. For example in *R v Cambridge Health Authority ex p B* [1995] 2 All ER 129; (1995) 23 BMLR 1; *R v Secretary of State for Social Services ex p Hincks* (1980) 1 BMLR 93; *R v Central Birmingham Health Authority ex p Walker* (1992) BMLR 32

xli. From MacNair J's direction to the jury in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582.

xlii. From *Associated Provincial Picture Houses v Wednesbury Corporation* [1948] 1 KB 223

xliii. At 880

xliv. At 896

xlv. *Supra*, at 379, para. 41

xlvi. An attempt in *Bland* to say that Tony Bland had an interest in ending the distress to others caused by his condition was given short shrift: see Lord Mustill at 897.

xlvii This is so, in the terms in which Article 8 understands enjoyment, even if A devoutly wishes the physical death of B. Whether there has been a *breach* of Article 8 by the withdrawal of treatment might depend on A's feelings: it is unlikely that A's feelings are relevant to Article 8's *engagement*.

xlviii In the case of Baby K, an anencephalic, an American court said that the mother's request that the child should continue to be ventilated should be respected, even though physicians had said it was futile. Insofar as this amounts to a relative's right of veto over clinicians' decisions, this must be viewed as eccentric. This was a decision under the Americans with Disabilities Act 1990, which makes it unlawful to discriminate against persons with disabilities. Cited in K.E. Schrode, *Life in limbo: revising policies for permanently unconscious patients*. *Houston Law Rev.* 1995; 51, 439

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<sup>xlix.</sup> See, for example, the guidelines of the General Medical Council: *Withholding and withdrawing life-prolonging treatments: Good practice in decision-making*: August 2002: Clauses 15, 17, 20, 21, 26, 32, 40, 54, 56, 57, 58, 59, 60, 61, 64, 80, 81, 82 and 95. Clause 80 illustrates the tenor of the guidelines. It states: “*In deciding which of the options for providing artificial nutrition or hydration are appropriate in meeting a patient’s assessed need, you must ensure that the patient (where able to decide), the health care team, and those close to the patient (where the patient’s wishes cannot be determined), are fully involved in the decision making. You should take appropriate steps to help those participating in the decision making to understand your assessment of the patient’s requirements for nutrition or hydration, and any uncertainties underlying the options you consider appropriate for meeting those needs.*”