

***An alternative conceptual structure for the resolution
of 'end-of-life' problems involving PVS patients.***

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Introduction

"Mr. Kelly himself did not look a day over ninety, cascades of light from the bed-lamp fell on the hairless domes and bosses of his skull, scored his ravaged face with shadow. He found it hard to think, his body seemed spread over a vast area, parts would wander away and get lost if he did not keep a sharp look-out, he felt them fidgeting to be off."

Beckett¹

The Ward Case

In 1972 a young woman attended a Dublin hospital for a minor gynaecological operation. During the operation she suffered a cardiac arrest which caused her severe brain damage resulting in her being left spastic, bedridden, and incontinent. She was unable to speak, her mouth was permanently clenched and she was unable to swallow. She was fed artificially, at first by a nasogastric tube - which seemed to cause her considerable distress - and subsequently by a gastrostomy tube. Her eyes were open and often followed people moving in her vicinity. The judgement of her doctors was that such behaviour was 'reflex' in nature and not evidence of any underlying consciousness. She was diagnosed as being in a 'near-Permanent Vegetative State' and it was the opinion of her doctors that recovery was most unlikely. For over twenty years her condition remained essentially unchanged.

The Permanent Vegetative State or, more accurately² the Persistent Vegetative State ('PVS'), is one characterised by wakefulness in the absence of cognition.³ The patient, in the instant case, was diagnosed as being in a 'near-Permanent Vegetative State' because it appeared that some minimal cognitive capabilities remained in that she appeared both to recognise her long term nursing staff and to show distress in the presence of strangers.

In the intervening years the patient had been made a 'ward of court' and, in consequence, the High Court exercised a supervisory role in relation to decisions affecting her welfare. In 1995 her family, believing that the patient's continued medical treatment, and in particular the tube feeding, was causing the Ward considerable distress, sought an order from the High Court that medical treatment, other than that of a purely palliative nature, be discontinued, and that the patient be

¹ Samuel Beckett, Murphy, p.67.

² Jennett and Plum in their 1972 paper (which named the syndrome 'Persistent Vegetative State' as such) opted for 'persistent' rather than 'permanent'; see Jennett and Plum, 'Persistent Vegetative State after Brain Damage - a syndrome in search of a name.' The Lancet 1972. The Multi-Society Task Force on PVS - reported in 'Medical Aspects of the Persistent Vegetative State' (First of Two Parts) The New England Journal of Medicine (1994) - draw a distinction between 'Persistent Vegetative State' and 'Permanent Vegetative State' when they state: "Persistent vegetative state is a diagnosis; permanent vegetative state is a prognosis." In contrast, the BMA [The British Medical Association] has recently decided to continue to use the term 'persistent' rather than 'permanent' when speaking of the vegetative state. (Reported in 'BMA Guidelines on Treatment Decisions for patients in Persistent Vegetative State' The Medico-Legal Journal of Ireland, (1996) at p. 58) [NB. I have adopted an abbreviated reference system for footnotes which gives sufficient information to enable the full reference to be found in the bibliography.]

³ The definition of PVS given by Sir Thomas Bingham, MR, in *Airedale N.H.S. Trust v Bland*, [1993] AC 789 at 806: "P.V.S. is a recognised medical condition quite distinct from other conditions sometimes known as 'irreversible coma', the Guillain-Barré syndrome, 'the locked-in syndrome' and 'brain death'. Its distinguishing characteristics are that the brain stem remains alive and functioning while the cortex of the brain loses its function and activity. Thus the P.V.S. patient continues to breathe unaided and his digestion continues to function. But although his eyes are open, he cannot see. He cannot hear. Although capable of reflex movement, particularly in response to painful stimuli, the patient is incapable of voluntary movement and can feel no pain. He cannot taste or smell. He cannot speak or communicate in any way. He has no cognitive function and can thus feel no emotion, whether pleasure or distress." was adopted by Lynch J. (In the Matter of a Ward of Court High Court unreported at p.2) and by Denham J. in the Supreme Court (In the Matter of a Ward of Court [1995] 2 ILRM 401 at p.447).

allowed to die. The High Court,⁴ and on appeal the Supreme Court,⁵ acceded to the family's request; gastrostomy feeding was discontinued, the patient was sedated and died eight days later. Although there had been similar cases in other jurisdictions, most notably that of Karen Quinlan in the US and Tony Bland in England, this was the first case of its kind to come before the Irish courts.

The aim of this thesis

The aim of this thesis is to bring a philosophical - as distinct from a legal or medical - approach to bear on the issues involved in the Ward case. It is necessary to elaborate on this distinction. Criticisms of the decisions in the Ward case could be made from within a number of different disciplines:

- * From a legal perspective, for example, it might be argued that the court was in error in implying a constitutional right to refuse medical treatment in cases where death would be the inevitable result of such a refusal. Similarly objections to the effect that the court was in error in exercising this right on behalf of the Ward in the manner that it did, or that the right to refuse treatment on the Ward's behalf should have been exercised by the Ward's immediate family, are predominantly legal issues.
- * From a medical viewpoint, for example, it might be suggested that the diagnosis of 'near-PVS' was incorrect⁶ and that a diagnosis of PVS was more appropriate. Similarly the argument that the actual behaviour of the Ward could not be classified as being solely 'reflex', is essentially a medical question.
- * From within a particular ethical theory, or religious tradition, it could be argued, for example, that no meaningful distinction can be drawn between letting an individual die - when the means to sustain his life are readily available - and the killing of that individual; the implication being that a prohibition on the killing of an individual necessarily implies a prohibition on the withdrawal of life-sustaining medical treatment.

This thesis is not concerned with either the legality of the decision in the Ward case nor with whether the diagnosis was in fact correct nor with whether the judgement of the court contravenes some particular ethical theory. Such arguments properly belong to their respective disciplines. More positively, this thesis could be described as being concerned with criticisms of the Ward decision which originate from within the discipline of philosophy. However, such a description is singularly unenlightening. If, however, the criticisms of the Ward decision are categorised by the *level* on which they operate, rather than by the *disciplines* from which they originate, the standpoint adopted in this thesis can be more clearly seen. To explain this idea of 'level of criticism' let us consider the analogy of a 'game', that is a system of commonly accepted rules which permit certain actions ('moves') but prohibit others.

A discussion about a game, *any* game, could be:

- (i) about whether a particular move was in breach of a rule of the game; or,
- (ii) about the meaning of the rules of the game, or whether such rules are consistent; or,

The case '*Airedale N.H.S. Trust v Bland*' is cited hereafter as '*The Bland Case*'.

⁴ In the Matter of a Ward of Court, unreported judgment of Lynch J. delivered on 5.5.1995.

⁵ In the Matter of a Ward of Court [1995] 2 ILRM 401 at p.447.

The case '*In the Matter of a Ward of Court*' is cited hereafter as '*The Ward Case*'.

⁶ It has been suggested that the diagnosis of 'near-PVS' was in fact the result of a compromise between the views of the doctors - who argued that the Ward was PVS - and the nursing staff who were of the view that the Ward had some degree of awareness. [This view is based on a conversation between Dr. Dolores Dooley of UCC, and a consultant neurologist who gave testimony in the Ward case.]

- (iii) about whether the rules of the game, as they currently exist, are appropriate when consideration is given to wider concerns.

Similarly in a discussion about a suggested resolution of a problem (such as PVS patient care) three, quite distinct, approaches are possible.

The first approach accepts the conceptual structure⁷ used (in the Ward case, that used by either the medical authorities or by the courts in discussing treatment withdrawal for PVS patients) and argues that certain conclusions were drawn which were not supported by the evidence available, or, perhaps, that certain concepts were either misunderstood or misapplied. The arguments used by lawyers in criticising a court judgement, or medical professionals in discussing decisions of colleagues, would not attempt to transcend the framework within which the problem was usually stated and, as such, would embody this first approach. An example of such an argument, in the context of the Ward case, would be a discussion as to whether the patient's eye movements, in tracking people moving in her vicinity, could properly be described as being reflex movements or were, on the contrary, indicative of the patient's consciousness.

The second approach again accepts the conceptual structure. However, in this case it conducts a more abstract analysis in that it investigates the conceptual structure itself, *from within that structure*, for internal consistency. Such an approach has been termed one of '*immanent criticism*'.⁸ An example of such an approach, in the context of discussions about the PVS diagnosis, is found in a series of papers by Chris Borthwick⁹ where he argues that the common assertion that PVS patients have no consciousness is invalidated by the inability to find a method which will in all cases distinguish between PVS patients and those suffering from *Guillain-Barré Syndrome*¹⁰ who are commonly asserted to have such consciousness.

The third approach is exemplified in the remarks of a commentator who, writing on a subject quite removed from that currently under discussion, noted that:

*"It¹¹ is perfectly analogous to the problem of 'Achilles and the Tortoise'; the manner of posing the problem encloses it within the very limits that it is necessary to overstep, and as a result, renders it insoluble."*¹²

These remarks suggest a much more radical approach than either of the previous two; an approach which would investigate the very concepts used to analyse a problem in an attempt to find alternative, more fruitful, concepts. Such an approach requires firstly, that the rules of the 'game' be made explicit, and then that they be justified. In a game, the obligation to make the rules explicit usually presents no problem, however, in other contexts - as in the context of legal and medical decision-making concerning PVS patient care - it presents the greatest difficulty. It is a task that can be likened to an archaeological excavation, but one which brings to light - not artefacts - but the

⁷ A tentative definition of the term 'conceptual structure' is the system of concepts, and the propositions linking these concepts, within which a problem is placed. These ideas are discussed later in this introduction.

⁸ Herbert Marcuse in his book on Soviet Marxism employed this terminology when he used the concepts employed by Marxism as the very tools with which to analyse, and criticise, the theory of Soviet Marxism itself. Such a method is essentially one of analysing a theory for internal consistency.

⁹ Chris Borthwick,

(1995a) 'Persistent Vegetative State; A Syndrome in Search of a Name, or a Judgement in Search of a Syndrome' *Monash Bioethics Review* 1995

(1995b) 'The Proof of the Vegetable; A Commentary on Ethical Futility' *Journal of Medical Ethics* 1995

(1996) 'The Permanent Vegetative State; Ethical Crux, Medical Fiction?' *Issues in Law and Medicine*. 1996.

¹⁰ More commonly known as 'Locked-in Syndrome'.

¹¹ i.e. using an inappropriate conceptual structure to analyse a problem.

assumptions and beliefs which are usually treated, if indeed they are ever acknowledged, as commonsensical propositions so 'obviously true' as to be beyond question. Both modern physics and mathematics gives eloquent testimony to the fact that whilst intuition - in the sense of a guide to that which is '*obviously true*' - is perforce a friend when all else fails and one is utterly lost, it is not a reliable longterm companion. The great difficulty with such propositions is that they go unnoticed, and as such they can never be challenged. 'Solutions' which emerge from a discussion containing such propositions may then appear to possess a spurious uniqueness or inevitability. Recognising such implicit assumptions and dragging them out into the cold light of day where they can be subject to a critical scrutiny, is - in the context of the Ward case - the primary aim of this thesis. Once these assumptions are recognised then a new creative process can begin where new, more appropriate, hypotheses can evolve which in turn will allow more fruitful solutions to emerge.

An observation made by Wittgenstein¹³ is particularly apposite. He had noted how:

*"The first step is the one that altogether escapes notice" and consequently "the decisive movement in the conjuring trick has been made, and it was the very one that we thought quite innocent."*¹⁴

When such 'innocent first steps' are not recognised then the problem becomes either insoluble as in the case above of 'Achilles and the Tortoise', or putative solutions cannot be exposed for what they are.

It is the task of this thesis to lay bear some of these '*innocent first steps*' made by both lawyers and medical people, in their discussions of issues such as occurred in the Ward case. The goal is that once this has been done then a search can begin for a conceptual structure which will allow a more fruitful resolution of the problem than is permitted by the conceptual structures used at present. This of course presumes that the analysis embodied in the Ward decision was unsatisfactory. The difficulties implicit in the decision will become fully apparent as, in the course of this thesis, its various facets are analysed. It will also become apparent that the problems associated with the traditional analysis are of such a fundamental nature as not to be resolvable by any cosmetic tampering with its concepts and definitions, but require a radically new approach.

In summary; the initial tasks to be pursued in this thesis are best expressed by two questions:

- (i) *Are all the legal, or medical, concepts used in the Ward case logically coherent?*
- (ii) *What, if any, are the implicit assumptions that underlie the medical and legal methods of addressing the problem posed by the Ward case? Can these implicit assumptions be justified?*

So far the discussion on the conceptual structure used in the Ward decision has been perhaps insufficiently concrete. These structures - which will be analysed in detail in the course of the thesis - will now be briefly sketched as will the problems associated with them. An outline of the full argument to be developed in the thesis will then be given. Before doing this it is necessary to return briefly to an examination of the term 'conceptual structures'.

¹² Hubert Benoit, Zen and the Psychology of Transformation, at p.2.

¹³ In discussing his concept of 'private language'.

¹⁴ Ludwig Wittgenstein, Philosophical Investigations Part 1[cited in future as 'PI-1'], § 308.

P.M.S. Hacker (at p.7) quotes Wittgenstein as stating:

"One keeps forgetting to go right down to the foundations ... one doesn't put the question marks deep enough down." a perception that is echoed by Marie McGinn (at p.113 - 4) when she suggests that Wittgenstein:

"... does not address the familiar doctrines of philosophy directly, but goes back to their roots in the first temptation to form false pictures of language or psychological phenomena, which the grammar of our concepts presents. ... It is not the philosophical accounts we construct which interests Wittgenstein, but the 'logical sleights-of-hand'."

Conceptual Structures

I have used the term 'conceptual structure' to refer to that body of concepts¹⁵ which provide the necessary framework within which a particular debate take place. It is of importance to recognise that - in relation to a particular problem - such conceptual structures have no necessary uniqueness, and secondly they can be of such a complexity as to be incapable of being made fully explicit.

Often in discussing the analysis of a problem not only is there a considerable inertia against changing the concepts that are habitually used to analyse similar problems, but there is an unwillingness to recognise that such a choice exists; so that - in relation to the Ward case - even if it is accepted that the Ward decision is unsatisfactory in a number of respects, there is a considerable reluctance to see that this may be the result of the conceptual structures that were used in the original framing of the problem. Furthermore, in the context of such as the Ward decision there may be a sceptical belief that the term 'conceptual structure' is 'much ado about nothing' and that it is devoid of significance or point. Both of these questions need to be briefly addressed.

The non-uniqueness, and complexity, of conceptual structures

The *non-uniqueness* of conceptual structures is clearly shown by the example of modern physics. Its development has shown that a multiplicity of conceptual structures may exist within which a problem can be considered, the choice between them being made on grounds of elegance or fruitfulness, but not of truth. Questions as to the truth of a conceptual structure - with the implication of uniqueness which this carries - are inappropriate. Thus, for example, to ask as to which of the 'wave theory' or the 'particle theory' of atomic movement, is true is a confusion of categories; the more appropriate question is as to which of the two permits a more fruitful discussion. In this context an observation by Albert Einstein is apposite:

*"Physical concepts are free creations of the human mind, and are not, however it may seem, uniquely determined by the external world. In our endeavour to understand reality we are somewhat like a man trying to understand the mechanism of a closed watch. He sees the face and the moving hands, even hears its ticking, but he has no way of opening the case. If he is ingenious he may form some picture of a mechanism which could be responsible for all the things he observes, but he may never be quite sure his picture is the only one which could explain his observations. He will never be able to compare his picture with the real mechanism and he cannot even imagine the possibility of the meaning of such a comparison."*¹⁶

The belief in the uniqueness of conceptual structures is quite marked within legal debate. On reading court judgements, there often appears to be a certain inevitability in the decisions reached. Our particular constitutional philosophy separates the role of making law from that of applying the law and it reserves solely to the legislature the right to make law; our jurisprudence thus requires an

¹⁵ and to the propositions linking these concepts. The term conceptual structure is also used by P.F. Strawson. Strawson conceives the task of the philosopher as being to 'lay bare' the 'massive central core of human thinking which has no history'. He describes the categories and concepts which make up this perennial structure of human thinking as 'the commonplaces of the least refined thinking' as well as the 'indispensable core of the conceptual equipment of the most sophisticated human beings.' see: Passmore p.504 and Strawson *Individuals* p. xiii

¹⁶ Quoted by Gary Zukav, *The Dancing Wu Li Masters*, at p.35.

acceptance of the proposition that judges do not make law. Accordingly it is one of the marks of a good legal judgement that the conclusion seems to follow inexorably from the application of relevant legal principles to the facts of a particular case. The philosopher, looking at the same problem must attempt to strip away the mask of certainty and inevitability. The quarry that he must mine is that of the uncertainties, the lacunae and the ambiguities; the very area that would render the lawyer impotent, dazzled, adrift without bearings.

To appreciate the *complexity* of conceptual structures a useful mental exercise, which will also help demolish the mask of certainty often found in legal judgements, is to imagine any such legal judgement being set out as a formal logical argument; the conclusion – *i.e.* the legal decision – being *formally* deduced from given propositions – *i.e.* from the facts of the case and the relevant legal principles. It is clear, on a moments reflection, that to reformulate even the simplest legal judgement as a strict logical deduction would be a truly Herculean task. It would require us to make explicit that which we regard as so obvious as to be indubitable. However, as mentioned earlier, it is one of the lessons learned from the study of logic and mathematics that often indubitability and obviousness are not hallmarks of truth. This mental experiment makes clear that informal arguments that appear to be incontrovertible depend for this apparent incontrovertibility on a vast substratum of shared, unconscious, belief.

In the context of the Ward decision, these ideas of complexity and non-uniqueness of conceptual structures can be better appreciated if one imagines:

- * the *pre-conceptualised experiential* situation of the patient at the time of the court hearing and
- * the pre-conceptualised experiential situation after artificial feeding has been withdrawn.

Before any discussion is possible both situations must be described using concepts *i.e.* conceptualised; the phrase '*PVS conceptual structure*' is used to refer both to the concepts that are used to describe the initial and final situations and to the set of propositions, ethical and other, which would be sufficient to permit a rigorous deduction of the conclusion – that is that the actual result of treatment withdrawal was ethically appropriate – from the premises – that is the circumstances of the initial situation. This conceptual structure will differ somewhat depending upon whether it is being carried out primarily by lawyers or by medical professionals so that it is possible to speak of both a '*Legal PVS conceptual structure*' and a '*Medical PVS conceptual structure*.'

It is clear from the definition of conceptual structure that it is not possible to make such a structure fully explicit. We are utterly immersed in this structure, it not only gives us our words but also 'the facts' which we like to think of as objective and independent, but which can have no meaning without concepts. We are like the fish swimming in the sea, unable to transcend it, unable to stand outside it to achieve a perspective. Much of the content of the conceptual structures that we use is provided by our culture. The very term 'culture' means the system of shared beliefs which, by providing predictability, enable a group of people to live their lives with a certain harmony and stability. To members of a society their shared beliefs may seem obvious and immutable; however it is only when, like Herodotus, they encounter other cultures that it becomes clear that much of their shared substratum of belief is in fact peculiar to their own culture. Equally we also can become aware of aspects of the conceptual structures within which a problem is usually embedded by seeking out differing conceptual structures with which to examine the problem. These differing conceptual structures can provide a background against which the original conceptual structures can be seen as it were in silhouette.

The lessons that I wish to draw from this discussion are firstly, that there is no *a priori* reason why either the '*Legal Conceptual Structure*' or the '*Medical Conceptual Structure*' used in the Ward decision is unique. Other conceptual structures may offer many appropriate ways to resolve the problem. The second lesson is that these legal, and medical, conceptual structures are of such a complexity that any attempt to give a complete account of them is doomed to failure. For the most part they are hidden and destined to remain so. However, like a guerrilla band seeking to gauge the extent of a hidden enemy, the best tactic is to use a probing analysis, at as many points of vulnerability as can be found, in order to force that which was once hidden to manifest itself.

The conceptual structures used in the Ward case

The Medical Conceptual Structure

A diagnosis of PVS implies that the patient has no consciousness which, in turn, entails that the patient cannot experience pleasure or pain, comfort or discomfort. Furthermore it follows from the definition that the condition - once a determined time has elapsed - is permanent. In such circumstances the question immediately arises as to the 'point' of medical treatment - '*Is such treatment futile?*' A broader question can also be posed - '*Is it in the best interests of the patient that they be helped to continue living?*' The concept of 'quality of life' is often used to resolve these questions; the reasoning being that if the quality of life of the patient is so poor that '*their life is no longer worth living*' then they will not be helped to continue living and they will be allowed to die. The medical discussion on these issues relates only to decisions as to whether, or not, to continue medical treatment. The giving of ANH (Artificial Nutrition and Hydration) is considered to be a medical treatment, and the question at issue is whether this particular treatment (ANH) should be withdrawn. In assessing the morality of possible procedures considerable reliance is placed on the distinction between '*acts*' and '*omissions*'; and between '*direct*' and '*indirect*' intention; the death of a patient, if directly intended or caused by an act, is considered wrongful, in contrast to deaths indirectly intended or caused by an omission.

It is often sought to justify the medical decision to withdraw ANH *solely* in terms of the interests of the individual patient; however the concerns of the wider society, particularly in relation to '*scarcity of resources*', often find expression in the medical literature. However, it should be noted that such grounds were not relied on in either the Ward or the Bland cases.

Some problematic aspects of the '*Medical Conceptual Structure*'

The definition of PVS

The definition of PVS is itself problematic for a number of reasons. Firstly, one of the criteria used in the definition of PVS is that the patient, though wakeful, lacks consciousness. This criterion is relied on to distinguish the PVS condition from a similar condition called 'Locked-In Syndrome'. It is important to note that the criterion is not the lack of '*consciously manifested behaviour*' or some such criterion, but '*lack of consciousness*'. It will be argued that this latter criterion is, strictly speaking, not amenable to a scientific determination.

Secondly, the definition of PVS is such that it confuses issues of diagnosis with prognosis. The effect of this is that it becomes *logically impossible* for a PVS patient, who was in that condition for over a year, to recover consciousness. Any such recovery *invalidates* the original diagnosis of

PVS.¹⁷ Thus, the question as to whether such recovered patients had periods of consciousness during the time when they were diagnosed as PVS patients - and assumed to have no consciousness - a question which is easily resolvable by research and which might reasonably be thought to shed light on the question of the possible consciousness of PVS patients - is, for strictly logical reasons, irrelevant. The proposition that a PVS patient has no consciousness is in essence 'fact-proof.'¹⁸

The misdiagnosis of PVS

There is considerable evidence of misdiagnosis - the Andrews¹⁹ 1996 study found a misdiagnosis rate of 43% - that is 43 in every 100 of those diagnosed as PVS were not PVS. Furthermore it is possible that the Andrews 1996 study under-reported the misdiagnosis rate in that it assumed that the hearing of the non-PVS patients was unimpaired. It is instructive to dwell on this figure because had the diagnosis between PVS and non-PVS been carried out purely at random by the tossing of a coin the expected misdiagnosis rate²⁰ would be 50%!

