In both Scotland and England, the law in respect of the patient in permanent vegetative state was clarified by two recent cases. In England and Wales, the decision of the House of Lords in *Airedale NHS Trust v Bland* produced the first real clarity in such cases. In this case, the House of Lords agreed that nasogastric feeding and hydration could lawfully be removed from a young man in a permanent vegetative state (PVS). Although this seemed to provide some clarity, critiques of the House of Lords decision have focused to a large extent on the variety of ways in which their Lordships reached their conclusions, perhaps suggesting that in the future a reconsideration might be necessary.

For some of the judges, the appropriate way of considering the issue was by using the vehicle of consent to treatment. Thus, since Anthony Bland had not consented to the treatment, which was invasive, its continuation when there was no interest being served by so doing, might amount to an assault. This of course begged the question of what interests Mr Bland might have in the situation in which he found himself, and some judges chose to address the question from the perspective of whether or not it would be in his “best interests” to continue treatment.

Lord Goff, for example, said:

“...if the justification for treating a patient who lacks the capacity to consent lies in the fact that the treatment is provided in his best interests, it must follow that the treatment may, and indeed ultimately, should be discontinued where it is no longer in his best interests to provide it.”

This approach has been criticised as it seems somewhat difficult to apply in logic. Arguably, by definition, Mr Bland had no interests whatsoever, far less “best” ones, rendering this test suspect. Moreover, the fundamental question about whether or not nasogastric feeding and hydration amount to treatment at all was largely glossed over, or at least no convincing reason was presented as to why it should be considered as such. Indeed, one judge went to far as to suggest that it was medical treatment because the vast majority of doctors believed it to be so.

Some also looked at the question of futility, suggesting that—assuming nasogastric feeding to be treatment—its continuation was futile, as Mr Bland would never recover consciousness. This approach must also be regarded with some dubiety, as the treatment (if such it is) could not in fact be considered futile. To be sure, recovery was impossible, but nasogastric feeding was not futile in that it fulfilled the function it was supposed to—namely keeping the patient alive.

A further route explored by some judges was the difference between acts and omissions. It was argued that failing to continue feeding and hydrating Mr Bland was equivalent to an omission to act and therefore would not be culpable. There is immense debate about whether or not nasogastric feeding and hydration amount to treatment at all was largely glossed over, or at least no convincing reason was presented as to why it should be considered as such. Indeed, one judge went to far as to suggest that it was medical treatment because the vast majority of doctors believed it to be so.

Some also looked at the question of futility, suggesting that—assuming nasogastric feeding to be treatment—its continuation was futile, as Mr Bland would never recover consciousness. This approach must also be regarded with some dubiety, as the treatment (if such it is) could not in fact be considered futile. To be sure, recovery was impossible, but nasogastric feeding was not futile in that it fulfilled the function it was supposed to—namely keeping the patient alive.

In Scotland, the first decision was made in the case of *Law Hospital v Lord Advocate*. In this case the Lord president, Lord Hope, slightly refined the tests used in Bland by asking whether or not continued treatment was of benefit to the patient. However, although this may be a clearer and perhaps more useful test, it still rests on the presumption that assisted nutrition and hydration can be counted as medical treatment, rather than as basic care.

There is one further difference between the outcomes in these cases which may be important and will be returned to later; namely that in England and Wales cases of this sort are required to be decided by a court. In Scotland, the Lord Advocate (Scotland’s senior criminal legal officer) indicated that he would only guarantee not to prosecute in cases which had been given the authority of the Court of Session, but there is no obligation to refer cases to that court, although the prudent doctor might see the value in so doing.

**PVS AND HUMAN RIGHTS**

It has been widely questioned whether or not the passing of the Human Rights Act 1998 would make a difference to decisions in cases such as these, specifically in light of Article 2 which guarantees as follows:
Everyone’s right to life shall be protected by law. No one shall be deprived of 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.

This right is therefore a qualified right, permitting of certain exceptions, but it is worth noting that these exceptions do not include the circumstances of the PVS patient. Considerable interest was therefore generated by the hearing of the case of NHS Trust “A” v Mr M and NHS Trust “B” v Mrs H.10 Both patients were in PVS, although their circumstances differed. In the case of Mrs M, PVS had been diagnosed for three years and she could have lived in that condition for many more years, whereas in the case of Mrs H, not only was the diagnosis of only nine months’ duration, but there was an element of urgency about the decision, as the percutaneous tube into her intestine had become blocked. Although some hydration could be provided, it was insufficient to sustain life for long, and it was thought that alternative methods for providing nutrition and hydration would be invasive and likely to be only of short term efficacy.