The results from other studies have not been as dramatic. A study by Tresch²¹ found that 18% of patient diagnosed as PVS were aware. Other studies have concentrated on the lack of medical confidence in the making of a diagnosis²² of PVS ; one such - a study by Grubb²³ *et al* - found 7.8% of European doctors were 'not at all confident' at predicting the outcome for a patient who has been in PVS for more than one year.

Were there no other reasons for disquiet, these studies provide eloquent testimony to the need for a revaluation of the criteria used in defining PVS.

Reflex actions and absence of consciousness

Amongst the tests used to determine lack of consciousness is the 'reflex test'. In this test the patient is subjected to various stimuli to determine whether any of their responses can be categorised as being other than reflex. The absence of non-reflex behaviour is considered to be determinative of a lack of consciousness.

The concept of 'reflex actions' - in contrast to 'willed actions' - with the associated belief that such willed actions are the essential characteristic of being truly human, will be found to rely on the implicit assumption of a Cartesian metaphysic. Without such philosophical support, it becomes necessary to re-examine the meanings of the terms 'reflex' and 'intended action', and the conclusions that it is appropriate to draw concerning the supposed absence of consciousness.

¹⁷BMA (1996) at p.58:

"In the BMA's view, recoveries, where they can be verified, indicate an original misdiagnosis."

¹⁸ Maurice O'Connor Drury, who was a pupil of Wittgenstein's and a medical doctor, has described some logical fallacies to which scientists, and in particular medical doctors, are prone. One of these he calls the '*fallacy of the missing hippopotamus*' and describes it thus:

"We are inclined to fall in love with an hypothesis, and so when facts begin to tell against it, we invent a subsidiary hypothesis to save the face of the first, and this process continues until without realising it our first hypothesis has become so secure as to be irrefutable. ... The theory has become 'fact proof'; it just cannot be refuted. But that which cannot be proved wrong by any conceivable experience is without meaning."

M. O'C Drury, *The Danger of Words and Writings on Wittgenstein*, (eds.) D. Berman, M. Fitzgerald and J. Hayes, p.16.

¹⁹ Keith Andrews *et al* 'Misdiagnosis of the Vegetative State: Retrospective Study in a Rehabilitation Unit.' *British Medical Journal* (1996) at p.13

²⁰ Assuming, for simplicity, the same target population and that 'PVS' and 'non-PVS' were equally likely conditions within that target population.

²¹ Donald Tresch *et al* 'Clinical Characteristics of Patients in the Persistent Vegetative State.' *Archives of Internal Medicine*, (1991), at p.930.

²² It could be argued that this is lack of confidence as to *prognosis* but the BMA guidelines that indicate that:

"In the BMA's view, recoveries, where they can be verified, indicate an original misdiagnosis."

[BMA (1996) at p.58]

²³ Andrew Grubb *et al* *Doctors' views on the management of Patients in Persistent Vegetative State: A European Study*, at p.32.

Pain

Discussion on the presence of consciousness in PVS patients may seem to be an esoteric question of purely academic interest and devoid of practical consequence. This is not so. The assumption that PVS patients lack consciousness has as an immediate consequence the conclusion that such patients cannot experience pain. Certainly sedation is given to such patients when ANH is withdrawn but its purpose is as a muscle relaxant and is given, not for any supposed benefit to the patient, but so that the medical carers will not suffer the distress of witnessing the contortions of the dying patient.

There have been instances in recent times where the medical judgements that pain could not be experienced have been made with a certitude that countenanced no doubt; judgements which were subsequently found to be erroneous. This has occurred in relation to certain anaesthetic practices and in relation to infants and animals. For example, as recently as a decade ago it was believed that newborn infants could not experience pain and accordingly, they were not given pain relief during surgical procedures. The justification for this was that such infants lacked the ability to think conceptually and having no concept of pain, could not experience pain. Similar arguments are put forward in relation to the ability of animals to experience pain. The speciousness of this argument becomes quickly apparent when the distinction is made between the ability to have an experience and the ability to know that experience as an experience of a particular type²⁴ - this latter requiring conceptual thought.

The justifications offered for the assertion that 'PVS patients cannot experience pain' will be examined at a later stage, suffice to say that they are less than compelling. It will be argued that the correct conclusion to draw is that there is a doubt as to whether patients diagnosed as PVS can suffer pain. This conclusion can be justified simply on the basis of the studies on misdiagnosis but there are other equally compelling reasons for its adoption. Once this is accepted then current methods of dealing with PVS patients become extremely difficult to justify.²⁵

The ethical criteria to be used in incorporating the presence of doubt into medical decision-making will be discussed. It will be argued that - because the detriment of treating a PVS patient as if they were conscious when they were in fact not so, is so much less than the detriment of treating a PVS patients as having no consciousness when in fact they have consciousness - the ethical course is to treat all PVS patients *as if* they were conscious. This is a conclusion that is eloquently supported by descriptions of PVS patient behaviour, such as that given by Mr Justice Lynch of the patient at the centre of the Ward Case:

²⁴ Imagine a child born to an extended family all of whom were blind, but not so the child. Imagine further the child growing up only amongst such adults so that the *concept* of 'seeing' was not utilised and not available to the child. Certainly the child would not have the concept of seeing but surely it could see?

A more realistic, but less striking, example could be constructed from the experience of the neurologist Oliver Sachs outlined in his 'Island of the Colour Blind'.

The absence of the distinction between '*having an experience*' and '*having an experience and knowing it was an experience of a particular type*' would also imply, for example, that a dog could not be hungry since it has no *concept* of hunger.

²⁵ Ronald Cranford, for example, notes:

"It would be dreadful indeed to stop treatment in patients who were thought to be unconscious but who could in fact experience thirst and hunger when treatment, including artificial nutrition and hydration, was stopped."

Ronald Cranford 'Misdiagnosing the persistent vegetative state' British Medical Journal, (1996) at p.6.

*“... she never got used to the nasogastric tube. She reacted against it by pulling it out an enormous number of times, probably well over a thousand times and probably also by way of reflex reaction to an unpleasant stimulus ...”*²⁶

The confidence, indeed arrogance, behind a statement such as that of Sir Stephen Brown in the Bland Case that:

*“... Although Antony Bland's body breaths and reacts in a reflex manner to painful stimuli it is quite clear that there is no awareness on his part of anything that is taking place around him. ... He is fitted with a catheter which has given rise to infection necessitating surgical intervention. It is to be noted that the necessary surgical incision was made without any anaesthetic because Anthony Bland is utterly devoid of feeling of any kind.”*²⁷

needs to be challenged particularly when it is realised that the ‘cost’ of treating such a patient as if they can feel pain, is slight. The resistance to such a course of action suggests that other, deeper, issues are at stake.

It will be suggested that one of these deeper issues is the concept of personhood. This is a concept which does not explicitly feature in either the medical, or legal, conceptual structures, yet as will be argued, it is crucial to an adequate resolution of the problem. The presence or absence of consciousness functions in both the medical and legal conceptual structures as a *surrogate* for this concept of personhood. This it does by virtue of assuming an underlying Cartesian metaphysic, which is again implicit and unquestioned.

The Legal Conceptual Structure

The ‘*Legal Conceptual Structure*’ used in the Ward case adopted the medical conceptual structure (as outlined above) as its foundation. The Ward court assumed that the problem it was presented with essentially related to the giving, or withholding, of *medical treatment*. Certainly this was the *form* in which the problem was presented to the court but it was not essential that this be adopted as the framework for *legal* analysis. It is important to note how crucial this step is to the subsequent analysis and, secondly, its contingency. It is crucial because without it, an alternative conceptual structure is required to resolve the problem; with it, the steps required for a ‘solution’ are clear. Its contingency is clear from the argument that the existence of ‘tube feeding’ was a purely fortuitous circumstance and that had the patient been ‘spoon fed’ this first step in the courts’ analysis would not have been possible (it being difficult to construe feeding by spoon as a ‘medical treatment’).

In the event the courts had, and exercised, a choice in their adoption of the medical conceptual structure. In the Bland case the courts showed an awareness of this. They recognised that other conceptual structures - such as a refinement of the rules relating to ‘killing’ - might be more appropriate, but felt that such would require a radical alteration of the law as to require legislation. The courts in the Ward case recognised no such alternatives.

Once the problem is regarded as being essentially about the decision to give, or withhold, medical treatment, it is easily resolvable by asking a number of subsidiary questions:

1. *Has a competent person the right to refuse medical treatment even if their death is the inevitable result of such refusal?*

²⁶ The Ward Case, High Court, unreported judgement at p.21.

2. *Is the giving of ANH a medical treatment?*
3. *Is this right to refuse such medical treatment lost by virtue of the incompetency of the patient to give consent?*
4. *If not, who can exercise the right on their behalf?*
5. *What criteria should be used in exercising this right?*

The Ward court answered 'yes' to the first two of these questions and 'no' to the third. The fourth question was to be resolved by the patient's family and medical carers, if these were in agreement with the course of action to be adopted. If not, application was to be made to the court. The criterion to be used was the 'best interests' of the patient judged by their existing, and predicted, quality of life.

Some problematic aspects of the 'Legal Conceptual Structure'

ANH a 'medical treatment'

The difficulty in considering ANH as a medical treatment is well illustrated in a comment made by Keith Andrews, in relation to his evidence to the court in the Bland case:

"At the trial I suggested that treatment, by its very nature, was given to treat an abnormality and said that I could not understand what abnormality the food was supposed to be treating ... although it is standard practice to provide prescribed preparations of food for nasogastric tubes, there is no reason, apart from the time needed for its preparation, why liquidised 'normal' food should not be used." ²⁸

The term 'treatment withdrawal'

The phrase 'treatment withdrawal' is often used in relation to the Ward decision. It is a term which is at once both too narrow and too broad in its ambit, and, more importantly, it camouflages one crucial aspect of the underlying problem - the resulting death of the patient.

It is too broad in that it seems to include decisions which are of a purely medical nature, where the death of the patient is not a foreseeable outcome and which are quite uncontroversial.

It is too narrow because it restricts the discussion to (non)treatment, thereby medicalising the problem, and implicitly rules out consideration of other possible resolutions which do not depend on (non)treatment.

It camouflages the problem because it permits the brute fact to be avoided that the inevitable result of such a procedure is the death of the patient. Furthermore this is the *desired* - although perhaps not the legally intended - result. This may seem a provocative suggestion yet if the question is posed as to what is the procedure's criterion of success, the answer is undoubtedly the death of the patient.²⁹ The essential point of the procedure is not to successfully remove the tube and to wean the patient away from ANH. To understand that this is so imagine that, on the withdrawal of ANH by the medical carers the patient's family began to spoonfeed the patient (a situation not unlike that which occurred in Glass case³⁰) and that the patient continued to survive much as they did when ANH was being administered. Would those who suggested the withdrawal of ANH not regard such a survival as a bizarre and 'unintended' result? If so, why?

²⁷ The Bland case at p.795 [emphasis added]

²⁸ Andrews (1993a) at p.1600.

²⁹ More accurately the 'good death' of the patient. The concept of 'a good death' is discussed in Chapter 9.

³⁰ Reported in The Times 22 April 1999 and also in The Guardian 23 April 1999.

It seems that the withdrawal of treatment is acting as a mask³¹ and thereby permitting what is in reality a social problem to be resolved by medical means. In the Ward case, the issue of death - and as we shall see later that of 'personhood' - are like spectres permeating the entire discussion yet not fully acknowledged. It is necessary that such issues be placed centre-stage, and that the discussion be refocused on the *death* resulting from the non-treatment, for it is this that gives rise to the ethical importance of the decision and to the apparent ethical paradox of justifying a medical decision, supposedly taken in the best interests of an individual, yet which foreseeably results in their death.

As the first step in finding an ethically appropriate solution to a problem is to see the situation with clarity, it is most unlikely that a fitting solution will emerge in the presence of denial. Commentators such as Elisabeth Kubler-Ross have noted³² the prevalence of '*death denial*' amongst medical professionals and it is important that such denial find no haven within philosophical discussions. An important step in ensuring this is to insist on an appropriate terminology, one which does not obfuscate, or distort, the underlying problem.³³ To this end the phrase '*end-of-life problems involving PVS patients*' is to be preferred to '*treatment withdrawal for PVS patients*'; hence the choice of title for this thesis '*An alternative conceptual structure for the resolution of end-of-life problems involving PVS patients*'.

Aside from questions of terminology it may well be that '*treatment withdrawal*' is an inappropriate procedure for resolution of end-of-life problems involving PVS patients. This viewpoint is not without support. Mr Patrick Hanafin, writing recently in the Journal of the Irish College of Medical Practitioners stated that:

*"... those in a permanent vegetative state (PVS), were "objectified and silenced" in official discourses ... the current legal conception of the right to die was "woefully inadequate". Not only was there a lack of certainty for all concerned, but the very method - treatment-withdrawal - was not necessarily the most respectful of human autonomy."*³⁴

Andrews, in his discussion of misdiagnosed patients, had noted that:

"Fifteen of the 17 misdiagnosed patients showed the ability to respond ... within 16 days of admission. The exception was patient B; we did not identify his responses until 25 weeks after his admission, though it was obvious from subsequent conversations with him that he had not been vegetative for some time. ... It is disturbing to think that some patients who were aware had for several years been considered to be, and treated as being, vegetative. It must

³¹ Peter B. Lloyd in an article entitled 'Which Beings should be Given Rights?' Philosophy Now. (1993) (Internet Source, at p.3 of 4) argues that

"Euphemisms are appropriate for grieving parents, but not for bringing out the underlying moral factors."

Noreen O'Carroll in an article 'The Right To Die' Studies, considers that the Ward case uses euphemistic language which functions to distance from the actual experience. She continues (at p.382):

"Corrupt language has one particularly grotesque characteristic, that is, it deceives and bewitches the intelligence of human beings, even such human beings as sit on the Supreme Court bench."

³² The phenomenon of '*death denial*' will be discussed in Chapter 9.

³³ M. O'C. Drury The Danger of Words writes on the importance of using an appropriate nomenclature in medicine. He warns (at p.3) against the danger that from:

"... unsystematic nomenclature suppositions are drawn, which then become presumptions and only too easily pass over into established truths."

He continues:

"[T]he chief danger of an unsystematic nomenclature is the danger of regarding its classification as mutually exclusive and completely exhaustive."

³⁴ As reported in The Irish Times 17 August 1998.

*be extremely distressing to be aware but unable to make contact with family or clinical carers.”*³⁵

For a patient to be aware and yet be treated as being vegetative is indeed horrendous, yet how much more so is the position of the patient who is aware, is treated as vegetative and whose carers stop his feeding?

The ambiguous role played by consciousness

Many of the legal and medical discussions concerning ‘end-of-life’ decisions for PVS patients give a central role to the supposed absence of consciousness of such patients. It has been already mentioned that the presence of consciousness implicitly functions as a surrogate for personhood, the supposed absence of consciousness thus justifying the withdrawal of treatment. The court in the Bland case, for example, were insistent that their decision applied only to insensate patients, though subsequent English cases have widened this criterion. However, in the Ward case,³⁶ the Irish court not only applied the Bland principles to a case where there was some level of awareness but amazingly this very awareness became a *motive* for treatment withdrawal. In the words of Lynch J.:

*“... but if such minimal cognition as she has includes an inkling of her catastrophic condition, then I am satisfied that that would be a terrible torment to her and her situation would be worse than if she were fully P.V.S..”*³⁷

The concept of ‘consciousness’ is thus playing a truly paradoxical role³⁸ in discussions of PVS. On the one hand, when discussing PVS patients, its supposed absence serves as a reason for treatment withdrawal; yet in considering ‘near-PVS’ patients, its existence is considered as an added reason for treatment withdrawal.

The concept of ‘quality of life’

The concept of ‘quality of life’ is a concept of great usefulness in many areas of life. In medicine, for example, before carrying out a procedure, it is necessary to know whether the proposed intervention would benefit the patient. The concept that is used to assess this is the ‘quality of life’ of the patient; the obligation on medical carers being to desist³⁹ from the intervention if it would not improve the ‘quality of life’ of the patient. The term ‘quality of life’ is also used in the context of ‘end-of-life’ decisions for PVS patients where it seeks to offer a measure of the value of the patient’s life considered as a *totality*. It was so used in both the Ward and the Bland cases and is common in the medical literature.

I will seek to draw a distinction between these two usages of the phrase ‘quality of life’. In the first usage the task is to determine whether a particular intervention will lead to a positive or negative increment in the ‘quality of life’ of another - such a judgement I will call an ‘*incremental quality of life judgement*’. However, the phrase ‘quality of life’ is used in the Ward case in quite a different sense. There the task is to measure the *totality* of a patient’s ‘quality of life’ and the question that is asked is

³⁵ Andrews (1996) at p.14-15.

³⁶ The patient in the Ward case was diagnosed as not ‘PVS’ but ‘near-PVS’ because she had some level of consciousness.

³⁷ The Ward case at p.8

³⁸ Ability to experience pain plays a similarly paradoxical role.

³⁹ This is a simplification as the change in life expectancy must also be taken into account. These questions are discussed more fully in Chapter 7.

"Is the totality of this patients life so bad that they would be better off dead?" I will use the term 'absolute quality of life' to refer to this usage of the term 'quality of life'.

It may seem that the ability to make 'incremental quality of life' judgements depends logically on an ability to make 'absolute quality of life' judgements: that to determine an 'incremental quality of life' judgement one needs first to determine the 'absolute quality of life' before the intervention, then after the proposed intervention, and then to compare both. This is certainly a *possible* procedure but, as will be shown, it is not a *logically necessary* procedure. This may seem like a particularly esoteric exercise but it is important to establish that the ability to make 'incremental quality of life' judgements is not logically dependant on the ability to make 'absolute quality of life' judgements. It is of importance because 'incremental quality of life' judgements are the 'bread and butter' of everyday medical practice and of great assistance in medical decision making. 'Absolute quality of life' judgements bear such a great similarity to 'incremental quality of life' judgements that they may appear equally innocuous.

'Absolute quality of life' judgements, however, are not innocuous; they declare that the life of another is such that they would be better off dead. Once such judgements are accepted in one legal sphere then it is difficult to find logical reasons to prohibit their being applied to others - to the severely disabled, the mentally retarded and those suffering dementia and from Alzheimer's Disease. To the judge, the 'absolute quality of life' of the alcoholic vagrant may indeed be slight; though it might surprise the judge to find that, perhaps, in the eyes of the vagrant - who values his life of 'freedom without rules' - the judges 'absolute quality of life' might appear equally deficient. These prejudices are amongst the inevitabilities of life. It is important that philosophy does not give them an added respectability, for if it does then the restraints which normally prohibit prejudice flowing into action are lessened with, as has been seen in recent history, horrendous results.⁴⁰

It will be argued that the distinction between 'absolute quality of life' and 'incremental quality of life' judgements is of fundamental importance in medical ethics in that it enables issues, which were hitherto confounded, to be disentangled thus permitting more appropriate solutions to emerge.

The distinction between 'Killing' and 'Letting die'

The courts, and many ethicists, seek to draw a strict distinction between the moral responsibility of an individual for his acts, and for his omissions. In the Ward, and similar, cases this distinction manifests as that between 'killing' and 'letting die'. This distinction can have momentous consequences. A procedure carried out by a clinician, if viewed as an *act*, can result in a charge of murder; however if viewed as an *omission*, the procedure can be considered as exemplary medical practice and beyond reproach.⁴¹ One might expect that procedures carrying such radically different

⁴⁰ As occurred, for example, in Nazi Germany.

⁴¹ Dr Tom Stuttford, the medical correspondent of The Times, in an article in that paper entitled 'Final moments of old friend who 'died on end of needle' (26 February 2000) exemplifies such an approach; according to Dr Stuttford:

"Ethically there is a great difference between the possible shortening of a life by the administration of analgesia, provided that the primary aim is to relieve pain, and the giving of an analgesic agent, not primarily to relieve pain but to hasten the patient's end, and assisted suicide in which the sole object of the 'treatment' is to kill. At no time in my 50 years in medicine has there ever, in approved medical practice, been any doubt that if a patient dies somewhat earlier as the result of drugs administered to relieve discomfort, it was an acceptable price to pay for a patient's peaceful end. This difference was well illustrated by a case when I was a GP in Norfolk in the 1960s. A colleague, who had greatly outlived his life expectancy, was dying from lung cancer. Each lunchtime we met for a beer, and every morning and evening I gave him his shot of heroin. The pain was beginning to break through, and one evening I met with his son, a fellow GP, and his son-in-law, a consultant, at a teaching hospital, and together we decided to increase the dose, by an agreed modest amount - not to kill him, but to relieve pain so that he could sleep, I gave him the injection. He lay back on the pillow, smiling peacefully. Suddenly he sat bolt upright, saying: "Tommy, you have overdone it, you have killed me." He collapsed back on the pillow - dead. This used to be known on the ward as having a patient who died on the end of the needle. It is unfortunate, but, so long as the only intention was to relieve pain, the outcome is not only legitimate, but good medical practice. "

consequences, would be clearly distinguishable. This, however, is not the case, as is seen in the following example where it can be seen that the distinction requires a jesuitical subtlety of thought.

Consider a patient on artificial ventilation who cannot survive in its absence. A person cuts the ventilation tube. If that person is the patient's physician who decided to withdraw treatment, then the procedure is classed as an *omission* - i.e. an omission to continue providing medical treatment. If, however, the physician wanted the patient to die and the cutting of the tube was a means to achieve this end then procedure is an *act* and the physician is guilty of a murder.⁴² Similarly if the person is a relative of the patient, then the cutting of the tube is, in all cases, considered to be an *act* and the relative is guilty of murder. This is so irrespective of whether the family member was motivated by altruism or by ill-will.

Such distinctions are in danger of being perceived as mere casuistry, and a conceptual structure which is crucially reliant on such distinctions, is in danger of falling into disrepute.

The possibility of a 'slippery slope'

This problem concerns the possibility that the decision in the Ward case will be applied to 'end-of-life' problems in other than vegetative state cases. The judges in the Ward case were emphatic in stating that their decision was to be strictly construed and that it had no broader applicability. However, there are a number of reasons for suggesting that this limitation is ineffective, of no more effect than a mere aspiration.

Firstly, the Ward judgement did not require that, in future cases, application be made to the courts for permission to withdraw ANH. In England, the Bland court insisted on the necessity of such application with the result that the development of clinical practice in this area is closely monitored by the courts.

Secondly, the Ward decision was not restricted to cases where it was believed that the patient had no consciousness.⁴³ In the Ward case Egan J., in his dissenting judgement, noted that all parties appeared to accept that if there were no cognitive function then treatment could be withdrawn; he distanced himself from this proposition and continued:

*"... this is not a case of no cognitive function ... If slightly more cognitive function existed, would a right to withdraw sustenance still be claimed to be permissible? Where would the line be drawn?"*⁴⁴

To this question there is no answer, nor hint of an answer, in the judgements of his colleagues.

Lastly, the Ward judgements placed reliance on the concept of '*absolute quality of life*'. Within the conceptual structure used by the court, the paucity of quality of life was, it was held, sufficient to justify withdrawal of ANH. In other jurisdictions - in England and the US, for example, - '*absolute quality of life*' judgements have been used in relation to disabled infants to justify either the withdrawal of ANH, or the non-use of routine treatments without which the infants die. Certain of these cases concerned infants suffering from very severe disability such as anencephaly, other cases, however, concerned Down Syndrome infants.⁴⁵ In cases of very severe disability such

⁴² It is necessary to bear in mind that, in law, the *motive* for carrying out an act is not relevant in ascribing criminal responsibility.

⁴³ The patient in the Ward case itself had some level of awareness in that she was diagnosed as 'near-PVS' rather than 'PVS'.

⁴⁴ The Ward case p.437.

⁴⁵ For example, the case *Re B (a minor) (wardship: medical treatment)* [1990] 3 All ER 927 concerned a Down Syndrome infant where the court ordered that treatment be withheld, though this decision was overturned on appeal [see Appendix C, number 7]. The Attorney General referred to this case in his submissions in the Ward case:

medical (non)treatment may indeed be an appropriate ethical response. The great difficulty is that in using the concept of 'absolute quality of life' to justify such (non)interventions there is *no natural boundary* beyond which it is possible to state that the 'absolute quality of life' of an individual is such that their life is worthwhile. For these, and other, reasons I will argue that - unlike 'incremental quality of life' judgements - 'absolute quality of life' judgements are ethically impermissible, and that alternative means of resolution of the problems posed by anencephalic infants must be found.

In fact the conceptual structure which will be proposed for resolution of the PVS cases does allow a resolution of these 'infant cases' without the need for making 'absolute quality of life' judgements. It has the further advantage that it does incorporate a natural boundary - the ability to communicate at some future stage - on one side of which are cases such as anencephaly, and on the other those of Down Syndrome infants. This permits a radical distinction to be drawn between the criteria used for treatment decisions for these two types of cases.

An Alternative Conceptual Structure

The concepts that will form the core of the proposed conceptual structure have already been intimated. These are the concepts of '*death*' and '*personhood*'.

In relation to the 'death' it will be argued that the proposition '*Death is an evil*' (*simpliciter*) cannot be substantiated.⁴⁶ This will lead to the conclusion that some deaths - called 'good deaths' - are a 'good'. The concept of 'a good death' will be clarified and it will be argued that, in certain circumstance, there is a moral obligation on medical carers to ensure that their patients achieve such a 'good death.'

In relation to 'personhood' it will be argued that the '*ability to communicate*' is a necessary condition for the ascription of 'personhood'.

A distinction made by Phillipa Foot is of considerable help in elaborating on the moral obligations on medical carers to their patients and will be adopted in this thesis. Foot distinguished between the obligations that arise from the virtue of Charity and from the virtue of Justice. It will be argued that the obligations flowing from Justice (and which imply 'rights') preclude any steps being taken, whether by acts or omissions, to end the lives of anyone to whom such obligations are owing (*i.e.* 'persons'). In contrast obligations flowing from Charity ('moral obligations'), and which - in the context of medical care - are to always act in the best interests of a patient, carry no such implication in relation to the death of patients.

The conclusion to be drawn is that, if the ability to communicate is judged to be permanently lost, personhood ceases as do the obligations to that individual that flow from Justice. The obligations that flow from Charity persist. These latter obligations may, in certain cases, imply that steps be taken, either by acts or omissions, to end the lives of such patients. The broader requirements of Social Justice may however influence such decisions particularly in relation to the best utilisation of scarce resources and the requirement that 'a slippery slope' not develop. This latter danger will also be lessened by the suggested prohibition on '*absolute quality of life*' judgements.

The suggested analysis will also permit two further contributions to be made to the ongoing debate on PVS:

⁴⁶ "... and said that that case uniquely illustrates why quality of life should not be adopted as a test."
[The Ward Case at p.449]

⁴⁶ By '*death is an evil, simpliciter*' I mean to speak of the *unqualified* proposition that '*death is evil*'. I do not seek to deny that certain types of death, or death in certain circumstances, could be classified as evil.

Given that there is a measure of doubt underlying certain medical judgements, it will suggest certain ethical principles to permit the existence of such doubt to be incorporated into medical decision-making. One consequence of such an approach is the conclusion that PVS patients should, in all but the most extreme cases, be treated as *if* they are conscious.

The definitions of PVS can be recast in terms of 'inability to communicate' rather than in terms of 'lack of consciousness'. This redefinition has the advantage of allowing the distinction between PVS and 'Locked-In Syndrome' to be placed on a more secure philosophical footing and, in addition, it allows the differing ethical problems posed by these two groups of patients, to emerge with a greater clarity.

The Structure of this thesis

The thesis is divided into three parts followed by a final chapter entitled '*Thesis Conclusions*' :

Part 1 considers the 'Medical Conceptual Structure' and some of the difficulties connected with it.

Part 2 considers the 'Legal Conceptual Structure' and some of its associated problems.

Part 3 develops a new conceptual structure for resolving 'end-of-life' decisions concerning PVS patients. It is called the '*P-GD conceptual structure*' - in that it relies on the concepts of 'personhood' and 'a good death' - in contrast to the '*C-AQL conceptual structure*' - which relies on an assumed ability to make judgements as to consciousness and 'absolute quality of life'.

There are a number of issues subsidiary to the main argument of this thesis which, for reasons of clarity, have been assigned to separate appendices:

Appendix A Studies on the misdiagnosis of PVS

Appendix B Borthwick's criticism of the definition of PVS

Appendix C Relevant Legal Judgements

Appendix D Phillipa Foot's analysis of the ethics of euthanasia

Appendix E The development of euthanasia in pre-war Germany

Appendix F Some modern definitions of personhood.

Part 1: Introduction

"No cry of torment can be greater than the cry of one man.

Or again, no torment can be greater than what a single human being may suffer. ...

The whole planet can suffer no greater torment than a single soul."

*Wittgenstein*¹

Part 1 of this thesis is essentially concerned with subjecting three aspects of the medical conceptual scheme to scrutiny.

The first aspect is the assertion that PVS patients have no consciousness; this will be discussed in Chapter 1. The judgement that PVS patients lack consciousness - and consequently cannot experience pain - is crucial to much of the current ethical discussion concerning PVS patient care. One of the methods traditionally used to establish such lack of awareness is the 'reflex test'. This test consists in subjecting a patient to repeated stimuli - such as loud noises or pin pricks on the skin - and examining the nature of the patient's responses to such stimuli. The determination that all of a patient's responses are 'reflex actions' is considered to be both a necessary, *and a sufficient condition*, for making the judgement that a patient lacks consciousness. Chapter 2 is concerned with uncovering the theoretical grounds offered in support of the 'reflex test' and subjecting these to a critical examination.

The second aspect to be examined is the claim that PVS patients are unable to feel pain. In one sense this is an obvious corollary to the proposition that PVS patients have no consciousness; however, it can also be examined as an assertion in its own right and in a context wider than that of PVS patients. Chapter 3 will consider the justifications offered for, and the reliability of, judgements that certain patients cannot experience pain.

The third aspect to be investigated is the definition of PVS and the features which, it is asserted, distinguish PVS from 'Locked-In Syndrome'.² In particular, consciousness is assumed to be absent in the former but present in the latter; the presence of consciousness in the Locked-In Syndrome being shown by the existence of some non-reflex actions. These non-reflex actions - such as the intentional flicker of an eyelid - are so minimal that they can be effectively masked by the presence of muscle 'twitches'. This possibility has been used by Chris Borthwick³ to argue that PVS is not a well defined condition because, in certain cases, it is indistinguishable from the 'Locked-In Syndrome', and that in these cases there is no test - and in particular no brain scan - which can differentiate between the conditions. Chapter 4 examines problematic aspects of the definition of PVS and will utilise aspects of Borthwick's arguments. His arguments, which are summarised and examined in Appendix B, would - if valid - undermine the assertion that PVS patients necessarily lack consciousness.

The argument being advanced in this thesis is *not* that patients diagnosed as PVS are, in all cases, conscious and able to experience pain, but rather that a reasonable doubt exists as to both

¹ Wittgenstein *Culture and Value*, at p.46; (quoted in Norman Malcolm. *Wittgenstein: A Religious Point of View?* at p 128.) [emphasis in the original]

² Also known as the 'Guillain-Barré Syndrome'.

³ See Borthwick 1995a, 1995b and 1996.

propositions. Of considerable relevance to this question are a number of studies which have sought to ascertain the extent of misdiagnosis of PVS; these studies are summarised in Appendix A. If it is accepted that doubt exists as to the consciousness of PVS patients, it then becomes necessary to attempt to quantify this doubt and then to show how this doubt, once quantified, can be incorporated into good medical practice. This is the focus of Chapter 5.

Chapter 1: Difficulties in judging 'consciousness'

The discussion in this chapter proceeds by first showing (in Section 1) that there is an assumption, widespread in both in the medical literature and in the legal cases which involve PVS, that PVS patients have no consciousness and cannot feel pain.

In Section 2 the arguments offered from philosophy and science, for the proposition that PVS patients have no consciousness¹ are considered.

In Section 3 a number of possible meanings of the term 'consciousness' are examined. It is argued that many of the purported conclusions concerning the consciousness of PVS patients rely on the existence of ambiguities most particularly in the equation of 'consciousness' with 'reflexive consciousness'.²

In Section 4 it is suggested that there is a clear and demonstrable congruence between the Medical Conceptual Framework and the Cartesian philosophy of consciousness and reflex action and, furthermore, that ideas of consciousness are, in Cartesian philosophy, intimately connected with ideas of personhood. To this end the philosophy of Descartes - in so far as it is relevant to this discussion - is briefly sketched. To the extent that the Cartesian analysis is not only admittedly contingent but, more importantly, incorrect in its claims, so too is the current Medical Conceptual Framework. The strongest challenge to the Cartesian position on consciousness and personhood is from Wittgenstein's '*Private Language Argument*' ['PLA'] and this is outlined in Section 4 but the main discussion of the 'PLA' is reserved until a fuller discussion of the concept of personhood in Chapter 10. The conclusions of the discussion are summarised in Section 5.

Section 1: The pervasiveness of the assertion that PVS patients lack consciousness and cannot experience pain.

In legal judgements

Perhaps the most forthright expression of the view that PVS patients have no consciousness and cannot experience pain, is to be found in the statement of Sir Stephen Brown P., in the Bland Case:

"... [Tony Bland] has remained ever since in a state of complete unawareness. This is known to the medical profession as a "persistent vegetative state" ("P.V.S."). Although his brain stem is intact he suffered irreparable damage to the cortex. All the higher functions of Anthony Bland's brain have been destroyed. There is no hope whatsoever of recovery or improvement of any kind. That is the unanimous opinion of all the distinguished doctors who have examined Anthony Bland ... Although Anthony Bland's body breaths and reacts in a reflex manner to painful stimuli it is quite clear that there is no awareness on his part of anything that is taking place around him. E.E.G. and C.T. scans reveal no evidence or cortical activity. Indeed recent scans ... show that there is more space than substance in the relevant part of Anthony Bland's brain. ... He is fitted with a catheter which has given rise to infection necessitating surgical intervention. It is to be noted that the necessary surgical

¹ The arguments, both from science and philosophy, that PVS patients cannot feel pain will be considered in Chapter 3.

² The term 'reflexive consciousness' is explained in Section 3.

incision was made without any anaesthetic because Anthony Bland is utterly devoid of feeling of any kind.”³

In this same case, at the Court of Appeal, Sir Thomas Bingham, M.R., stated:

“Its [PVS’s] distinguishing characteristics are that the brain stem remains alive and functioning while the cortex of the brain loses its function and activity. Thus the P.V.S. patient continues to breath unaided and his digestion continues to function. But although his eyes are open, he cannot see. He cannot hear. Although capable of reflex movement, particularly in response to painful stimuli, the patient is incapable of voluntary movement and can feel no pain. He cannot taste or smell. He cannot speak or communicate in any way. He has no cognitive function and can thus feel no emotion, whether pleasure or distress.”⁴

This description of PVS was adopted by Lynch J., in the Ward Case⁵ in the Irish High Court proceedings, and by Denham J. in the Supreme Court.⁶ Sir Thomas Bingham M.R. continued:

“The absence of cerebral function is not a matter of surmise; it can be scientifically demonstrated. The space which the brain should occupy is full of watery fluid.”⁷

It is quite clear from the above quotations that the courts entertain no doubts as to the lack of consciousness of PVS patients and their ability to feel pain; it remains to be seen whether this certainty is also found in the writings of medical commentators.

It is important however to recognise that, whilst the courts often may not exhibit the same subtlety of reasoning as is to be found amongst academic commentators, it is the opinions that are prevalent in the courts that have the most immediate and far-reaching effects. Although it is undoubtedly true that the views of the courts on these issues have their origins in medical testimony; these views, because of the doctrine of precedent, take on an independent life of their own in subsequent legal discussion.

In the medical literature

Later, in discussing the definition of PVS in Chapter 4, many examples are given where medical authorities assert that PVS patients have no consciousness and cannot feel pain and, rather than needlessly repeating these here, I will just quote the recent (1996) British Medical Association guidelines which describe, and endorse, the conventional view on these questions:

“It is widely accepted that PVS patients are unconscious and incapable of suffering mental distress or physical pain although many reflex responses remain.”⁸

³ The Bland case at p.795 [emphasis added].

⁴ *ibid.* at p.806.

⁵ The Ward case at p.2.

⁶ *ibid.* at p.446.

⁷ The Bland case at p.807. It is of interest to contrast this statement with one by Lord Donaldson, MR, who, in *Re J.*, stated (at p.933):

“Ultrasound scans of his brain. ... showed a large area of fluid filled cavities where there ought to have been brain tissue ... It is highly unlikely that he will develop even limited intellectual abilities. Most unfortunately of all, there is a likelihood that he will be able to feel pain to the extent of a normal baby, because pain is a very normal response.”

In *Re J* the court was dealing with the issue of withdrawal of life saving treatment from a baby who was grossly handicapped and it considered that the existence of the ability to feel pain lent support to the argument to withdraw treatment. This is in contrast to the Bland case where the inability to experience pain - in so far as it was further evidence of ‘inability to experience (*simpliciter*)’ - was considered as an added reason for withdrawing treatment. It was noted earlier that both the presence and the absence of consciousness have been adduced as a reason for withdrawing treatment and it seems that the ability to experience pain is playing a similarly paradoxical role.

⁸ BMA (1996) p.58.

Section 2: Arguments for the assertion that PVS patients lack consciousness

Philosophical arguments are considered first and then the question is examined from a scientific perspective, and finally it is sought to draw some conclusions from the discussion.

The Philosophical Path

Philosophy has long wrestled with the difficulties inherent in ascribing consciousness to others; this recurrent problem has become known as the '*problem of other minds*'. Not only has philosophy been unable to satisfactorily settle this issue but it has not been able to resolve the more basic question of whether consciousness is solely a property of 'living' things or may be ascribed to 'inanimate' matter. Thomas Nagel, for example, concludes his essay on 'Panpsychism' with the following words:

*"But we know so little about how consciousness arises from matter in our own case and that of the animals in which we can identify it that it would be dogmatic to assume that it does not exist in other complex systems, or even in systems the size of a galaxy, as the result of the same basic properties of matter that are responsible for us."*⁹

It seems that questions as to the existence of consciousness can be divided into two types. Firstly, general questions such as '*What are the necessary and sufficient conditions for ascribing consciousness to other entities?*' or indeed '*Has a plant consciousness?*'. We can, following Nagel, accept our inability to answer these broad questions, and turning to less esoteric topics we can ask apparently simpler questions of the form '*Given a class to whom consciousness is normally ascribed [i.e. fellow humans] how can we tell whether an individual member of that class possesses consciousness?*' Our concern in this section is only with questions of this second type as our context is that of determining whether a particular PVS patient has some level of awareness. Recognising the difficulty - indeed impossibility - of solving the general questions can these simpler questions of the second type find a philosophical resolution?

We can begin by asking if it is possible to determine whether other humans who live apparently normal, uneventful, everyday lives, are really conscious? Could they simply be machines or robots? Wittgenstein, amongst many others, considered this question and his answer is illuminating (though more for what it leaves unsaid!):

*"But can't I imagine that the people around me are automata, lack consciousness, even though they behave in the same way as usual? ... But just try to keep hold of this idea in the midst of your ordinary intercourse with others, in the street ... And you will either find the words become quite meaningless; or you will produce in yourself some kind of uncanny feeling ..."*¹⁰

⁹ Thomas Nagel, Mortal Questions, p.195.

¹⁰ Wittgenstein, PI-1 § 240

This appears to acknowledge that whilst we may *logically* hold that others are robots this is - for *emotional reasons* - an impossible standpoint to consistently adopt. It seems that even by restricting the discussion to questions of the narrower sort little progress is possible.¹¹

The role of philosophy in this discussion of consciousness.

If philosophy cannot establish with certainty the consciousness of other, apparently normal, individuals then it would seem clear that it cannot resolve doubts as to the consciousness of PVS patients. From this it might seem that philosophy has nothing to offer towards a resolution of the problem of PVS patient consciousness; but such a view would be seriously in error. Philosophy can help to:

- (i) clarify ambiguities in the use of the term 'consciousness' [As discussed in Section 2].
- (ii) elucidate the reasons why the ascription of consciousness is considered to have the importance that it does.
- (iii) uncover and critically analyse the criteria that are commonly used for the ascription of consciousness.

In relation to the second point, I will argue that consciousness is being used as a surrogate for personhood; more particularly, that the possession of consciousness is implicitly used as a criterion of, if not personhood, then '*moral objecthood*'¹² and that it is these concepts that are, and should be, primary in the discussion. This position would be supported by P.F. Strawson who sees the problem of personhood as primary and that of consciousness as derivative:

*"So the concept of the pure individual consciousness - the pure ego - is a concept that cannot exist; or, at least, cannot exist as a primary concept in terms of which the concept of a person can be explained or analysed. It can exist only, if at all, as a secondary, non-primitive concept, which itself is to be explained, analysed, in terms of the concept of a person ... The concept of a person is logically prior to that of an individual consciousness. The concept of a person is not to be analysed as that of an animated body or of an embodied anima. This is not to say that the concept of a pure individual consciousness might not have a logically secondary existence, if one thinks, or finds, it desirable. ... A person is not an embodied ego ..."*¹³

Strawson's position contrasts with the Cartesian tradition which holds that the individual consciousness is logically prior to, and may exist independently of, all else. To Descartes the isolated - or pre-social - individual can philosophise and, by the famous '*cogito*' argument, settle his doubts about his own existence and consciousness and go forth and discover the world. This suggests that 'personhood' - whatever that may be defined to be - can be ascribed to such an isolated, pre-social, individual. Strawson's position is that the ascription of personhood is a mutual

¹¹ However other avenues of approach to the problem - such as Daniel Dennett's analysis of the meaning of the term 'intention'; the 'Turing Test' enunciated by Alan Turing; and P. F. Strawson's discussion of the concept of 'person' - suggest that this conclusion is unduly pessimistic. These issues are discussed in Chapter 10.

¹² I use the concept of '*moral objecthood*' - with its associated concept '*Objects of Intrinsic Moral Worth*' ['OMW's'] - to distinguish those objects which, if affected by a proposed action must be included in a calculus which seeks to determine the ethics of the proposed action, from those that need not be so included. For example, if I propose to assault a man with a stick whilst he is walking his dog, then the man, his dog and the stick would, amongst other things, be affected by my actions; in stating that the stick does not possess 'moral objecthood' is meant that damage to it, *for its own sake*, is considered irrelevant; however the dog might, and most certainly the man would, be considered to possess such 'moral objecthood' [and therefore be 'OMW's'].

The concept of '*Objects of Intrinsic Moral Worth*' is useful in discussions on '*Personhood*' in that it allows distinctions to be made which are otherwise not apparent. These topics are discussed in Part 3.

¹³ P. F. Strawson *Individuals* at p. 98-100.

judgement of individuals following social interaction, and could not be ascribed to an isolated, pre-social, individual; this implies that a necessary condition for the ascription of personhood to an individual is the ability of that individual to communicate to some minimal standard. To Strawson, the isolated pre-social individual could not be a 'person' without prior social interaction; and this conclusion is also supported by Wittgenstein's 'PLA' which implies that such an isolated pre-social individual would not be capable of conceptual thought. Surprisingly support for the 'ability to communicate' being a necessary condition for the ascription of personhood can also be found in the writings of Descartes. These questions will be considered more fully later in this chapter in discussing the philosophy of Descartes, and in Chapter 10 which discusses personhood.