The first landmark in the judgement of Dame Butler-Sloss was her clear recognition that these patients were alive and therefore that the right contained in Article 2 extended to them as much as to any other person. Thus, it might have been thought, the court would have no option but to decide that feeding and hydration must continue. However, Dame Butler-Sloss, in a conclusion which must be arguable, nonetheless argued that:

“Although the intention in withdrawing artificial nutrition and hydration in PVS cases is to hasten death, in my judgment 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 at the initial stage 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. It may be relevant to look at the reasons for the clinical decision in the light of the positive obligation of the state to safeguard life, but in my judgment, it cannot be regarded as falling within the negative obligation to refrain from taking life intentionally.”11

In this passage we see re-emerging the arguments from Bland, and, it is submitted, no real clarification of the issues raised above. It is by no means clear that intentional deprivation of life does in fact require “a deliberate act”. The distinction between act and omission has already been shown to be shaky, especially where the intention and outcome are the same, and particularly in a medical act, where the pre-existing duty of care legally changes the nature of omissions. Secondly, Dame Butler-Sloss also appears to import the Bolam Test12 by the back door—something of which Lord Mustill had been highly critical in the Bland judgement. In other words, it is not clear why the fact that a responsible body of medical opinion believes something to be acceptable in fact makes it so legally. Even in less significant cases the Bolam Test has been subject to legal scrutiny and refinement13—its use in life and death decisions must surely be more critically questioned. Equally, it is manifestly not true to say that the person dies as “the result of the illness or injury from which he suffered”. PVS is not in se a terminal condition, any more than life is. With the provision of food and water we all live—with assistance (at least in the case of Mrs M) that life (albeit without quality) would be maintained in precisely the same way. The patient will die not because of their PVS but as a result of the deprivation of nutrition and hydration. In the short space available it is not possible to take the argument much further, although there are a number of other contentious statements made in the judgement. From the passage quoted above, however, there is one further matter of note which might have direct bearing. Dame Butler-Sloss makes the point that the reasons for decisions may be looked at in light of the terms of the Human Rights Act. This is critically important. Much of medical practice almost certainly already conforms to the spirit and the terms of the Human Rights Act, but what the legislation seems likely to do is to require a careful casting of qualified eyes over the process of decision making. Thus, the criteria on which decisions are made and the process of making them may become more vulnerable to scrutiny. It is here that the differences between Scots and English law may become particularly significant. It may be that (notwithstanding my criticism of the above judgements) the Human Rights Act will be satisfied where appropriate, perhaps even independent, scrutiny has been made of a particular decision. In England and Wales arguably this is provided by the requirement that cases are heard by a court of law, which is deemed to be independent and disinterested. In Scotland, however, such cases do not require to be heard by a court. Ultimately, this may leave the Scottish doctor more vulnerable than his or her English and Welsh counterparts to a human rights challenge. The pleasure with which Lord Hope’s decision was greeted in medical circles may now need to be tempered by this possibility.

References
2 See, for example, Mason JK and McCall Smith RA, Law and Medical Ethics, 5th ed, London, Butterworths, 199, particularly at chapter 16; McLean SAM, “Letting die or assisting death: how should the law respond to the patient in the persistent vegetative state?” in Petersen K, ed. Law and medicine, La Trobe University Press, 3, 1994.
3 [1993] AC at p 867.
4 See references in note 2, supra.
5 [1993] 1 All ER at pp 872 and 895.
6 See particularly the judgement of Lord Brown-Wilkinson in the Bland case.
7 [1993] 1 All ER at p 898.
8 1996 SLT 848; 1996 SLT 869.
9 For comment, see Robertson J, “Policy on right to die welcomed”, The Scotsman, 12 April 1996
11 At pp 33-34.
12 Derived from the case of Bolam v Friern Hospital Management Committee [1957] 2 ALL ER 118. Essentially, this test states that if a doctor acts in accordance with a practice accepted as reasonable by a body of medical men of similar standing to himself, he will not be liable for negligence.
13 In the UK, it was refined by the case of Bolitho v City and Hackney Health Authority [1997] 4 All ER 771. In Australia the test was effectively discredited in the case of Rogers v Whittaker [1993] 4 Med LR 79.

Glossary for references
AC: Appeal Cases
All ER: All England Law Reports
LR: Law Reports
SLT: Scottish Law Times