In relation to the third point, the suggestion that the role of philosophy is to analyse the criteria used to ascribe consciousness and not to speculate on whether or not some mental state actually exists, does not find a ready acceptance from Nagel, though he acknowledges that it would be Wittgenstein's position:

*"[Wittgenstein] holds that all kinds of familiar propositions about the mental states of individual living beings are true, but that there is almost nothing to be said about what property must be possessed by what thing if one of these ascriptions is to be true. All such specifications of truth conditions are trivial. What can be more fully described, however, are the kinds of circumstances, including evidential grounds, that make the ascription appropriate: criteria rather than truth conditions. For third person ascriptions the grounds are behaviour, stimuli, circumstances and testimony (once the subject has learned the relevant mental vocabulary). For self-ascription no evidential grounds are needed. Although facts about the body are among the criteria for ascribing mental state to others ... the mental states are not states of the body. The view is not reductionist. Mental states are no less real than behaviour ... In fact their situation ... is symmetrical, because physical processes have mental (specifically observational) criteria just as mental processes have physical criteria. According to Wittgenstein, everything there is must be systematically connected with other things in a way that permits public agreement, or at least public disagreement, about whether it is there or not. Mental phenomena meet the condition through their connection with behaviour and circumstances, but they are perfectly real in their own right. They cannot be analysed as dispositions to behaviour or properties of the organism, any more than physical phenomena can be analysed as multiple possibilities of sensation or of observation. If asked to say what any of these kinds of things really is, or what statements about them really assert, we can give no reply that is not trivial."*¹⁴

Nagel does not accept Wittgenstein's view. He believes that it depends too heavily on an analysis of language and that it surrenders, what he believes is, the important question - the consciousness of another - in favour of resolving a subsidiary question - the criteria for the ascription of consciousness to another. To highlight the difference he takes a striking example:

"... if things emerged from a spaceship which we could not be sure were machines or conscious beings, what we were wondering about would have an answer even if the things were so different from anything we were familiar with that we could never discover it. It would depend on whether there was something it was like to be them, not on whether behavioural similarities warranted our saying so ... I believe that the question about whether the things

*coming out of the spaceship are conscious must have an answer. Wittgenstein would presumably say that this assumption reflects a groundless confidence that a certain picture unambiguously determines its own application. That is the picture of something going on in their heads ... that cannot be observed by dissection."*¹⁵

This point is particularly apposite for our purposes in that the question of the consciousness of a PVS patient is often reduced simply to the quite different question as to whether the behaviour of the patient would normally merit application of the term 'conscious'. It is perhaps worthwhile to formalise the distinction drawn by Nagel between consciousness as it is 'internally experienced' - *Consciousness_{IN}*, for short - and consciousness as determined by behaviour - *Consciousness_B*, for short. Wittgenstein's position would be that the distinction between *Consciousness_{IN}* and *Consciousness_B* could not be sensibly made; Nagel's is that it must. A simple gesture of introspection would favour Nagel's perspective; such a gesture will immediately make clear that the existence of one's own consciousness does not depend on one's manifesting any particular, or indeed any, behaviour; consciousness being quite compatible with extended periods of physical stillness; in short we can conclude that:

Conclusion ₁₋₁:¹⁶ *Consciousness_{IN} and Consciousness_B - though normally found in such a close association as to have a factual interdependence - are, strictly speaking, logically independent. As applied to a PVS patient, this suggests that, although it may be adjudged that Consciousness_B does not exist, no necessary implication follows concerning Consciousness_{IN}.*¹⁷

The contribution of philosophy to the debate on the criteria for ascribing consciousness is not simply restricted to analysing, and criticising, particular criteria but is much more fundamental, it can determine the very boundaries of the debate. To see this it is first necessary to consider the scientific contribution to the debate on consciousness.

The Scientific Path

In order to gain access to the problem of consciousness, science needs to find some point of purchase, otherwise it faces precisely the same difficulties as does philosophy. The simplest assumption that permits this is that all mental processes are, if not *just* brain processes at least in some sense isomorphic to, or at least reflected in, brain processes.¹⁸ This assumption would suggest an investigation of the brain in an attempt to establish correlates of various mental phenomena and this indeed is what has happened in recent years. By identifying firstly those parts

¹⁴ Thomas Nagel *Mortal Questions* p.190-1.

¹⁵ *ibid.* p.191-2. Dennett's discussion of 'intention' (discussed in Chapter 2) is particularly useful in considering Nagel's example.

¹⁶ Conclusion are numbered first according to the chapter in which they are established and then within the chapter. Thus 'Conclusion ₅₋₇' refers to the 7th conclusion in Chapter 5.

¹⁷ Nagel's argument is interesting for another reason: his initial dichotomy between '*machines or conscious beings*' echoes a similar Cartesian dichotomy between machines and persons and shows again the intimate relationship that exists between the ascription of personhood and of consciousness; this relationship was crucial to Descartes but has become blurred, in recent times, by the now common ascription of consciousness to animals. To Descartes, animals were literally nothing other than machines - so called *bete-machine* - dispelling the animal-soul view that had been commonplace since Aristotle. [cf. Justin Leiber *An Invitation to Cognitive Science*, at p.22]

¹⁸ In relation to this assumption, Wittgenstein asks:

"The feeling of an unbridgeable gulf between consciousness and brain-process: how does it come about that this does not come into the consideration of our ordinary life? This idea of a difference in kind is accompanied by a slight giddiness, - which occurs when were performing a piece of logical sleight-of hand."

His answer appears to be that propositions as to consciousness and as to the existence of brain states usually have quite different contexts - the latter not featuring in everyday experience - and that this difference in context misleads us into thinking that consciousness and brain states are different in kind. cf. Wittgenstein PI-1 § 412.

of the brain - or brain process - associated with consciousness, and secondly those areas of the brain injury to which is associated with PVS, the hope would be that - by a comparison of these respective areas - the problem of PVS-patient consciousness could be resolved. This hoped for resolution fails for two reasons, firstly there is no one area of the brain, or no particular brain processes, that can be unequivocally associated with consciousness and secondly there is no one area of the brain, damage to which is uniquely associated with PVS.

Any area of the brain uniquely associated with consciousness?

The search to find an area of the brain uniquely associated with consciousness has not been successful. Owen Flanagan notes:

*"One mistake to stay away from is positing a centre of consciousness ... Some patterns of neural activity result in phenomenological experience; other patterns do not. The story bottoms out there."*¹⁹

He also reports that even in those areas where attempts at a neural mapping have had some success the boundaries of the neural regions themselves are unstable:

*"There are precise mappings for certain sensation types (for example, color sensation, taste touch and vibration), but the mapping are coarser and less consistent for other sensation types (for example, pain and temperature). Secondly, there is evidence ... of changing boundaries and intraindividual variation of neural maps. The mappings from the sensory receptors to the cortex are remarkably fluid within a certain range."*²⁰

Some current research suggests that consciousness, rather than being mirrored in some particular area of the brain, is manifested in a non-localised brain activity. Crick and Koch, for example, believe that consciousness is linked to oscillatory patterns in the 40 Hz range resonating across the brain;²¹ the fact that the experimental research offered in support of this hypothesis relates solely to visual awareness considerably weakens this hypothesis.

Bernard J. Baars, in a recent paper,²² throws even greater doubt on such attempts to find a neural correlate of consciousness:

*"A great variety of evidence may have a bearing on consciousness - hypnotizability, perceptual reaction time, memory measures, psychophysical scaling - but the relationships between these measures and 'consciousness per se' are probably indirect. Which measures are most relevant to understanding consciousness seems to be a great source of confusion. A review of the vast literature on event-related brain potentials concludes pessimistically that, although there are well-known ERP correlates of perception, decision-making, discrimination, and voluntary action, it is unclear whether any of them say anything about consciousness. (Donchin, McCarthy, Kutas, and Ritter, 1983)! The sticking point seems to be that there is no explicit agreement on what to look for in trying to understand 'real' consciousness. But of course raw observations won't tell us anything until we have some notion of what to look for."*²³

¹⁹ Owen Flanagan, Consciousness Reconsidered, (1992) at p.58.

²⁰ *ibid.* p.57.

²¹ *ibid.* p.15.

²² Bernard J. Baars, 'A Thoroughly Empirical Approach to Consciousness' Psyche (1994) (Internet source).

²³ *ibid.* p.3 of 14.

The conclusion can be drawn that:

Conclusion ₁₋₂: *There is no area of the brain, and no specific brain activity, that is uniquely associated with the possession of consciousness.*

For brain damaged (including PVS) patients the problem is even more intractable, because - even assuming that a neural correlate of consciousness has been established for normal subjects - we cannot conclude that the same neural correlate would necessarily be valid for brain damaged subjects. This is because, in brain damaged patients, a reorganisation of the brain can occur so that an (undamaged) area of the brain - not normally associated with a particular task - can take over the management of that task from the now damaged part of the brain. Furthermore the brain exhibits a so-called '*parallelism*'. Of this, Richard Gregory states:

*"The cortical events underlying complex and cognitive actions are probably so widely dispersed that no brain damage, however great, can either destroy them entirely or leave them wholly unimpaired."*²⁴

It seems that to approach the problem of determining PVS patient consciousness from the direction of consciousness is singularly unpromising; the alternative is to approach it from the direction of PVS - *i.e.* to examine the brain states of PVS patients in the hope that these may exhibit a uniformity of damage to specific areas of the brain; this, in turn, might suggest new methods of resolving the question of PVS patient consciousness. We now examine the correlation of PVS with specific brain damage.

PVS and associated brain damage

An article by Jennett and Plum was the first to name the syndrome 'Persistent Vegetative State' as such.²⁵ Its authors were cautious in suggesting links between PVS and damage to any particular location of the brain or to any particular brain activity.²⁶ They stated:

*"... the clinical syndrome we are describing can be produced by lesions which largely spare the cortex structurally, and the E.E.G may even show persistent alpha rhythms. ... the lesion may be in the cortex itself, in subcortical structures of the hemisphere, or in the brain-stem, or in all of these sites. But the exact site and nature of the lesion is unknown to the bedside clinician, and the name for the syndrome should not imply more than is known. ... In the first few weeks after injury the electroencephalogram (E.E.G) may resolve doubts about whether the patient is really attentive; if there is extensive neocortical death the record will be initially flat ... However this is rare and there is very little information about the significance of E.E.G. changes months after the initial incident; ... However, we cannot yet accurately predict the specific pathological substrate or the precise E.E.G abnormality which will be found in association with the persistent vegetative state."*²⁷

²⁴ Richard L. Gregory (ed.), The Oxford Companion to the Mind at p.438.

An example of such brain reorganisation is given in a report by the science correspondent of 'The Sunday Times': the case concerned a 10 year old boy who was suffering from severe, incapacitating epilepsy and who had been unable to speak since birth (he had been suffering from Sturge-Weber syndrome which caused the blood vessels to the left side of his brain to be constricted during development in the womb). In order to cure his very severe epilepsy, the left hemisphere of his brain was removed. The boy subsequently learned to speak like a normal child but utilising only the right side of the brain; (up until then it was believed that the left side of the brain was uniquely responsible for speech). [The Sunday Times, 4-5-1997.]

²⁵ Jennett and Plum, 'Persistent Vegetative State after Brain Damage - a syndrome in search of a name,' The Lancet (1972) at p.734.

²⁶ such as might be measured by an electroencephalograph ('E.E.G').

²⁷ *ibid.* pp. 736,734,734-5, and 736.

The Jennett and Plum paper was published in 1972 and there have been considerable developments since then both in the general study of the brain, and in the relationship between brain damage and PVS. One such study, by Hannah Kinney,²⁸ concerned a neuropathological analysis of the brain of Karen Quinlan²⁹ in which her entire brain and spinal cord were systematically examined. The Kinney study, which was published in 1994, is of particular interest in that its results were contrary to the expectations of the neuropathologists. This divergence between the expectation and the result is eloquent testimony to the gap that still exists in the understanding of how PVS manifests in the brain. The study states:

*"Contrary to expectation the most severe damage was not in the cerebral cortex but in the thalamus, and the brain stem was relatively intact ... The persistent vegetative state raises fundamental questions about the neuroanatomical basis of human consciousness and the nature of brain damage that leads to a dissociation of cognition and awareness from arousal. ... In Quinlan's case, however, the most extensive and bilateral damage was not in the cerebral cortex or white matter. In other patients in the persistent vegetative state, cerebral cortical damage has varied widely, and as in Quinlan, has sometimes seemed insufficient to cause the global defects."*³⁰

A more recent study by Dr. Keith Andrews of the London Royal Hospital for Neuro-disability, states:

*"It has been pointed out that neurodiagnostic tests can neither confirm the diagnosis of a vegetative state nor predict the potential for recovery."*³¹

Although Ronald Cranford, in responding to the Andrews study, says:

*"Both the multi-society task force on the vegetative state in the United States and the working group of the Royal College of Physicians in Britain stated that these neurodiagnostic studies have some use in the diagnosis. It is unfortunate that Andrews et al did not make use of them."*³²

One point, however, clearly emerges from the Kinney study and from the conflict between Andrews and Cranford, and that is that neurodiagnostic tests are not definitive in diagnosing PVS.

Conclusion¹⁻³: *There is no definitive neurological test for PVS.*

It has been argued earlier that, given neural activity, there is no neurological test which will determine the presence of consciousness. We are thus led ineluctably to the conclusion that:

Conclusion¹⁻⁴: *There is no neurological test which will determine PVS patient consciousness.*

This leads us to question the medical practice which has hitherto been used to resolve the problem of determining PVS patient consciousness.

²⁸ Hannah Kinney *et al* 'Neuropathological Findings in the Brain of Karen Ann Quinlan - The Role of the Thalamus in the Persistent Vegetative State' *New England Journal of Medicine*, (1994).

²⁹ Karen Quinlan's case was the first case involving PVS to come before the US courts. Her breathing had been sustained by a respirator and the court application was for permission to remove the respirator. This the court permitted. However, on the removal of the respirator, Karen Quinlan did not die but continued to breathe, unaided. She survived for a further 10 years in a PVS. She died in 1985 of acute pneumonia. Antibiotics had not been given to treat the pneumonia. The case was decided in 1976 and is reported as *In the Matter of Karen Quinlan, An Alleged Incompetent*, Supreme Court of New Jersey 355A 2d 647. This case is discussed in, amongst others, Bonnie Steinbock and Alistair Norcross (eds.), *Killing and Letting Die*, p 51; James Rachels, *The End of Life*, p.101.

³⁰ Kinney *op.cit.* p.1469,1472.

³¹ Andrews (1996) at p.13.

³² Ronald Cranford Editorial, *British Medical Journal*, (1996) at p.5 [emphasis added].

The 1972 article by Jennett and Plum, referred to earlier, is again a good starting point. This article, particularly in its discussion of patient consciousness, exhibits a precision of language not always found in other discussions of PVS. As is shown in the quotations following, Jennett and Plum were fully aware of the distinction between the existence of patient consciousness as 'internally experienced' - 'Consciousness_{IN}', and the existence of patient consciousness as judged by external behaviour - 'Consciousness_B';

*"We propose this³³ as the most satisfactory term to describe this syndrome, for several reasons. It describes behaviour, and it is only data about behaviour which will always be available, ... What is common to all these patients ... is that, as best can be judged behaviourally, the cerebral cortex is not functioning ..."*³⁴

They acknowledge the tenuous nature of the judgements as to absence of mental activity but see no alternative:

*"Although we would not deny that a continuum must exist between this vegetative state and some of the others described, it seems wise to make an absolute distinction between patients who do make a consistently understandable response to those around them, whether by word or gesture, and those who never do. ... the immediate issue is to recognise that there is a group of patients who never show evidence of a working mind. This concept may be criticised on the grounds that observation of behaviour is insufficient evidence on which to base a judgement of mental activity: it is our view that there is no reliable alternative available to the doctor at the bedside, which is where decisions have to be made."*³⁵

Their recognition of the tenuous nature of the judgements as to the absence of mental activity in conjunction with their (seemingly) obligatory duty to make such a judgement, raises the pivotal question as to the role this judgement plays in the conceptual structure that they are using. I suggest that it is being implicitly used as a criterion of personhood. The United States President's Commission for the Study of Ethical Problems³⁶ in its discussion of PVS was quite explicit in linking personhood to consciousness; they stated:

*"Most of what makes someone a distinctive individual is lost when the person is unconscious, especially if he or she will always remain so. Personality, memory, purposive action, social interaction, sentience, thought and even emotional states are gone. Only vegetative functions and reflexes persist."*³⁷

They also took note of Joseph Fletcher's criteria for 'personhood',³⁸ and that these criteria implied that a PVS patient ought not to be considered a 'person'. Without registering disagreement with Fletcher's approach, they did not pursue the issue of defining personhood. I wish to leave the issue of personhood to one side for the moment and return to it at a later stage (in Chapter 10) where I will argue that possession of consciousness is not a suitable criterion for 'personhood'.

³³ i.e. 'Persistent Vegetative State'.

³⁴ *ibid.* at p.736 [emphasis added].

³⁵ Jennett and Plum (1972) at p.736,737; [emphasis added].

³⁶ President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research. Deciding to Forego Life-Sustaining Treatment, (1983).

³⁷ *ibid.* at p. 174-5.

³⁸ *ibid.* at p.175, footnote 10. See Appendix F which discusses Fletcher's criteria.

Returning to the main question - which is the meaning of the term 'consciousness' as used in medical practice - the Commission, whilst noting that: "*No one can ever have more than inferential evidence of consciousness in another person.*"³⁹ neatly seeks to resolve the difficulty of determining PVS patient consciousness by making the equation:

$$\text{Consciousness}_{IN} = \text{Consciousness}_B$$

- an equation which is a relic of a somewhat discredited behaviorist psychology. They continued:

*"Medical science has been unable to detect or postulate neurologic damage to the brain that would result in a functioning cerebrum capable of consciousness but able to perform absolutely no purposeful actions. At the least, to have consciousness a person must have some functioning cerebrum connected to adequate activating structures in the midbrain. Neurological findings indicate that having that much of a functioning central nervous system entails having at least the ability to blink voluntarily or move the eyes deliberately, and usually much more. Patients with the rare neurological syndrome termed 'locked-in state' retain only the ability to control movements of the eyes or eyelids."*⁴⁰

There are three reasons why this proposition is difficult to sustain:

- (i) It is not compatible with statements, quoted earlier, showing that the search to find a neural correlate of consciousness has been unsuccessful.
- (ii) Consider the example of a 'locked-in syndrome' patient unable to move any part of his body except for one eye.⁴¹ Imagine that such a patient develops a persistent and permanent twitch in his eye rendering it incapable of voluntary control. The proposition that the existence of this twitch *necessarily* implies his losing consciousness seems quite absurd. Borthwick's papers, considered later, urge a similar conclusion.
- (iii) On a purely methodological level, the attempt to establish that a PVS patient has no consciousness seems beset by difficulties of such a nature as to render the problem *theoretically* unsolvable. We will return to this topic shortly.

A more recent (1994) US study by the Multi-Society Task Force on PVS⁴² again considers the question of PVS patient consciousness. They, however, retreat somewhat from the equation $\text{Consciousness}_{IN} = \text{Consciousness}_B$ as asserted in the 1983 President's Commission report. They state:

*"Patients in a coma are unconscious because they lack both wakefulness and awareness."⁴³
Patients in a vegetative state are unconscious because, although they are wakeful, they lack awareness. ... By definition, patients in a persistent vegetative state are unaware of themselves or their environment. They are noncognitive, nonsentient, and incapable of conscious experience. There is, however, a biologic limitation to the certainty of this*

³⁹ *ibid.* at p.174.

⁴⁰ *ibid.* at p.175, footnote 12

⁴¹ The case of Jean-Dominique Bauby (discussed in Chapter 10) is an example of such a patient. Bauby was able to blink and used this to establish a system of communication.

⁴² Multi-Society Task Force on PVS, The. 'Medical Aspects of the Persistent Vegetative State' (First of Two Parts) The New England Journal of Medicine (1994); cited hereafter as 'Multi-Society Task Force on PVS (a)'
Multi-Society Task Force on PVS, The. 'Medical Aspects of the Persistent Vegetative State' (Second of Two Parts) The New England Journal of Medicine (1994); cited hereafter as 'Multi-Society Task Force on PVS (b)'

⁴³ The study had adopted William James' definition of consciousness as '*awareness of the self*' and noted that it has two dimensions '*wakefulness*' and '*awareness*'.

definition, since we can only infer the presence or absence of consciousness in another person. A false positive diagnosis of a persistent vegetative state could occur if it was concluded that a person lacked awareness when, in fact, he or she was aware. Such an error might occur if a patient in a locked-in state (i.e., conscious yet unable to communicate because of severe paralysis) was wrongly judged to be unaware. Thus it is theoretically possible that a patient who appears to be in a persistent vegetative state retains awareness but shows no evidence of it."⁴⁴

The study then turns to the evidence for the assertion that PVS patients lack consciousness:

*"At present, three lines of evidence based on careful clinical and laboratory studies support the conclusion that patients in a persistent vegetative state are unaware of their environment. First, motor or eye movements and facial expressions in response to various stimuli occur in stereotyped patterns that indicate reflexive responses integrated at deep subcortical levels rather than learned voluntary acts. The presence of these responses is consistent with complete unawareness. Second, positron-emission tomographic studies of regional cerebral glucose metabolism show levels far lower than those in patients who are aware or in a locked-in state. These low metabolic rates are comparable to those reported during deep general anesthesia in normal subjects whom all would agree are unaware and insensate. Finally, all available neuropathological examinations of the brains of patients with a clinical diagnosis of a persistent vegetative state show lesions so severe and diffuse that awareness would have been highly improbable, given our biologic understanding of how the anatomy and physiology of the brain contribute to consciousness."*⁴⁵

Three reasons are offered to support the judgement that PVS patients lack consciousness. Let us isolate and consider each reason separately:

- (i) *"eye movements ... indicate reflexive responses ... The presence of these responses is consistent with complete unawareness."*

It need only be pointed out that, as a simple gesture of introspection will prove, they are equally consistent with awareness.

- (ii) The second reason draws on the evidence of positron-emission tomographic (PET) studies. Two assertions are made.

The first is:

"... positron-emission tomographic studies show levels far lower than those in patients who are aware or in a locked-in state."

This clearly begs the very question that it seeks to answer for it presumes that PVS patients are not aware. However leaving the circularity aside, obviously there are many differences between PVS and non-PVS patients, one such is that the responses of PVS patients to stimuli are of a lower order of complexity than are those of locked-in syndrome, or other, non-PVS, patients. It would surely not be unexpected that this lower level of complexity be reflected in lower levels of cerebral activity.

Secondly, the Andrews 1996 study on misdiagnosis, referred to earlier, made no reported use of such PET scans as a diagnostic tool.

⁴⁴ Multi-Society Task Force on PVS (a) p.1501 [emphasis added].

⁴⁵ *ibid.* p.1501-2.

Thirdly, the statement is difficult to reconcile with the high rate of misdiagnoses of PVS which exists. The extent and nature of this misdiagnosis is discussed later. The second assertion is that:

"The low metabolic rates are comparable to those reported during deep general anesthesia ... who all would agree are unaware and insensate."

This is open to two objections:

Firstly, recent studies of some patients undergoing surgery show that they were aware of what was happening even though they were supposedly in a deep general anaesthesia.⁴⁶ This was shown by their being able, subsequently, to report on the conversations of the medical staff which occurred during the surgery.

Secondly, it assumes that consciousness is a unitary phenomenon.⁴⁷ Studies⁴⁸ of yogic mediators show EEG patterns considerably different from those found in 'normal' consciousness. Of these Charles Tart notes:

"The adept practitioners of both forms of meditation [i.e. Zen and Yoga] show almost continuous alpha waves (normally associated with a state of relaxed alertness in ordinary subjects) during meditation. This is particularly startling in the case of Zen monks because their eyes are open: one almost never sees alpha rhythm in the eyes-open condition in ordinary subjects."⁴⁹ ... The Yogis ... show no response to stimulation at all."⁵⁰

(iii) *"... neuropathological investigations of the brains [of PVS patients] ... show lesions so severe that awareness would have been highly improbable, given our ... understanding of how the anatomy and physiology of the brain contribute to consciousness."*

Firstly, the neuropathology report on the brain of Karen Quinlan, quoted earlier, is difficult to reconcile with this statement. It had stated:

"In Quinlan's case, however, the most extensive and bilateral damage was not in the cerebral cortex or white matter. In other patients in the persistent vegetative state, cerebral cortical damage has varied widely, and as in Quinlan, has sometimes seemed insufficient to cause the global defects."⁵¹

Secondly, as is evident from the 1996 BMA Guidelines,⁵² the very fact that post-mortems are not carried out on PVS patients as a matter of routine lessens the authority of the statement.

Lastly, as has been shown earlier, the understanding of how consciousness manifests in the brain is still in its infancy a fact which further militates against the evidence base of the 1994 US Study on PVS.

⁴⁶ A recent press report in 'The Sunday Times' 'Medical Notes' 22.3.1998, stated:

"Doctors at the Institute for Anaesthesiology in Munich report in the British Journal of Anaesthesia that in about 1% of operations patients are aware to some degree. Of these, 73% recalled their surgeons conversations and 17% were in severe pain."

This problem is further considered in Chapter 3.

⁴⁷ Hypnosis and meditation are examples of so-called altered states of consciousness; the existence of such altered states refutes the unitary view of consciousness. (The 1998 conference on 'consciousness' which was held in Tucson, Arizona, devoted considerable time to academic discussions of such states.)

⁴⁸ Some such studies are included in Charles Tart (ed.) *Altered States of Consciousness*, (1990).

⁴⁹ It may be of interest to note that such alpha activity also occurs in PVS patients and these are also open eyed - see Jennett and Plum (1972), p.736.

⁵⁰ Tart *op.cit.* p.576.

⁵¹ Kinney *op.cit.* p.1472.

⁵² In 1996 the BMA was reported as considering the advisability of routinely carrying out post-mortems of PVS patients, the implication being that this was not then current practice. [BMA (1996), p.59].

The conclusion to be drawn is that:

Conclusion₁₋₅: *In relation to the problem of PVS patient consciousness, medical practice has assumed that Consciousness_{IN} = Consciousness_B. Furthermore, it has used the 'reflex test' as the criterion for establishing Consciousness_B.*

A number of conclusions have been drawn in the course of this discussion concerning the validity of the methods used for determining the consciousness of PVS patients. We have seen that, as yet, science has not been able to penetrate the concept of Consciousness_{IN}. It has restricted itself to Consciousness_B. Without doubt, the current situation is unsatisfactory. There are problems⁵³ associated with the concept of Consciousness_B and with the equation of Consciousness_B to Consciousness_{IN} which (*pace* Wittgenstein) is something of a 'logical sleight-of-hand'.

Certainly the results of scientific studies on how consciousness is manifested in the brain have been less than encouraging. An optimist may well hope that this will soon be rectified. Can we hope that sometime in the future, science can penetrate directly to a study of Consciousness_{IN} or are there theoretical reasons why Consciousness_{IN} can never be made amenable to a scientific approach? It is to this question that we now turn.

Science and Consciousness_{IN}

I wish to suggest that a philosophical approach can offer good theoretical reasons why Consciousness_{IN} can never be made amenable to a scientific approach and that this is *particularly so in relation to PVS patients*.

First consider how experiments to establish a neural correlate of, say, visual consciousness are carried out. A subject is presented with various images whilst his brain is being monitored for activity; he is questioned as to the images of which he was conscious, he is further questioned to see if certain images of which he was not conscious were perceived by the brain (the phenomenon of 'blindsight'⁵⁴); the subsequent correlation of these three sets of images (the ones consciously perceived, the ones unconsciously perceived in 'blindsight', and the ones not perceived) with the corresponding brain states, yield a tentative neural map for visual consciousness. It is clear that a communication with the subject to establish that of which they were conscious, is an essential part of this investigation.

Can the same methodology be used in relation to consciousness? Let us return to first principles. From the minimal assumption that any level of consciousness manifests in some level of activity in the brain [either electrical or chemical] what follows? Certainly the conclusion can be drawn that if no such activity manifests in the brain then consciousness is absent, in other words that brain activity is a necessary condition for consciousness. Is it, however, a sufficient condition? If some activity remains in the brain what type of conclusions can be drawn?

To best resolve this problem imagine that brain studies are performed on people in their normal state of waking, communicating consciousness. Let us assume that there is a common brainstate found amongst all such subjects and let us call it *BrainState_C*. Furthermore let us assume that *BrainState_C* is found to be absent in subjects who are asleep or anaesthetised. Can the conclusion be drawn that the existence of *BrainState_C* is a necessary and sufficient condition for ascribing

⁵³ The coherence of the concept Consciousness_B and the validity of the 'reflex test' is the subject of Chapter 3.

⁵⁴ Discussed in Chapter 2.

consciousness (*i.e.* consciousness_{IN})? The answer is no! - a subject after recovering from anaesthesia reports that he was conscious; the medical team consult the records of his brain scans made during the procedure and find that he was indeed in *BrainState_C*. They doubt his story. However he is able to report details of conversations between the medical team held whilst he was supposedly unconscious. The existence of further such cases, and more experimental studies, suggest that the definition of *BrainState_C* was too coarse and a distinction is introduced which has the effect of dividing it into two sub-states *BrainState_{C1}* and *BrainState_{C2}*. The presence of *BrainState_{C1}* now being regarded as the test for consciousness. This process can continue with no limit to its refinements. It is clear however that although there may be a pretence at completeness and an assertion that *BrainState_{C1}* is both a necessary and sufficient condition for consciousness, in actuality only its sufficiency can be established.

It is clear that the mechanism which enables the scientific processes of correlation to continue is the ability to communicate with the subject of the investigation. However this is exactly what is not available in cases of PVS. One avenue of investigation might appear to lie in the questioning of recovered PVS patients. Herein is the 'Catch 22' - for if such patients assert that they were conscious during the time when they were diagnosed as PVS then this, of itself, invalidates the original diagnosis. Indeed simply the bare fact of their recovery is sufficient to render null the original diagnosis.⁵⁵ Had they been in *BrainState_{C3}* during their period of apparent PVS this has no consequences for the proposition that PVS patients lack consciousness⁵⁶ although it may have repercussions on the sufficiency test elaborated above. Of course in the extreme case of all brain activity having ceased, then clearly consciousness could be assumed to be absent but such does not obtain in cases of PVS. Thus, in summary, we have a sufficient condition for ascribing consciousness - *BrainState_{C1}* - and a necessary condition for the absence of consciousness - some brain activity. The conclusion is that, unless the presence of *any* brain activity is taken as a sufficient condition for ascribing consciousness, there is *necessarily* a lacuna.

Others also urge the conclusion that there are theoretical reasons why science cannot 'lay hold of' consciousness. Drury, for example, writes:

*"The data of every natural science are data for consciousness. You cannot then bring consciousness in as one of the items of the hypothesis. The material used in the foundation cannot at the same time form the coping stone on the roof. Consciousness is not just one of the things we are conscious of."*⁵⁷

⁵⁵ Because recovery, if a sufficient time has elapsed, *invalidates* the diagnosis of PVS:

"In the BMA's view, recoveries, where they can be verified, indicate an original misdiagnosis." [BMA (1996) at p.58]

⁵⁶ Because, by definition, PVS patients cannot possess consciousness. This is fully discussed in Chapter 4.

⁵⁷ Drury, *The Danger of Words* at p. 108.

See also Drury's comments (p.75-6) on a passage in Ranson's *Anatomy of the Nervous System*, in which he gives a salutary, but perhaps overstated, reminder of the dangers of using imprecise language when discussing consciousness:

"But then you find, even in Ranson, a reference to the question at what point the nerve impulse 'enters' consciousness. Notice the complete change of language here; this is no longer descriptive and verifiable, but metaphorical and speculative. In everyday language if we use the word enter we imply a threshold both sides of which can be observed and entering means passing from one side of this threshold to the other. But in this sense, the common everyday sense, of 'entering', you cannot speak of anything entering consciousness. For consciousness has no boundary, no threshold which can be observed. If it had then there would have to be a third from of consciousness which was conscious of both what was conscious and what was not yet so. This is obvious nonsense. Consciousness is not just one of the many things we are conscious of: the mind has no particular place in nature."

I have suggested that Drury's comments may be overstated in that a third party observer can ascertain that a subject is informationally - but not consciously - aware of a particular state of affairs, and can thus meaningfully speak of information 'entering' consciousness; such a situation does not require that any 'third type of consciousness' be assumed. (The concept of 'informational awareness' is discussed in the following section.)

An interesting parallel to these issues concerns scientific studies on 'dreaming'. It has been argued⁵⁸ that scientists who use the existence of eye movements as a criterion for dreaming are using quite a different concept than is normally used. They are redefining the concept of 'dreaming' and are *pretending* by experimental methods to establish facts concerning what is normally called 'dreaming'. This is an observation which finds a ready counterpart in statements concerning consciousness⁵⁹ and brings to mind Karl Jaspers' admonition that there must be freedom from 'scientific superstition, i.e. from false absolutes and pseudo-knowledge.'⁶⁰

The conclusion to be drawn is that:

Conclusion ¹⁻⁶ : *There are theoretical limits to the determination of necessary and sufficient conditions for the ascription of consciousness. Any attempt by science to assert that particular criteria are both necessary and sufficient for ascribing consciousness is unwarranted.*

Section 3: Ambiguities in the term 'consciousness' .

In this section a number of different meanings of the term 'consciousness' are identified, in the hope that this will permit some of the problems often found in discussions on 'consciousness' to be disentangled.

I begin with the report of "The Multi-Society Task Force on PVS"⁶¹ which adopted William James's definition of consciousness as '*awareness of the self*', and suggested that it has two dimensions: '*wakefulness*' and '*awareness*'. However, they made no distinction between '*awareness*' and '*consciousness*'.⁶² Can such a distinction be made and are there other ambiguities in the term 'consciousness'?

There is considerable academic support for the view that the term 'consciousness' is open to ambiguity. Ned Block, for example, states:

*"The concept of consciousness is a hybrid or better, a mongrel concept: the word 'consciousness' connotes a number of different concepts and denotes a number of different phenomena. We reason about 'consciousness' using some premises that apply to one of the phenomena that fall under 'consciousness', other premises that apply to other 'consciousnesses' and we end up with trouble. There are many parallels in the history of science. Aristotle used 'velocity' sometimes to mean average velocity and sometimes to mean instantaneous velocity ... very different concepts are treated as a single concept. I think we all have some tendency to make this mistake in the case of 'consciousness'."*⁶³

Bernard Williams notes the confusion of '*consciousness*' and '*consciousness of*' in the writings of Descartes:

"If Descartes was disposed to see all conscious experience as consisting of some kind of conceptual thought, this will also help to explain the notorious confusion to which he is

⁵⁸ By Norman Malcolm - see Passmore *op.cit.* p.513.

⁵⁹ Bernard Baars takes the question '*When are psychologists entitled to call a certain theoretical construct 'consciousness'?*' as the focus for his paper 'A Thoroughly Empirical Approach to Consciousness'

⁶⁰ Karl Jaspers 'On my Philosophy' included in Walter Kaufmann *Existentialism from Dostoevsky to Sartre*, (1956) at p.172

⁶¹ Part 1 p.1499.

⁶² *ibid.* at p.1501:

"In this report we use the terms awareness and consciousness interchangeably."

⁶³ Ned Block 'On A Confusion About A Function Of Consciousness' p.1.

*subject between mere consciousness and reflexive consciousness; the confusion that we found him making ... between consciousness in seeing and consciousness of seeing.”*⁶⁴

This conclusion is also supported by others.⁶⁵ However, this awareness of the many meanings of ‘consciousness’⁶⁶ has not penetrated into the medical and legal discussions of PVS, and there appears to be a confusion between at least three distinct concepts: ‘consciousness’, ‘awareness’, and ‘intentionality’. Often indeed the term ‘consciousness’ is used as a conflation of all three. I will proceed by first contrasting ‘consciousness’ with ‘awareness’ and then contrasting it with ‘intentionality’ and finally by offering some conclusions.

‘Consciousness’ contrasted with ‘awareness’

A distinction can be made between consciousness and awareness in that one can have awareness without consciousness; this occurs, for example, in the phenomenon of ‘blindsight’ - which is when subjects are not aware of perceiving - *i.e.* they do not ‘see’ - certain stimuli yet it can be shown, by implication, either from questioning or by their subsequent conduct, that they have indeed perceived them. Thus awareness and consciousness are distinct concepts. Furthermore, since it seems contradictory to speak of consciousness without awareness, it is possible to treat consciousness as a ‘subcategory’ of awareness - *i.e.* to take awareness as the primary concept and to define consciousness in terms of it.

At least four different types of awareness can be considered. ‘Informational awareness’ which is of two types - conscious and unconscious; the former I term ‘Experiential awareness’ and the concept of ‘Blindsight’ covers the latter. The third type is ‘Conceptual awareness’ and the last is ‘Intentional awareness’.

‘Informational awareness’

‘Informational awareness’ occurs when a system operates in a fashion consistent *only* with certain information having passed into that system. Thus, for example, a robot can be (informationally) aware that an object is blocking its way and move to avoid it, or indeed a snail can be informationally aware that cabbage is close by and move towards it.

As mentioned informational awareness can either be conscious or unconscious. The informational awareness of the robot is (presumably) unconscious, as is that of the ‘blindsighted’ awareness of the human subject. In subsequent discussions the term ‘informational awareness’⁶⁷ is used to cover just such unconscious awareness and the term ‘experiential awareness’ is used to describe cases of conscious informational awareness.

‘Experiential awareness’

‘Experiential awareness’ is an existential concept; a conscious awareness of an experience, fully in the present and thus unmediated by concepts or language. It can be contrasted with ‘conceptual awareness’ - or ‘awareness of’, or ‘consciousness of’, or ‘reflexive consciousness’. ‘Conceptual awareness’ implies an awareness of the experience as one happening within a larger context, either

⁶⁴ Bernard Williams *Descartes*, 1978. at p.286

⁶⁵ See, for example, Preben Bertelsen ‘Review of Arheim ‘Matter Matters?’’ *Journal of Consciousness Studies* (1998) at p.375:

“The main thesis is that one has to differentiate between consciousness and cognition, which are not synonymous categories ...”

⁶⁶ It has been suggested that Buddhism recognises 89 different types of consciousness.

of past and future, or of personal and other, or some such. Such 'conceptual awareness' is necessarily dependent on language. It is what we mean by '*conceptual thought*' and is a precondition for '*cognition*'. However, is the distinction between '*consciousness*' and '*consciousness of*' a valid distinction - *i.e.* is it a distinction without a difference?

Some have suggested - most notably Descartes - that 'consciousness' is equivalent to 'consciousness of'; *i.e.* that there cannot be 'consciousness' without the ability to think conceptually. For example, the proposition that it is not possible to experience pain without the ability to think conceptually has been advanced as an argument to suggest that neither animals nor newborn infants can experience pain. The refusal to distinguish between '*having an experience*' and '*having an experience and knowing it was an experience of a particular type*' would also imply, for example, that a dog could not be hungry since it has no *concept* of hunger. The argument will be considered in detail in Chapter 3.⁶⁸ Suffice to say at this stage that it is fallacious and rests on a refusal to distinguish between 'conceptual awareness' and 'experiential awareness'. The error can be readily seen by performing a simple thought experiment.⁶⁹ Imagine a child born to an extended family all of whom were blind, but not so the child. Imagine further the child growing up only amongst such adults so that the *concept* of 'seeing' was not utilised in everyday conversation and not available to the child. Certainly the child would not have the concept of seeing but surely it could see? A more realistic, but less striking, example could be constructed from the actual experience of the neurologist Oliver Sachs outlined in his *Island of the Colour Blind* by imagining a child born with perfect sight but living in a village populated only by the colour blind. The child's lack of the *concept* of colour would surely not affect the nature of the image presented to the brain.

Accepting that a distinction can be drawn between 'consciousness' and 'consciousness of', must 'consciousness of' be manifested in action of some sort? A simple gesture of introspection will show that such 'conceptual awareness' is independent of action and that it is possible to be conceptually aware of one's circumstances and to take no action as a result of this awareness. It follows that 'conceptual awareness' has no logically necessary connection to Consciousness_B.

⁶⁷ or, simply, '*blindsight*'.

⁶⁸ Chapter 3 discusses pain judgements.

⁶⁹ The example was mentioned earlier - see Introduction, footnote 23.

'Consciousness' contrasted with 'intentionality'

A recent article by K. Ramakrishna Rao in the Journal of Consciousness Studies⁷⁰ distinguishes between Eastern and Western conceptions of consciousness. Rao notes that in the Western tradition *intentionality* is regarded as a defining characteristic of consciousness which itself is regarded as being synonymous with mind. In the Eastern tradition consciousness is believed to be non-intentional whilst the mind is regarded as intentional. Rao's suggestion raises the question as to whether '*consciousness*' can be considered as distinct from '*intention*' and, if so, how can intention be characterised.⁷¹

It seems clear that experiential consciousness can exist without intention. A gesture of introspection will show that one can rest in the fullness of an experience and be, at that moment, without dissatisfaction, or intention to move out of that experience. Anything experienced *fully in the present* precludes a further intention; the existence of intention being possible only in context of contemplating 'future' and such is incompatible with experiencing 'fully in the present'. Assuming then that consciousness can be distinguished from intention, how do we characterise intention?

Intention is distinct from 'goal directed behaviour'. Goal directed behaviour is obviously a necessary constituent of intentional behaviour yet 'intentionality' is more than goal directed behaviour as can be seen by considering the example of a robot programmed to reach a certain point and to avoid any obstructions that it encounters. The robot exhibits goal directed behaviour with informational awareness of the obstacles; yet it could hardly be said that it had intentions. Neither can goal directed behaviour with experiential consciousness, or indeed with conceptual awareness, be considered as necessarily intentional. Consider a person acting under an 'irresistible impulse' or whilst under the spell of hypnosis; such subjects are both experientially aware and conceptually aware of their actions but they would not consider themselves, nor be considered as, 'intending' these actions. They are not the '*author*' of their actions. This idea of authorship, or ownership, of one's actions seems fundamental to 'intentional awareness'; this ownership necessarily requires a reflexive consciousness but that alone is not sufficient. What else is required? The concept of 'ownership' of actions has as a corollary the proposition that the subject is 'responsible' for his actions;⁷² this is a concept closely connected with ideas of 'personhood'. Thus again we find the concept of personhood playing an unstated but important role in the discussion. It was suggested earlier that consciousness was sometimes used as a surrogate for 'personhood', 'ability to act intentionally' is another.

Is intention separable from behaviour? Can we distinguish between '*executable/executed intentionality*' - involving some act referable to the intention - and '*pure intentionality*' unconnected with any overt act. In other words can there be 'pure intention'? Some accept the distinction. Williams⁷³ for example - distinguishes between 'willing that my arm move' and 'moving my arm'.

⁷⁰ K. Ramakrishna Rao 'Two Faces of Consciousness: a look at Eastern and Western Perspectives', Journal of Consciousness Studies, 1998.

⁷¹ Daniel Dennett's analysis of intention, which is particularly helpful and enlightening, is summarised in Chapter 2. It clarifies the meaning to be given to the term 'intention' when used in relation to machines such as robots.

⁷² Even more fundamentally, it is often considered that a 'person' is one who has actions *i.e.* is involved in '*doing*' rather than just in '*being*'. Owen Flanagan, for example, considers personhood to be intimately linked to the ability to have, and execute, 'life plans'. Western philosophy - in contrast to Eastern - considers man as essentially a '*doer*'; it would regard a life lived without such '*doing*' as purposeless and pointless. Such views are often encountered in relation to elderly inactive patients, and are implicitly dependent on judgements which distinguish between the value of '*being*' and '*doing*'. It is important that the values underlying such judgements be made explicit and subject to scrutiny. In this respect the Eastern philosophical tradition provides a useful counterpoint.

⁷³ Williams, Descartes, p.291:

Others, such as William James do not. James considered that the act *is* the intention. The example of a paralysed person might suggest the contrary; such a person might first have the 'pure intention' to walk though be unable to execute any action referable to that intention, but may slowly regain the ability to walk.

Before finishing this section we consider an example, taken from the medical literature on PVS, of misuse of the term 'consciousness'.

An example of ambiguity in the use of the term 'consciousness'

The Multi-Society Task Force on PVS ['MSTF'] state:

*"None of these"⁷⁴ however, can evoke the experience of pain and suffering if the brain has lost its capacity for self-awareness. The perceptions of pain and suffering are conscious experiences: unconsciousness, by definition, precludes these experiences."*⁷⁵

This is clearly a nonsequitur.

Firstly, the term 'self-awareness' means the possession of a *concept of self*; it is often used as a criterion to distinguish between humans and other animals - man having a concept of self unlike, it is said, other animals. When it is said of such animals that they do not have a concept of self this does not imply that they do not have an existential awareness of their own body and can thus not experience its sufferings - such a suggestion would be bizarre. The term relates to the possession of a concept of self which is a particular type of 'Conceptual awareness', and the lack of conceptual awareness does not necessarily imply a lack of experiential awareness.

Secondly, the MSTF uses lack of 'executed intentional awareness' - i.e. lack of purposeful actions - as the criterion for 'unconsciousness' in relation to PVS patients. The proffered conclusion - i.e. that unconsciousness, by definition, precludes experience - is something of a sleight of hand in that it relies on two senses of the term 'unconscious' - its normal sense and the sense used by the MSTF.

Conclusions - the link between behaviour and the many meanings of consciousness.

Of the many meanings of consciousness that we have discussed - 'Informational awareness', 'Experiential awareness', 'Conceptual awareness', 'Pure Intentional awareness' - all can exist without any outward expression, it is only 'executed intentional awareness' that logically requires a behavioural manifestation. However, the Medical Conceptual Framework ignores all meanings other than that of 'executed/executable intentional awareness'.⁷⁶ The PVS patient who does not show evidence of actions executed with intentional awareness - purposeful actions - is considered to have no consciousness.

"My moving my arm, on Descartes's account, just is my willing, plus my willing's being effective; ... To suppose, then, that the intentional content of the willing - what I will - refers to the action of moving my arm would be to suppose that the intentional content itself refers to an act of willing, so that I will that I will, and that must be wrong ... Put your hand next to some object, such as this book, and 'will' your hand to approach the book. Nothing happens. Now 'will', in that same way, your hand to approach the book. Still nothing happens. Direct application of psychokinesis is no more effective with my limbs than with anything else."

⁷⁴ i.e. reflexive responses.

⁷⁵ Part 2, p.1576.

⁷⁶ 'Executed/executable intentional awareness' is identical to the *Consciousness_B* spoken of earlier.

Conclusion ₁₋₇: The term 'consciousness' has a number of meanings. These various meanings can be arranged as a hierarchy with each succeeding level incorporating the levels beneath and with only the topmost level requiring a behavioural manifestation:

Level ₁ : Informational awareness

Level ₂ : Experiential awareness

Level ₃ : Conceptual awareness

Level ₄ : Awareness with pure intention

Level ₅ : Awareness with executable/executed intention

The Medical Conceptual Framework, in discussing 'consciousness', recognises only Level ₅.

Passing mention has already been made of the Cartesian view of consciousness; its role in creating the confusion between 'consciousness' and 'consciousness of' has been noted. A digression is necessary so that certain aspects of Cartesian philosophy can be outlined. This is of assistance because Cartesian philosophy acts in many ways as a foundation for the Medical Conceptual Framework, and the most fundamental attack on any structure is achieved by first laying bare its foundations.

There are a number of congruences between Cartesian philosophy and the Medical Conceptual Framework and in order that the following discussion be more clearly focused, these correspondences are now listed:

- * 'Consciousness' and 'consciousness of' are considered to be equivalent.
- * Pain cannot be experienced in the absence of reflexive consciousness.
- * Possession of consciousness is regarded as the criterion of being a person.⁷⁷
- * Once an individual's behaviour can be given a fully mechanistic explanation - such as, for example, when all the behaviour is considered to be 'reflex' in nature - then that individual is not a person.

Furthermore, the idea that an isolated, pre-social, individual could be considered a person is implicit in Cartesian philosophy. The challenge to this idea - particularly from Wittgenstein 'PLA' - is of crucial importance in justifying the necessary condition for personhood which is advocated in Chapter 10. It is convenient at this stage to set out the Cartesian position on these questions as a unit and in a reasonably structured fashion, rather than having to treat it piecemeal as the need arises. It is to this task that we now turn.

Section 4: A brief sketch of some aspects of Cartesian philosophy relevant to the discussion of PVS patient consciousness

Introduction

Much of the discussion of consciousness, of reflex actions and indeed of personhood, is embedded in a landscape fashioned by Cartesian philosophy. The concepts of Cartesian philosophy have become the spectacles which permit us to view, or more accurately to structure, the world. However, this structuring is largely unconscious and the spectacles - which necessarily cast their own shadows - become invisible and the view through the Cartesian 'conceptual spectacles' begins to wear the mask of unique, necessary, truth.

⁷⁷ The term 'person' is used for convenience; a more accurate term would be '(truly) human'. As will be discussed in Chapter 10, the concept of 'personhood' owes its origin to John Locke.

In this century modern physics has been the only discipline to present a serious challenge to the Cartesian world view, and the effects of this challenge have been largely restricted to science and the philosophy of science, and have not yet infiltrated the wider society. In physics the reevaluation of Cartesianism has been particularly fruitful though the resistance to such a reassessment has been noted by Heisenberg - one of the founders of quantum mechanics at the beginning of this century - who wrote that:

*"The Cartesian partition has penetrated deeply into the human mind during the three centuries following Descartes, and it will take a long time for it to be replaced by a really different attitude towards the problem of reality."*⁷⁸

Others have been less forgiving of the influence of Cartesian philosophy on the modern mind - Jaspers, for example, says:

*"Descartes' perverted conception of science and philosophy made his influence disastrous. Because of this, and because of the basic fallacy that is obvious in his work, we should study him in order to know the road that is to be avoided."*⁷⁹

P.M.S. Hacker is no less critical:

*"The Cartesian myth like all great myths is insidious. It can assume many guises, and even those who think of themselves as liberated from Cartesianism adopt crucial elements of the tale. A striking feature of contemporary philosophers, psychologists and neurophysiologists is that, while rejecting mind/body dualism, they accept the fundamental conceptual structure of the Cartesian picture."*⁸⁰

As mentioned earlier, the Medical Conceptual Framework is one of those theoretical structures which is deeply indebted to Cartesianism. What are the essential features of this Cartesianism?

The Philosophy of Descartes - a brief sketch

Descartes (1596-1650) has been considered the father of modern philosophy; a modernist in his attitude to science and scientific explanation, much impressed with 'those long chains of very simple and easy reasonings which geometers use to arrive at their most difficult demonstrations'.⁸¹ He sought to place philosophy on equally secure foundations.

Unlike La Mettrie⁸² - who believed that all nature, including man himself, was amenable to a scientific explanation - Descartes set a limit to the scope of mechanistic explanation; he believed in

⁷⁸ Fritjof Capra, Uncommon Wisdom, (1988) at p.19.

⁷⁹ Karl Jaspers, Way to Wisdom, (1954) at p.184. In his essay 'On My Philosophy' (Kaufmann *op.cit.* at p.184) Jaspers says:

"In my Descartes I wanted to present historically typical modern errors at their root, viz. mistaking speculative thought for rationally cogent insight ..."

⁸⁰ P.M.S. Hacker, Wittgenstein, (1997), at p.16.

⁸¹ John Cottingham, Descartes, (1997), at p.13.

⁸² La Mettrie in his Man a Machine (1748) had argued - in what he claimed to be a natural extension of Descartes' views - that man himself could be explained entirely mechanistically. He even suggested that Descartes had accepted this but concealed it in fear of the Church. Unlike Descartes, La Mettrie did not conceive of the existence of a mechanistic explanation and the individual experience of consciousness, as being mutually exclusive:

"For after all, although he [Descartes] extols the distinctness of the two substances, this is plainly but a trick of skill, a ruse of style, to make the theologians swallow a poison, hidden in the shade of an analogy which strikes everybody else and which they alone fail to notice. ... I believe that thought is so little incompatible with organised matter, that it seems to be one of its properties on a par with electricity, the faculty of motion, impenetrability, extension, etc."

[Julien Offray De La Mettrie, Man a Machine, p.145]

La Mettrie's suggestion is bolstered by a remark made by Descartes in a letter to a friend:

"But for all the world I did not want to publish a discourse in which a single word could be found that the Church would have disapproved of: so I preferred to suppress it rather than to publish it in a mutilated form ..."

see Cottingham *op.cit.* p.15; see also: Leiber, An Invitation to Cognitive Science, p.26.

the necessity of preserving the very clear distinction between the animal and the human which was made by Christianity in its doctrine of the immortal soul. Descartes needed to find some philosophical counterpart for this soul and he found it in the concepts of 'mind' or 'consciousness'.⁸³ This 'consciousness' was the sole preserve of man, his essence. Animals, in contrast, had no consciousness, they were just machines.

Before Descartes, the fundamental distinction in any analysis of the world was that between 'living' and 'non-living' matter. However Descartes, following the Christian doctrine of the soul, saw the distinction between man and all else as providing the fundamental line of cleavage and this change of focus changed the categories of philosophy. The focus of wonder was henceforth to be, not that border between living non-living matter, but that between man and nature.

Descartes' Method

Descartes' method was to doubt *all*. His goal was to find that of which he could entertain no further doubts. This, he believed, would be the certain foundation on which he might build. Applying this method he was lead ultimately to his famous '*Cogito, ergo sum*' - often translated as '*I think, therefore I am*'.⁸⁴ Descartes elaborates on this:

*"... from the very fact that I thought of doubting the truth of other things, it followed very evidently and very certainly that I was ..."*⁸⁵

The validity of Descartes' method, *i.e.* whether the inability to doubt is a valid criterion of truth, is open to question, but is not relevant to our purposes. Descartes, from his own perspective, had found the secure foundation and could now commence to build.

Descartes' essential characteristics of man

Having found the indubitable 'I', the next question is '*What is this 'I'?*' Descartes refused to accept the Aristotelian answer - that he is a rational animal - as this would have lead to an infinite regress of definitions.⁸⁶

Descartes believed that:

*"... I could pretend that I had no body and that there was no world or place for me to be in, I could not for all that pretend that I did not exist."*⁸⁷

which led him to conclude:

*"... this 'I' - that is, the soul by which I am what I am - is entirely distinct from the body, ... and would not cease to be everything it is even if the body did not exist."*⁸⁸

⁸³ Descartes regarded 'mind' and 'consciousness' as synonyms.

⁸⁴ The formulation is unfortunate in that it appears to be an inference. Roger Scruton points out that this formulation was due to a friend of Descartes. Descartes' own formulation in the *Meditations* was that '*the proposition 'I am, I exist' is necessarily true each time I pronounce it or 'inwardly affirm it'.*' [Roger Scruton *Modern Philosophy*, 1994, at p.34] The proposition is reminiscent of Augustine:

"For if I am deceived I am. For he who does not exist cannot be deceived; and if I am deceived, by this same token I am."

Vernon J. Bourke, *The Essential Augustine*, (1964), at p.33.

⁸⁵ Bernard Williams's essay *The Certainty Of The Cogito*, in Willis Doney (ed.) *Descartes*, (1968), at p. 89.

⁸⁶ *i.e.* first as to what is meant by 'animal' and then by 'rational' and then to the terms used to define these, and so forth. Stephen Priest *Theories of Mind*, (1991), at p.17.

Accepting such a definition would have redirected his attention 'outwards'; however, Descartes sought to find the answer through introspection. Had his initial direction been outwards his ideas of what was most essential in man might have reflected more the social characteristics of man rather than just his internal state of consciousness. We will return to this question in discussing 'personhood'.

⁸⁷ Descartes *Discourse on Method* Part 4 [quoted by Cottingham *op.cit.* p.21].

⁸⁸ *ibid.* p.22.

Descartes concluded that '*mind*' and '*body*' were of essentially different natures; he expressed this by saying that they were two distinct substances. These substances interacted in man by means of the pineal gland.

These two substances of which man was composed were by no means of equal importance; the existence of the body could, after all, be doubted but not so the mind. The essential characteristic of man lay in the possession of '*mind*' or '*consciousness*'.

*"I am then, in the strict sense only a thing that thinks; that is, I am a mind, or intelligence, or intellect or reason ..."*⁸⁹

and more emphatically:

*"... I was a substance whose whole essence or nature of which is to think, and that for its existence there is no need of any place, nor does it depend on any material thing; ..."*⁹⁰

Descartes' meaning of the term 'consciousness'

The consciousness of which Descartes speaks, had its origins in his attempt to doubt his own existence; such a doubt can only exist in the context of conceptual mental activity and the consciousness of which he had such certainty, was necessarily a 'reflexive consciousness'.

Stephen Gaukroger notes that:

*"... awareness of ones own mental states is the key to the difference between creatures with a mind and automata, and that without such awareness the characteristic features of human mental life would not be possible."*⁹¹

Does Descartes, however, acknowledge an experiential consciousness distinct from a reflexive consciousness?

Williams thinks not:

*"If Descartes was disposed to see all conscious experience as consisting of some kind of conceptual thought, this will also help to explain the notorious confusion to which he is subject between mere consciousness and reflexive consciousness; the confusion that we found him making ... between consciousness in seeing and consciousness of seeing."*⁹²

To Descartes, not only were the terms '*consciousness*' and '*reflexive consciousness*' synonyms, but equally so were the terms '*I*', '*soul*' and '*mind*'.⁹³

Descartes' equation of '*consciousness*' with '*reflexive consciousness*' has further implications:

- * consciousness is a definitive and exhaustive description of the mental, in particular there can be no unconscious mental processes⁹⁴
- * consciousness is a unitary phenomenon. A reflective consciousness if it is to be a self-consciousness must clearly be unitary; any breach in the unitary nature would be destructive of the self - it would be schizophrenic in the classical sense of the term.

⁸⁹ Descartes Meditations 'The Second Meditations' [quoted by Cottingham *op.cit.* p.28].

⁹⁰ Descartes Discourse on Method, Part 4, Para 33; (trans. Haldane) included in Enrique Chavez-Arviso (ed.) Descartes: Key Philosophical Writings, (1997).

⁹¹ Stephen Gaukroger, Descartes: An Intellectual Biography, (1995), p.350.

⁹² *op.cit.* p.286 (quoted earlier in this chapter).

⁹³ Priest *op.cit.* p.31.

⁹⁴ *ibid.* p.27

In an attempt to further elucidate Descartes' view on consciousness an examination of his attitude to animals is instructive⁹⁵ in that it highlights the role Cartesian philosophy assigns to beings who lack self-consciousness.

Animal Consciousness from a Cartesian standpoint

Descartes considered that there were two methods by which 'we may recognise the difference that exists between men and brutes.'

The first lay in the human *ability to communicate*:⁹⁶

"For it a very remarkable fact that there are none so depraved and stupid, without even excepting idiots, that they cannot arrange different words together forming of them a statement by which they make known their thoughts; ..." ⁹⁷

The second lay in the breadth of *human versatility*:

"... although there are many animals which exhibit more dexterity than we do in some of their actions, we at the same time observe that they do not manifest any dexterity at all in many others." ⁹⁸

The fact that some animals can do certain tasks better than humans does not prove that they can reason; rather it proves:

"... they [animals] have no reason at all, and that it is nature which acts in them according to the dispositions of their organs, just as a clock, which is composed of wheels and weights is able to tell the hours and measure the time more correctly than we can do with all our wisdom." ⁹⁹

An alternative formulation of the argument is:

"... if there had been such machines, possessing the organs and outward form of a monkey or some other animal without reason, we should not have any means of ascertaining that they were not of the same nature as those animals. On the other hand if there were machines which bore a resemblance to our body and imitated our actions ... we should always have two very certain tests by which to recognise that, for all that, they were not real men. The first is, that they could never use speech ... For we can easily understand a machine's being constituted so that it can utter words ... But it never happens that it arranges its speech ... in order to reply appropriately to everything that may be said in its presence, as even the lowest type of man can do. And the second difference is, that although machines can perform certain tasks ... perhaps better than any of us can do, they infallibly fall short in others, by the which means we may discover that they did not act from knowledge but only from the disposition of their organs." ¹⁰⁰

Descartes considered animals to have 'no souls, no thoughts or experiences and to be in fact automata'.¹⁰¹ To a commentator who expressed outrage at his 'snatching away life and sensibility

⁹⁵ In so far as PVS patients are also believed to be individuals without self-consciousness.

⁹⁶ In Chapter 10 I will argue that '*ability to communicate*' is a necessary condition for the ascription of 'personhood'.

⁹⁷ Descartes *Discourse on Method* Part 5 para 57 [Chavez-Arviso *op.cit.* p.108]

⁹⁸ *ibid.* p.108

⁹⁹ *ibid.* p.109. See also: Desmond M. Clarke, *Occult Powers and Hypotheses*, (1989) - especially Chapter 6 entitled '*Mechanical Explanation*' - and Desmond M. Clarke, *Descartes's Philosophy of Science*, (1982).

¹⁰⁰ *ibid.* p.107.

¹⁰¹ Williams, *Descartes* p.282.

from all the animals', Descartes replied to the effect that - although we cannot prove there is no thought in animals since our mind 'does not penetrate their hearts' - their responses are purely mechanical. The 'passions' of animals are purely physical disturbances in the nervous system which can generate behaviour but are not associated with experiences. Descartes gives the example of the flight of a sheep on seeing a wolf; the flight behaviour is, he believed, mechanically caused by light reflected from the body of the wolf and is performed without consciousness.¹⁰²

In summary, to Descartes animals can neither be conscious nor experience pain; they are 'natural automata' because they have only limited responses and above all have no use of language.

Williams has observed that, to Descartes:

*"... some human behaviour is of this type. Quite a lot of human bodily movement and actions, in fact, are thought by Descartes to bypass the soul, and to be products of self-contained mechanical cycles within the body. Such actions or movements are not just analogous to animal behaviour, but are produced in exactly the same way."*¹⁰³

These actions 'which bypass the soul' are precisely the reflex actions spoken of earlier.¹⁰⁴ These actions which lie outside the 'will' - that is are not intentional - are not to be considered as having a mental origin. Descartes, after all, had no conception of an unconscious aspect to the human mind. The choice permitted by Descartes is stark:

*"... either a creature has a full range of conscious powers ... or is an automaton, with no experience of any kind."*¹⁰⁵

To Descartes, all that lay outside our self-consciousness was to be considered as purely mechanical:

*"... if I consider the body of a man as being a sort of machine so built up and composed of nerves, muscles, veins, blood and skin, that though there were no mind in it at all, it would not cease to have the same motion as at present, exception being made of those movements which are due to the direction of the will, and in consequence depend upon the mind ... I easily recognise that it would be as natural to this body, supposing it to be, for example, dropsical, to suffer the parchedness of the throat which usually signifies to the mind the feeling of thirst, and to be disposed by this parched feeling to move the nerves ... in the way requisite for drinking."*¹⁰⁶

An argument which bears uncanny resemblance to current medical theories of PVS patient responses. Let us now look at this question directly and see how a Cartesian framework would resolve the problem of PVS patient consciousness and ability to experience pain.

¹⁰² *ibid.* p.283.

¹⁰³ *ibid.* p.283-4.

¹⁰⁴ Chapter 2 will examine the coherence of the Cartesian claim that all human actions can be split into two quite distinct and mutually exclusive classes, the 'reflex' actions and the 'non-reflex' actions. Williams is critical of the possibility of such a strict dichotomy:

"However, Descartes's specification of this class of movements or actions suffers considerably from vagueness ... It is hardly surprising that Descartes's account is unclear on this point since he is engaged on an impossible task of sorting all human movement into two sharply delimited classes, as having ultimately different causal histories, one which does, and one which does not, involve the 'intervention of the mind'. It is one product of his 'all or nothing' account of mind and consciousness: either a creature has a full range of conscious powers ... or it is an automaton, with no experience of any kind."

[*op.cit.* p.284].

¹⁰⁵ *ibid.* p.284.

The PVS patient from a Cartesian perspective

Let us accept, for the sake of argument, that the actions and responses of a PVS patient are of such a predictable nature as to be correctly classified as purely mechanical or 'reflex'.¹⁰⁷

Would such a PVS patient be considered conscious?

To one who suggested that an animal might be conscious, Descartes replied (as paraphrased by Williams):

*"... we cannot prove there is no thought in animals since our mind 'does not penetrate their hearts', but he does think their responses are purely mechanical and that they are ... 'natural automata'. His principle ground for this view ... is that animals ... have ... only limited responses ... and, above all, have no use of language at all, ..."*¹⁰⁸

Is it possible, within Cartesian philosophy, to make a distinction between the case of animals and PVS patients, if it is accepted that both manifest purely mechanical behaviour and neither can communicate? A Christian theologian certainly might make a distinction; he could say that the PVS patient has a 'soul' and the animal has not. Descartes used the same term 'soul';¹⁰⁹ can he make the same distinction as the theologian without distorting his philosophy? I suggest not. To Descartes 'soul' was a *manifested* soul. It was manifested in either the possession of language or complex behavioural patterns. To permit an unmanifested soul would *structurally* damage the Cartesian edifice. There is no 'gap' where such a distinction¹¹⁰ could find a point of purchase.

Hence we can conclude that, to Descartes, such a patient would be a mere automaton, without consciousness, and equivalent to one of Descartes' '*brutes*'. Descartes would not have discriminated between '*reflexive consciousness*' and '*experiential consciousness*' and would have concluded that such a patient could not have '*experiences*' and thus could not suffer pain.

This conclusion calls to mind the quotation given earlier from The Multi-Society Task Force on PVS:

*"None of these,"¹¹¹ however, can evoke the experience of pain and suffering if the brain has lost its capacity for self-awareness. The perceptions of pain and suffering are conscious experiences: unconsciousness, by definition, precludes these experiences."*¹¹²

¹⁰⁶ Descartes *Meditations*. Sixth Meditation, Para 84. [Chavez-Arviso *op.cit.* p.186].

¹⁰⁷ Actions which Cartesian philosophy classifies as 'purely mechanical', are classified by the Medical Conceptual Framework as 'reflex actions'. The two terms are synonyms; for if not, an action must exist which is either a non-mechanical reflex action or a mechanical non-reflex action; such is not possible; though see the discussion - in Chapter 2 - concerning ambiguities in uses of the term 'reflex'.

¹⁰⁸ Williams, *Descartes*, p.282.

¹⁰⁹ see earlier discussion at footnote 82.

¹¹⁰ i.e. a human with an 'unmanifested soul' and an animal.

¹¹¹ i.e. reflexive responses.

¹¹² Part 2 p.1576.

We have already commented on the fundamental confusion inherent in concluding - from an assumption of lack of reflective consciousness - that the ability to experience pain is absent. The confusion is that between '*experiencing something*' and '*experiencing that something as pain*' - the latter obviously requiring use of the concept 'pain' and hence a 'reflexive consciousness'. Concerning this point Williams states (*Descartes* p.82):

"An interesting case in this connection is pain. It would be generally agreed that pain is a conscious experience: one who is in pain feels something. Now it may, further, be true that a language user who is in pain will believe that he is in pain, unless perhaps he is such a reduced state that he has lost effective hold on his language use. If one possesses and can use the concept pain, its application to oneself will be elicited by one's being in pain, and in this pains importantly contrasts with wants. But non-language users can be in pain (though Descartes ... denied it); they have no concept of pain they can apply to themselves, and to them we cannot in all seriousness ascribe, in addition to their pain, a belief that they are in pain."

Judgements as to the possibility of another experiencing pain are discussed in Chapter 3.

The congruence between the Cartesian attitude to animals and the medical attitude to PVS patients is patent. It is inescapable. Furthermore it is not coincidental. It is based on precisely the same theoretical analysis.

Conclusion₁₋₈: *Both Cartesian philosophy and the Medical Conceptual Framework share a common deductive structure. The progression is from*
'lack of non-reflex movements' to
'lack of self-consciousness' to
'lack of ability to experience pain' and
'the subject is not 'truly human' or is not a 'person' '.

This last step requires some further discussion.

The Cartesian criteria for 'personhood'?

Within Descartes' philosophy, being a person¹¹³ is equivalent to having a 'reflexive consciousness' or 'soul'. The question arises as to how one determines whether another being possesses such a 'reflexive consciousness'. Descartes, in his discussion of the '*cogito*', suggested that mind was not dependent on a body; he stated (as quoted earlier):

*"... this 'I' - that is the soul by which I am what I am - is entirely distinct from the body ... and would not cease to be everything it is even if the body did not exist."*¹¹⁴

This suggests that the soul - or 'reflexive consciousness' - could continue in the absence of the body; and *a fortiori* the reflexive consciousness could persist without any physical manifestation in the body. Yet, as discussed earlier, Descartes insisted on a *manifestation* of 'soul'.¹¹⁵ Animals, he argued, did not have a reflexive consciousness because their conduct was not sufficiently complex to escape a mechanistic explanation and, secondly, because they had not a language.¹¹⁶ In order to lay the groundwork for a subsequent discussion of personhood, it is of interest to pose the question - Can these two conditions be brought under the same rubric?

There are two cases to be considered. Firstly, could there be beings who had a language but whose behaviour was mechanical? If so how should they be characterised? Consider the example of an individual who was so severely paralysed that the only movements possible to him were spasmodic but who could still talk. Surely Descartes would not have doubted the existence of such a man's 'soul' or '*reflexive consciousness*'? This would suggest that the language criterion is primary.

The second case would concern an individual whose behaviour could not be classified as mechanical yet who had not language. Consider the example of a man who is a deaf mute who never learned any language but whose intelligence is beyond doubt because it is continuously manifested in his skills. Surely this man would also be, to Descartes, 'truly human'.

These conclusions can be summarised as:

¹¹³ The term 'person', owes its philosophical origin to Locke and was not used by Descartes. As mentioned earlier a more appropriate term would be '*truly human*' however 'person' is more convenient.

¹¹⁴ Cottingham *op.cit.* p.22.

¹¹⁵ It is clearly possible to conclude here that PVS patients have no such manifestation and accordingly are not persons; this indeed is the conclusion that was arrived at in the previous subsection. The discussion temporarily holds off on this conclusion in order that the Cartesian criteria for personhood be cast in the form of necessary and sufficient conditions.

¹¹⁶ Williams *Descartes* p.282 (quoted earlier):

"... but he does think there responses are purely mechanical and that they are ... 'natural automata' because they have only limited responses or routines and above all have no use of language."

Conclusion 1-9: *In Cartesian philosophy the ability to use language is a sufficient, but not a necessary, condition for personhood. In the absence of an ability to use language 'complexity of behaviour' is both a necessary and a sufficient condition for personhood.*

Applying this test to a PVS patient it is clear that the language condition is not met, neither is the behavioural patterns manifested by the patient of a sufficient complexity to warrant the imputation of a reflexive consciousness, and hence of personhood.

In the tests for personhood just outlined the underlying assumption appears to be that an individual who exhibits a sufficiently complex behaviour - without any ability to use or understand language - possesses the ability to think conceptually, and thus have a 'soul' or a 'reflexive consciousness'. Complex behaviour *per se* is not sufficient. This is because if complex behaviour were alone sufficient then that individual would be unable, *on his own behalf*, to participate in the *cogito* argument. He could never - even to himself, assert 'I think therefore I am' or even its 'wordless equivalent' whatever that might be. Hence, because the *cogito* argument plays such a fundamental role in Cartesian philosophy, it is reasonable to conclude that the 'sufficiently complex behaviour' criterion is of importance not for itself, but because of its evidential value in establishing 'reflexive consciousness'. However, Wittgenstein's '*Private Language Argument*' ['PLA'] - which will now be sketched - raises a fundamental challenge to these conclusions.

Wittgenstein's challenge to the Cartesian conceptual framework

Cartesian philosophy has been attacked from many directions but perhaps the most serious and fundamental challenge to the entire Cartesian edifice is from Wittgenstein's '*Private Language Argument*' ['PLA']. The 'PLA' will be considered in detail in Chapter 10; here I simply wish to outline the Cartesian position in a detail sufficient to enable the challenge posed by the 'PLA' to be understood.

Cartesian philosophy posits an isolated, pre-social but language using, individual as its starting point. This individual - by virtue of the *cogito* argument - establishes that his own existence and consciousness, is beyond doubt. This then becomes the rock on which he builds, or appropriates, the world. Wittgenstein's 'PLA' destroys this project at its base and forces a fundamental reassessment of Descartes' philosophy and, in particular, of the Cartesian conception of a person.

A slight detour to examine the organisational structure of Newtonian physics, is useful because aspects of its methodology are shared by Cartesian philosophy. Newtonian physics sought to describe the workings of an inanimate universe, but any direct approach to such a complex problem was doomed to failure. The genius of the Newtonian approach was that it first considered isolated particles of matter and sought to describe the laws which governed their motion. From the laws governing the motion of these isolated particles it deduced the motion of rigid bodies - which were after all only groups of such particles - and continued this progression until the motions of the planet fell within its ambit. The essence of the method was isolating the simplest constituent - the particle - and slowly, step by step, adding complexity until the workings of the heavens lay bare. Descartes, faced with an infinitely more complex universe than that sought to be explained by Newtonian mechanics - for Descartes took living and thinking things into his universe - equally sought the simplest constituent which he could find, and that was the individual. Descartes presupposed no environment for this individual - no society, no community of fellows, no governments or nationality, no culture, no history, nothing just a thinking thing. On this basis he began his project and set out to

construct his philosophy. However, Wittgenstein in his 'PLA' found the Achilles heel of the Cartesian project ¹¹⁷ and indeed of all philosophical systems which sought to explain the individual atomistically.

By a '*private language*' Wittgenstein means:

"... a language in which a person could write down or give vocal expression to his inner experience - his feeling, moods and the rest - for his own private use ... The individual words of this language are to refer to what can only be known to the person speaking; to his immediate private sensations. So another person cannot understand the language." ¹¹⁸

Wittgenstein's 'PLA' denies the possibility of such a language existing; it implies that an individual, isolated from all contact with his fellow man, can *never* develop any language. ¹¹⁹ Language is, in essence, a social activity. The existence of language depends on social rules and social interaction. *This is crucial for our purposes* for it follows from it that an isolated pre-social individual cannot have a '*reflexive consciousness*' because a reflective consciousness depends on concepts and these cannot exist without language. Conceptual thought is *impossible* without language. Thus the 'starting point' of philosophical analysis cannot be the 'isolated individual' but must be the wider society; the language speaking individual is a product of the wider society and not conversely. The analytical method must be 'top-down' and not 'bottom up'. As a heuristic device, certainly it may be convenient to first consider the individual and then to attempt to explain the society wholly in terms of the individual but this must not be allowed to mask the fact that society is logically prior to the individual. Thus, following immediately from Conclusion 1-9, we have:

Conclusion 1-10: *The Cartesian position, adapted to accommodate Wittgenstein's 'PLA', considers ability to use language as both a necessary, and a sufficient condition, for the ascription of personhood.* ¹²⁰

This has, as a further consequence, that Descartes' first ¹²¹ argument to show that animals did not have a reflexive consciousness ¹²² can be discarded. The very fact that animals do not have language is sufficient to imply that they do not have a reflexive consciousness.

In Chapter 10 I will argue that the *permanent loss of the ability to communicate is a necessary condition for the loss of personhood* and that this will provide the basis for an alternative, and more fitting, resolution of the ethical problem posed by PVS. I use the term '*social definition*' of personhood to contrast this approach with that implicit in definitions based on an '*isolated individual*' which flow from a traditional Cartesian standpoint. The term is meant to suggest that '*personhood*' is not a term that can be applied to an isolated individual, rather it is to do with the *relationship* between that individual and society. ¹²³

¹¹⁷ see Priest *op.cit.* p.57.

¹¹⁸ Wittgenstein, PI-1 § 243.

¹¹⁹ Wittgenstein's reasoning will be considered in detail in Chapter 10.

¹²⁰ It is of interest to compare this test with Heidegger's view that language created man and not conversely.

see George Steiner (Heidegger, (1992), at p. xxiv):

"... Heidegger's theory of a language that speaks man rather than being spoken by him is utterly seminal ..."

and Reinhard May (Heidegger's Hidden Sources, 1996. at p.39):

"[Heidegger] thus speaks of language as if it were a creature, but of the human being as if it were the work or instrument of language."

¹²¹ i.e. that their behaviour was not sufficiently complex.

¹²² That their conduct could be fully explained mechanically.

¹²³ Support for such a 'social definition' can be found in the writings of P. F. Strawson and many other philosophers as shown by, for example, the following brief quotations:

"... [this approach] ends the solitariness of the 'thinking self', sets man firmly in the world which he knows, and so restores him to a proper existence as a community of persons in relation. It is the purpose of this book to show how

Section 5: Conclusions

There is widespread acceptance, amongst the medical and legal communities, of the proposition that PVS patients lack consciousness and cannot experience pain. The justifications advanced for the view that they lack consciousness were examined¹²⁴ and it was found that there is no scientific test which can conclusively determine consciousness. Furthermore, there are philosophical grounds for holding that it is not theoretically possible to determine necessary and sufficient conditions for ascribing consciousness, *scientifically*. Secondly, there is no definitive test for PVS. Hence the conclusion that there is no scientific test for definitively determining PVS patients' consciousness.

The philosophical grounds for arguing that PVS patients lack consciousness were found to rest on the assumption that:

$$\text{Consciousness} = \text{Consciousness}_B$$

where '*Consciousness_B*' meant consciousness as determined behaviourally. This assumption is invalid because the term consciousness is capable of being, and is used with, a number of different meanings. Hence the philosophical grounds for asserting that PVS patients have no consciousness are open to serious dispute.

The relationship between aspects of Cartesian philosophy and the Medical Conceptual Framework were examined and it was noted that, in certain areas, there was a congruence between them. In particular, they both asserted that the absence of 'non-reflex' movements in conjunction with an inability to communicate implied a lack of consciousness. Cartesian philosophy explicitly - and the Medical Conceptual Framework implicitly - asserted the further conclusion that in such circumstances 'personhood'¹²⁵ was absent. The test for personhood in Cartesian philosophy was either the presence of non-reflex actions or language ability. Under the challenge of Wittgenstein 'PLA', it was necessary to refine this to read '*In Cartesian philosophy, the possession of language is both a necessary, and a sufficient, condition for personhood*'.

The conclusions that were established in this Chapter are:

Conclusion₁₋₁ *Consciousness_{IN} and Consciousness_B - though normally found in such a close association as to have a factual interdependence - are, strictly speaking, logically independent. As applied to a PVS patient, this suggests that, although it may be adjudged that Consciousness_B does not exist, no necessary implication follows concerning Consciousness_{IN}.*

Conclusion₁₋₂ *There is no area of the brain, and no specific brain activity, that is uniquely associated with the possession of consciousness.*

Conclusion₁₋₃ *There is no definitive neurological test for PVS.*

Conclusion₁₋₄ *There is no neurological test which will determine PVS patient consciousness.*

the personal relations of persons is constitutive of personal existence; that there can be no man until there are at least two men in communication."

[John Mac Murray, *Persons in Relation: Vol 2 of The Form of the Personal*, (1961), p.12] Mac Murray also notes that the unit of human life is not the 'I' alone but the 'you and I'.

Quassim Cassam's *Self and World* (1997) was described by Strawson as arguing:

"... for the thesis that a necessary part of being conscious of oneself as a subject of thought and experience is the being conscious of oneself as a corporeal object among others."

¹²⁴ Arguments advanced for the view that they cannot experience pain are considered in Chapter 3.

Conclusion ₁₋₅ In relation to the problem of PVS patient consciousness, medical practice has assumed that Consciousness_{IN} = Consciousness_B. Furthermore it has used the 'reflex test' as the criterion for establishing Consciousness_B.

Conclusion ₁₋₆ There are theoretical limits to the determination of necessary and sufficient conditions for the ascription of consciousness. Any attempt by science to assert that particular criteria are both necessary and sufficient for ascribing consciousness is unwarranted.

Conclusion ₁₋₇ The term 'consciousness' has a number of meanings. These various meanings can be arranged as a hierarchy with each succeeding level incorporating the levels beneath and with only the topmost level requiring a behavioural manifestation:

Level₁: Informational awareness

Level₂: Experiential awareness

Level₃: Conceptual awareness

Level₄: Awareness with pure intention

Level₅: Awareness with executable/executed intention

The Medical Conceptual Framework, in discussing 'consciousness', recognises only Level₅.

Conclusion ₁₋₈ Both Cartesian philosophy and the Medical Conceptual Framework share a common deductive structure. The progression is from

'lack of non-reflex movements' to

'lack of self-consciousness' to

'lack of ability to experience pain' and

'the subject is not 'truly human' or is not a 'person'".

Conclusion ₁₋₉ In Cartesian philosophy the ability to use language is a sufficient, but not a necessary, condition for personhood. In the absence of an ability to use language 'complexity of behaviour' is both a necessary and a sufficient condition for personhood.

Conclusion ₁₋₁₀ The Cartesian position, adapted to accommodate Wittgenstein's 'PLA', considers ability to use language as both a necessary, and a sufficient condition, for the ascription of personhood.

¹²⁵ in the sense of being 'truly human'.

Chapter 2: Distinguishing between 'reflex' and 'non-reflex' action

In Chapter 1 it was noted that, with few exceptions,¹ the term '*consciousness*' is interpreted in the Medical Conceptual Framework as '*consciousness as judged by behaviour*'; this identity was expressed symbolically as:

$$\text{Consciousness} = \text{Consciousness}_B$$

The analysis in Chapter 1 concentrated on the left hand side of this identity and concluded that - because the term '*consciousness*' was capable of a multiplicity of meanings - the identity was erroneous. This chapter focuses on the right hand side of the purported identity - on Consciousness_B - and asks whether it is a coherent concept. It asks:

'Is the concept 'consciousness_B' well defined, and if not, what consequences follow?'

The concept of '*behaviour*' is not transparent; it has connotations of '*purpose*' and '*intention*' which are unclear. In order to draw out these connotations, the question can be phrased in terms of the less opaque concept of '*action*',² either by using the concept of '*intentional action*',³ or the concept of '*reflex action*'.⁴ Expressed in terms of '*intentional action*' our question becomes:

'Can intentional action be clearly distinguished from non-intentional action?'

Expressed in terms of '*reflex action*' the question is:

'Are reflex actions well defined; and can reflex actions be clearly distinguished from non-reflex actions?' - That is, given any action is it possible to state unequivocally whether it is a '*reflex*' action or a '*non-reflex*' action?

A further question is immediately suggested:

'Is the distinction between 'reflex' and 'non-reflex' actions logically equivalent to that between 'intentional' and 'non-intentional' actions? That is, is an action 'reflex' if, and only if, it is 'non-intentional'?''

This last question is not as otiose as it might appear principally because, as we shall see, the term '*reflex*' is capable of being used with a number of different meanings not all of which are synonymous with '*intentional*'; furthermore the term '*intention*' is itself problematic in that its domain of applicability is closely associated with the concept of '*personhood*'.

At first sight the distinctions between '*reflex*' and '*non-reflex*' actions might seem to be of only slight interest and the questions posed above to be purely philosophical questions, of no relevance to everyday clinical decision-making. This view is seriously mistaken. Clinical decisions are made

¹ Most notably Jennett and Plum (1972).

² Passmore (op.cit. p.513) summarises the argument for the distinction between '*behaviour*' and '*action*' as follows: "... there is a distinction between motions of the body, such as the knee reflex, and activities of the person, or '*behaviour*'. Behaviour can never be defined in terms of movements of the body, since the very same set of movements can be present in quite different kinds of behaviour ... The physiologist can explain the motions of a body in terms of causes, but he cannot explain human behaviour. Indeed behaviour has no causes."

Later, in a footnote to his discussion of Austin's philosophy, Passmore continues:

"Austin's work has been particularly interesting to moral and legal philosophers, who have suggested that it is a '*descriptive fallacy*' to suppose that, for example, in calling something good we are describing it or that in saying that somebody did something we are describing the person's bodily movements, as distinct from ascribing responsibility to him." [ibid. p.598]

³ '*Purposive*', or '*willed*', actions are synonyms for intentional actions.

⁴ The term '*reflex action*' is used to describe actions which, it is asserted, occur automatically in response to a stimulus and without any intentional awareness or '*will*'. In the Medical Conceptual Framework the absence of '*non-reflex*' actions indicates the absence of consciousness.

on the basis of categorising a patient's behaviour as 'reflex' or 'non-reflex'. Actions are taken based on these distinctions, actions which can have life and death consequences for a patient.⁵ To the extent that these distinctions are dubious or lack a strong evidential basis, the consequences may well be humanly tragic.

In this regard it is important to realise that, *even if* the reflex/non-reflex distinction is *theoretically* sound, the distinction may be prone to error in practice. This difficulty was recognised by Jennett and Plum who noted that, amongst PVS patients:

"A significant grasp reflex often appears, and this may be provoked by chance touch of the bedclothes; to the inexperienced observer ... the resulting movement may look as though it was initiated by the patient and may even be regarded as purposeful or voluntary. Sometimes fragments of coordinated movements may be seen such as scratching, ..." ⁶

The difficulty can be more clearly seen by considering a specific case - that of 'Miss D' provides a good example; in this case the court was told that the patient did not meet the strict guidelines for diagnosis of PVS in that:

"Her eyes appeared to track moving objects, she flinches if a gesture is made and reacts to the feeling of ice on her body."⁷

However, an expert medical witness disagreed and regarded these responses simply as "primitive reflexes" which "existed within the nervous system at a lower level than consciousness". Yet in discussing similar responses the 'The Multi-Society Task Force on PVS' felt constrained to state that:

"In rare cases, patients who have no other evidence of consciousness ... have some degree of briefly sustained visual pursuit or fixation, which is believed to be mediated through brain-stem structures. Nevertheless one should be extremely cautious in making a diagnosis of the vegetative state when there is any degree of sustained visual pursuit, consistent and reproducible visual fixation, or response to threatening gestures."⁸

The recent (1995) case of Jean-Dominique Bauby⁹ is also relevant as had Bauby's nurse been less perceptive, or had Bauby's eyelid been subject to a slight twitch, his eye responses might easily have been regarded as either chaotic, or reflex, actions.

The discussion in this chapter is structured into five Sections. In Section 1 the reflex/non-reflex distinction is considered both as it is manifested in Cartesian philosophy and in the Medical Conceptual Framework; it is suggested that the term 'reflex' is open to ambiguity; a notation is introduced for the differing meanings. Section 2 considers scientific challenges, and Section 3 considers philosophical challenges, to the distinction between 'reflex' and 'non-reflex'. In Section 4 Dennett's analysis of the concept of '*intention*' is considered; his analysis is of considerable

⁵ A judgement that all of a patient's actions are 'reflex' can, to some, imply that consciousness - or indeed, personhood - is absent and that medical treatment is pointless.

⁶ Jennett and Plum (1972) p.734.

⁷ The patient, in this case identified as Miss D, was not fully PVS; the application to the court was for permission to withdraw treatment. [The Times 21.3.1997]

⁸ Part 1, p.1501.

⁹ Bauby had suffered a massive stroke which left him in a 'locked-in syndrome' - he was speechless and, with the exception of only one eyelid, completely paralysed. He dictated a book, The Diving-Bell And The Butterfly, letter by letter, by using this eyelid as in a system of Morse code.

assistance in disentangling the link between 'intention' and 'personhood'.¹⁰ Section 5 seeks to draw some conclusions from the earlier discussion.

Section 1: The distinction between 'reflex' and 'non-reflex'.

The distinction has value only insofar as it is embedded in a specific framework.

The distinction between 'reflex' and 'non-reflex' has, like all distinctions, importance *only* because of the theoretical framework within which it is embedded; without the theoretical framework the distinction is pointless. Given an action, the theoretical framework permits differing implications to be drawn concerning this action depending on whether it is classified as being either '*reflex*' or '*non-reflex*'.

There are two theoretical frameworks of interest that utilise the distinction between '*reflex actions*' and '*non-reflex actions*'; they are Cartesian philosophy and medicine. It was pointed out earlier that Western culture, and in particular Western medicine, is greatly indebted to the intellectual framework provided by Cartesian philosophy; indeed the influence is so widespread and all-pervasive as to be generally unrecognised. Our very language embodies Cartesian distinctions so that the terms '*will*' and the '*mind/body*' distinction have a naturalness that makes alternative philosophies seem forced. However, the distinction between '*reflex*' and '*non-reflex*' actions can also find an interpretation within other philosophical systems which differ considerably from Cartesian philosophy. These other systems - some of which are discussed in Section 3 - provide a true point of contrast to Cartesianism and, most importantly, allow those conclusions which are often considered to follow by *logical necessity*¹¹ to be seen for the contingent propositions that they really are.

The role played by the concept of 'reflex action' in both Cartesian philosophy and the Medical Conceptual Framework will be considered shortly, before doing so it is convenient to isolate some different meanings of the term 'reflex'.

Ambiguities in the term 'reflex' ¹²

The '*reflex actions*' of a human are often described as those actions which are purely mechanical - in the sense of predictable - responses to outside stimuli. There are many such actions - the knee jerk,¹³ the sneeze, the cough, the yawn, the laughter response to tickling, the involuntary blink¹⁴ to a threatening gesture. Descartes instanced¹⁵ the response of the pupil when a light is shone in the eye. These actions are described as automatic responses to stimuli, not requiring any awareness, or act of will, to occur.

¹⁰ The term 'personhood' is used in this chapter as being synonymous with 'truly human' because, in discussing the Cartesian distinction between human (who has a 'soul') and animal, some such term is required and 'truly human' is cumbersome. The term 'personhood' is discussed more rigorously in Chapter 10 as is the link between it and intentionality.

¹¹ Such as the absence of non-reflex actions implying the absence of consciousness.

¹² The discussion in this subsection presumes, to some degree, on the analysis of 'reflex' in Cartesian philosophy, and in the Medical Conceptual Framework, conducted later in this chapter. This order was chosen because it permitted the subsequent discussion to take place in the knowledge that the term 'reflex' was ambiguous and, secondly, because it permitted a notation to be introduced which is of assistance in the subsequent discussion.

¹³ Gregory (*op.cit.* p.676):

"The tendon below the kneecap is struck sharply with a rubber hammer and the muscles of the kneecap in the thigh are caused to give a brief twitch-like contraction which extends the knee joint and causes a little kick of the foot ..."

The tendon jerk is the simplest and fastest mammalian reflex known ..."

¹⁴ Recent research [see the ARCADI project in the University of Western Australia] on the blink response has shown that its apparent simplicity is deceptive. The research suggests that the strength and timing of the blink is indicative of the speed at which the brain processes information and this has been used as a method of monitoring the development of intelligence in infants under 12 months.

¹⁵ Gregory *op.cit.* p.676.

It could, however, be argued that only the broad outlines of these responses is predictable and that around this broad outline there is a penumbra within which individual responses lie but such that each individual response is not strictly predictable and is thus not mechanical - that, for example, though each may laugh in response to tickling each individual's laugh is different. To address this objection it is useful to consider the example of a ball bouncing on a horizontal surface - the very epitome of a mechanical system. Newtonian mechanics can predict the movement of the ball in general terms, however there will always be slight individual differences between bounces due to the individual nature of the system. However, the Newtonian model of the bouncing ball can be widened to accommodate increasing levels of complication - the roughness of the ground, the imperfections of the ball, and the air resistance can be included - so that *theoretically* the variations can be completely predicted. Is this theoretically possible for human reflexes? If not, can they be correctly categorised as mechanical?¹⁶

The objection to describing 'reflex actions' as *simply* the mechanical responses of the human body can also be approached from a different direction. A human, in that he has a body, is subject to precisely the same physical laws as an inert object; however, under certain conditions he may influence the physical system of which he is a part and the resultant response of his body to an outside stimulus is different from that of an inert body. An example may help explain. A man, whilst crossing the street, is hit by a bicycle. As he falls to the ground he twists his body to avoid an oncoming car. His motion is obviously different from that of an inert body, as is evident if one imagines a circumstance where he had lost consciousness on being hit by the bicycle. Dennett would consider the man moving to avoid the car as manifesting an intention to avoid the car - to be, in Dennett's words, an '*intentional system*'¹⁷ - whereas he would regard the unconscious man falling to the ground as purely a physical system in that the man's motion is completely determined by the laws of physics; accordingly, his response is a purely mechanical, or 'reflex', response. In short, to Dennett, the unconscious man has a mechanistic or reflex response, whereas the conscious man has an intentional response even though he would, perhaps, deny that he had a conscious intention to avoid the car.

This example is analysed quite differently when viewed from the perspective of the Medical Conceptual Framework. Medical practice - as we shall see - applies the term '*reflex*' to all actions which are not *consciously* determined or, alternatively it categorises the actions according to the nervous system required for their execution.¹⁸ Thus, the response of the conscious man ('unconsciously') moving to avoid the car is classified, medically, as a reflex response because it

¹⁶ The theoretical possibility of *completely* determining the response is crucial; this is because the broad outlines of human behaviour are a given - we all sleep and eat and, within certain broad parameters, have roughly the same desires. In speaking of 'free will', it is never assumed that such is exercisable in any absolute sense; the term 'free will' means that within the boundaries of what is given - and predictable - there is a residue that is not so. Thus, free will finds its expression within the crevices, or gaps, of that which is predictable.

¹⁷ That is a system which is best explained by imputing an 'intention' to it. Dennett's arguments on the meaning of 'intention' will be considered in Section 4 of this chapter and in Chapter 10; in summary, Dennett considers that systems should be classified as intentional or mechanical *solely* on the grounds of the predictive capacity of this classification. Thus, if when watching a dog chase a rabbit towards a clump of bushes, the unfolding situation is best predicted by assigning an intention to the rabbit - to seek the sanctuary of the bushes - and an intention to the dog - to forestall the rabbit escaping - then this is what should be done. The system of dog + rabbit + bushes is too complex to permit of a purely mechanistic prediction. Dennett eschews questions as to whether the dog *really* has intentions, finding such questions meaningless. Dennett does not argue that all systems are either mechanistic or intentional; some systems are simply too *chaotic* to be predictable.

¹⁸ *i.e.* by whether the action is mediated entirely through the spinal cord or whether the lower parts of the brain, or the cerebral cortex, are required.

Some actions classified as reflex do require the participation of the cerebral cortex:

"...there are many reflexes whose pathway is through the cerebral cortex. The involuntary blink to a threatening gesture is one." Gregory *op.cit.* p.676.

The relationship between reflexes and the various strata of the brain is discussed later in this chapter.

was performed without (conscious) intention, the response of the unconscious man being beneath categorisation, because no specific brain activity is required for this response.

Based on the differing analyses of the example just given, I wish to suggest a number of distinctions. Firstly, there is a distinction between the medical usage of the term reflex - I call it '*reflex_M*' - and its use in relation to a purely physical system - '*reflex_P*'. Secondly, within the medical usage there is a further distinction between 'reflex' as defined in terms of the brain level required for the implementation of the response - called '*reflex_{MB}*' - and as defined in terms of the absence of intention required to produce the response - '*reflex_{MI}*'. Returning to our example of the man turning to avoid the oncoming car; medically speaking this is a reflex action. If this assertion is based on the presumed lack of (conscious) intention of the man then it is a '*reflex_{MI}*' action; whereas if it is based on the areas of the brain required to orchestrate the response it is a '*reflex_{MB}*' action. Perhaps these are distinctions without a difference? This will be so if:

- (i) '*reflex_{MB}*' and '*reflex_{MI}*' are identical. If the areas of the brain uniquely associated with intention can be identified so that it is then possible to say of an action which does not 'activate' these areas, that it is 'non-intentional'; and if, furthermore, these areas associated with 'non-intentionality' are identical to those associated with '*reflex_{MB}*' actions; then the distinction is indeed unnecessary. Can areas of the brain be uniquely identified with intentionality?

To answer this it need only be pointed out that the theoretical grounds offered in the previous chapter against assuming that certain areas of the brain can be uniquely associated with consciousness, are equally valid in relation to intention.

- (ii) '*reflex_P*' and '*reflex_M*' are identical. This will be so if it can be shown that all (medically) reflex actions can be predicted in precisely the same manner as if the system was regarded as a purely physical system. It may well be that there is a class of human actions which are unambiguously reflex - i.e. both '*reflex_P*' and '*reflex_M*'. The reflex action of the tendon - the '*tendon jerk*' - is a paradigm example of such actions which are unambiguously those of a physical system. The extent and full movement of the jerk is predictable. There are, however, many other responses - particularly as seen in PVS patients where eye-tracking movements and the 'pulling away from' painful stimuli are common - which are often described *medically* as reflex actions - i.e. '*reflex_M*'. These actions, however, are of a complexity such that they cannot be precisely predicted if considered simply as the response of a physical system.¹⁹ This is particularly so in relation to those situations - as occurred to the subject of the Ward case - where a patient exhibits fear in the presence of strangers. Such actions can be much more readily understood as intentional actions. The example, just given, of the man avoiding the oncoming car supports a similar conclusion.

Until these equivalencies have been shown, it seems a wise precaution to accept the distinctions suggested. The following conclusions may be drawn:

Conclusion ₂₋₁ : *There is a distinction between the medical usage of the term 'reflex' - '*reflex_M*' - and its use in relation to a purely physical system - '*reflex_P*'.*

and:

¹⁹ The inability to predict does not necessarily imply that an intentional stance be adopted. See the discussion on Dennett, in Section 4 of this chapter and in Chapter 10.

Conclusion 2.2: Medically the term 'reflex' is used in two senses; as actions performed without (conscious) intention - 'reflex_{MI}' - and as actions which require only limited areas of the brain for their completion - 'reflex_{MB}'. 'Reflex_{MI}' and 'reflex_{MB}' are not necessarily equivalent concepts.

The distinction as manifested in Cartesian philosophy.

We have seen²⁰ how Descartes sought to draw a clear distinction between man and the animals by his assertion that animals were *just* machines,²¹ perhaps more complicated than, but essentially of the same nature as, the mechanism of a clock. Man, by contrast, had a 'consciousness' and a 'will'. This 'will' allowed man to be the originator of his own actions²² in contrast to animals whose actions were rigidly determined by stimulus and environment. Man, however, could not be defined solely as a self-determining entity for such could not explain the many involuntary behaviours - such as sneezing or blinking - to which he was prone. Descartes explained these involuntary actions by suggesting that man also partook of an 'animal nature'; that aspects of his behaviour were determined mechanistically - these are the 'reflex' actions.

Thus, Descartes conceived of the human as composed of two autonomous parts - the animal part which does not involve the mind and whose outward manifestation is in 'reflex' actions; and a mind or 'soul' which, in an interior sense, is manifested in consciousness and the exercise of will and whose outward manifestation is in 'non-reflex' actions. To Descartes all actions were either willed or mechanical, there could be no other. Furthermore, the categorisation into 'reflex' and 'non-reflex' was mutually exclusive - to accept otherwise would be to put the distinction between man and animal in jeopardy.

Conclusion 2.3: In Cartesian philosophy the term 'reflex' is used to refer to the purely physical, or mechanistic responses, of a physical system. This meaning of the term 'reflex' is denoted by 'reflex_P'. Furthermore the terms 'reflex_P' and 'non-reflex_P' are mutually exclusive.

Williams is critical of the coherence of such a strict dichotomy:

*"However, Descartes's specification of this class of movements or actions suffers considerably from vagueness and from his appealing to what seem to be several non-equivalent criteria. ... It is hardly surprising that Descartes's account is unclear on this point, since he is engaged in an impossible task, of sorting all human movements into two sharply delimited classes, as having ultimately different causal histories, one which does, and one which does not, involve the 'intervention of the mind'. It is one product of his 'all or nothing' account of mind and consciousness: either a creature has a full range of conscious powers ... or it is an automaton, with no experience of any kind."*²³

Before considering objections to the Cartesian approach let us note that two conclusions follow from it. Firstly, if an individual exhibits *only* 'reflex_P' actions, then he is to be regarded as a machine.

²⁰ in Chapter 1.

²¹ It is said that Descartes was fascinated by the statue of the naked goddess Diana in the gardens of St. Germain which was controlled hydraulically; the approach of an observer activated a concealed switch which caused the statue to disappear into the rosebushes.

²² It follows from this that man - in the Cartesian framework - is characterised by his purposeful 'doing' as distinct from his existing or just 'being'; we shall return to this point in Chapter 10.

²³ Williams *op.cit.* p.284.

There is no more reason to attribute consciousness, or mind or intention to him than to an animal. Secondly, irrespective of how personhood is defined, the individual - being just as a 'machine' - is not a 'person'.

Conclusion ₂₋₄: *In Cartesian philosophy an individual who manifests only 'reflex_P' actions lacks 'consciousness', 'mind' and 'intention'. Such an individual is not to be considered a 'person', howsoever that is defined.*

In Cartesian philosophy the assertion that a 'non-reflex action' is intentional, is a tautology - the very fact that it is 'non-reflex_P' *implies* that it is 'willed'.

Conclusion ₂₋₅: *In Cartesian philosophy a non-reflex_P action is necessarily an intentional action.*

The distinction as manifested in the Medical Conceptual Framework.²⁴

The medical usage of the term 'reflex' was introduced by the 19th century neurologist Marshall Hall²⁵ to describe certain muscle responses. He considered that these muscle responses reflected a stimulus much as a wall reflects a thrown ball. He suggested that the anatomical pathway used in the generation of the reflex action - which he called the 'reflex arc' and which linked the motor and the sensory nerves - was through the spinal cord. Details of the connections between these nerves, in the grey matter of the spinal cord, dates only from experiments by Eccles in 1951.

Descartes had suggested the existence of 'animal spirits' as the explanatory mechanism for those actions which he considered mechanical. However, it was not until the discovery of electricity and subsequently Galvanis' experiments with frogs, that the theory of a nervous system as we now know it - i.e. with electricity as one of the mechanisms of communication - was developed.

Up to the 19th century the term 'reflex response' was restricted to actions routed through the spinal cord. Orthodox medicine insisted on a clear distinction between the spinal cord and the brain. This is evidenced in the statement by Marshall Hall that:

*"The cerebrum itself may be viewed as an organ of mind. It is an the organ on which the psyche sits, as it were enthroned. All its functions are psychical. They imply consciousness ... How different from. ... the functions which belong to the true spinal nervous system. In these there is no sensation, no volition, no consciousness, nothing psychical at all."*²⁶

Jonathan Miller comments that:

*"Like Descartes, almost two hundred years earlier, Hall was prepared to make a large territorial concession to materialism in exchange for a treaty which recognised the local sovereignty of the soul and the brain. The only difference was that whereas Descartes' soul was confined to the somewhat cramped premises of the pineal gland, Hall furnished the spiritual monarch with the large upholstered apartments of the brain as a whole."*²⁷

The mind/body dualism of Cartesian philosophy was replaced with the body/brain dualism of theoretical medicine. However, this sideways translation of the Cartesian ideas into medicine is not

²⁴ In this section I have drawn on articles from the Encyclopaedia Britannica and from Gregory The Oxford Companion to the Mind. An essay by Jonathan Miller entitled 'Going Unconscious' - included in Robert B. Silvers (ed.) Hidden Histories of Science - has been particularly helpful. A lecture by Robert Kentridge of the University of Durham, on 'Comparative Psychology' which was accessed through the internet, has also been useful.

²⁵ The Royal Society refused to publish Marshall Hall's original paper on the subject, denouncing it as absurd (*vide* Encyclopaedia Britannica).

²⁶ Quoted in Miller *op.cit.* p.23.

²⁷ *ibid.* p.24

as seamless as it might appear. In Cartesian philosophy a 'non-reflex' action was *necessarily* intentional, however, once the mind is identified with the activity of the brain then it is theoretically possible to empirically verify the existence of 'mind' - *i.e.* brain activity. Thus an action which requires a physical manifestation in the brain is 'non-reflex'; one that does not so require, is 'reflex'. But what of intentional actions? It is no longer obvious that those actions which require the use of the brain are necessarily intentional actions.²⁸ If actions which were normally categorised as intentional were found not to necessitate any brain activity this would indeed destroy the equation of mind and brain activity (because intentional actions obviously involve mind); however, the corollary is not obvious - an action might necessitate the use of the brain, and hence be a 'non-reflex action' but not, in fact, be intentional. A thought experiment may help to clarify. Consider a sleep walker; imagine that it could be established that sleepwalking necessitated the use of the brain and was accordingly to be categorised as 'non-reflex'; but such an action is obviously not intentional!

Thus, once mind is identified with some physical process then there is no longer a *necessary* identity between mind activities - non-reflex actions - and intentional activities. Hence, as mentioned earlier,²⁹ it is necessary to distinguish between various senses of the term 'reflex' - '*reflex_{MB}*' and '*reflex_{MI}*'. The conclusion is that, once mind is equated to brain activity, the simplicity of the Cartesian system is no longer sustainable.

Conclusion 2-6: Within the Classical³⁰ Medical Conceptual Framework the presence of brain activity is both a necessary, and a sufficient, condition for the ascription of consciousness. This identification 'mind' = 'brain activity' = 'consciousness' readily enables the further identification 'consciousness' = 'personhood'. However, within this framework, though an intentional action is necessarily non-reflex, a non-reflex action is not necessarily intentional.

It remains to see what aspects of the Classical Medical Conceptual Framework still survive.

Section 2: Scientific challenges to the Classical Medical Conceptual Framework.

Hypnosis

Hypnosis³¹ presented the first challenge to the 19th century orthodoxy. The behaviour of subjects under hypnosis was so complex - and so close to quintessentially human activity - that it was precluded from being described as 'simply mechanical'; neither could it be considered as 'willed' and it thus fell outside the Cartesian categories.³² It was not a 'primitive' behaviour and accordingly could not be related solely to the spinal cord, nor was it a willed product of the human control centre, the brain, and thus it fell outside the medical categories.

Originally hypnosis - then known as '*mesmerism*' - was believed to be associated with magnetism. However Carpenter and Laycock, eminent medical academics of the mid-19th century, argued that hypnotism functioned by means of a cerebral process analogous to the automatic

²⁸ Unless intention is, by a logical sleight of hand, redefined to mean just that.

²⁹ In *Conclusion 1-1* and *Conclusion 1-2*.

³⁰ It is convenient to refer to the Medical Conceptual Framework which encompasses this 19th century understanding of the reflex/non-reflex distinction as the '*Classical Medical Conceptual Framework*'.

³¹ In discussing how the advent of hypnosis changed the medical view of the brain, I have drawn heavily on Jonathan Millers article '*Going Unconscious*'.

³² "... for a Cartesian, *unconscious mind* is a self-contradictory expression." Antony Flew, *An Introduction to Western Philosophy*, p.282.

reflexes of the spinal cord. This was the first acceptance of a reflex mechanism above the spinal cord. Carpenter gave the name '*unconscious cerebration*' to this process but Laycock preferred the term '*reflex functions of the brain*'. The existence of such reflex actions destroyed the previously accepted identity '*mind*' = '*brain activity*' = '*consciousness*' = '*intentional action*'.

Sir William Hamilton had also made the observation³³ that the mind has aspects which cannot be described as 'conscious', or 'willed'. He credited Leibniz with the original insight that it is often possible to recall having perceived something at a particular time, though unaware of perceiving it at that time. Hamilton said:

*"What we are conscious of is constructed out of what we are not conscious of. ... We are thus constrained to admit, as modifications of mind, what are not phenomena of consciousness."*³⁴

This aspect of the unconscious - the '*enabling aspect*' in Miller's apt phrase - is only now reappearing in scientific discourse. Until recently the Freudian aspect of the unconscious - *i.e.* its withholding or repressive nature - has held sway. This enabling view of the unconscious is resurfacing in academic discussion principally because of the discovery of the phenomenon of '*blindsight*' but also because of the recognition that a very high proportion of the actions that would usually be considered as quintessentially human, occur *automatically* and not as the result of a conscious act of will. This recognition has been reinforced by Libet's experiment, one reading of which suggests that consciousness rather than being understood as the originator of action³⁵ is in fact just a blocking mechanism - the action emerges from the unconscious as an appropriate response to an environmental stimulus; the role of consciousness often being at most to impede this response before it is manifested in action. This perspective also helps explain hypnosis as the inhibiting of the blocking action of consciousness, thus allowing the unconscious to respond in an unfettered fashion to the stimuli presented to it.

The phenomenon of hypnosis shatters the Cartesian simplicities. An unavoidable dilemma is posed. Either hypnotic behaviour is 'reflex' or 'non-reflex', there are no other possibilities, yet behaviour under hypnosis is just as complex as normal behaviour.³⁶ If it is to be judged to be 'reflex', then 'reflex' cannot be distinguished from 'non-reflex' actions simply by their complexity. If it is judged non-reflex then this is an acknowledgement of the existence of non-reflex behaviour which is non-intentional. Either way the categorisation of reflex actions as non-intentional 'mechanical' actions cannot be sustained.

Modern accounts³⁷ of the concept of '*reflex action*' no longer restrict its use to actions whose 'reflex arcs' are routed through the spinal cord; it is now accepted that there are many reflexes whose pathway is through the cerebral cortex - the blink response is one, as are the conditioned - or learned - responses. The term is now taken to mean a certain kind of inborn central nervous activity in which a stimulus, by exciting an afferent nerve, produces an immediate, stereotyped, response of a muscle or a gland. Yet even this description does not meet the challenge posed by hypnosis. Furthermore, modern accounts now longer consider the categories '*reflex_M*' and '*non-reflex_M*' as mutually exclusive:

³³ in 1842.

³⁴ Quoted in Miller *op.cit.* p.19.

³⁵ Echoing Thomas Huxley's statement:

"... [the] soul stands to the body as the bell of a clock to the works, and consciousness answers to the sound which the bell gives out when struck. We are conscious automata."

see: Flanagan *Consciousness Reconsidered* p.7.

³⁶ The behaviour of subjects under stage hypnosis - accepting that only some of these are cases of true hypnosis - amply bears this out.

*"The point at which an animal's responses to stimuli cease to be regarded as reflex and are called deliberate or voluntary, or by some similar term, is ill-defined. A mild cough can be suppressed by an effort of will during a concert; but such coughing would be regarded as reflex."*³⁸

Conclusion 2-7: *The phenomenon of hypnosis challenges the coherence of the distinction reflex/non-reflex and leads to the conclusion that, either reflex actions must be regarded as possessing a complexity comparable to non-reflex actions, or some non-reflex actions must be regarded as non-intentional.*

Conclusion 2-8: *The categories of actions, 'reflex' and 'non-reflex', can no longer be regarded as being mutually exclusive.*

Conclusion 2-9: *The cerebral cortex can no longer be regarded as the exclusive domain of non-reflex actions.*

Indeed the exclusive identification of 'mind' and 'brain' - which is a cornerstone of the Medical Conceptual Framework - has come under threat. A report in the Journal of Consciousness Studies of a recent conference on blindsight states:

"... we too easily assume that the mind just is the brain, and that mental processes just are the processes being carried out by the neural computer. From such a perspective, the fact that many of these processes are not consciously experienced is at first puzzling ... it leads to a bootless search for the mysterious 'X' factor that raises some select few of these processes to conscious level. Perhaps there is no such factor; ..." ³⁹

Let us now examine the phenomenon of 'blindsight', automaticity and Libet's experiment.

Blindsight

During experimentation on animals it was noticed that if the region of the cerebral cortex to which nerve fibres of the eye are connected, is removed, then the ability of the animal to discriminate between visual events was not destroyed. Humans, however, who had suffered brain damage to a similar area of the brain were, when questioned, unable to discriminate between visual events. This led to the theory of '*encephalization of function*' - the belief that, despite the close anatomical similarity between them, the brains of animals were organised in a different fashion to those of humans. However, when the research on humans was refocused from a direct interrogation of subjects as to their perceptions, to a more indirect approach - which asked the subjects to 'guess' the objects that were in their field of vision - a paradox became apparent. It was discovered that these subjects were able, with great accuracy and consistency, to correctly guess - whilst simultaneously denying any conscious knowledge of - the identity of those objects which were in their field of vision.

This phenomenon became known as '*blindsight*' and it bears witness to mental activity of which the individual has no explicit awareness. This indicates a perceptual competence operating well below the level of overt conscious perception. It also shows that the primary visual cortex, which

³⁷ Such as in Gregory (*supra*)

³⁸ Gregory *op.cit.* p.677.

had previously been thought necessary to vision, is not so; the visual signals can bypass the cortex and be processed by more 'primitive' parts of the brain. Phenomena similar to blindsight occur in relation to other senses, such as hearing and touch, and also in relation to 'implicit memory'- which is when a subject has no conscious memory of particular facts but acts in such a fashion as is *only* consistent with the possession of those facts.

The phenomenon of blindsight forces a recognition that the concept of 'mind' - which was regarded as coextensive with 'consciousness' in Cartesian philosophy - is considerably broader. This conclusion is reinforced by a consideration of the phenomenon of automaticity.

Automaticity and Inspiration

There are many occasions⁴⁰ when an individual performs quite complex tasks without an awareness of what he is doing. A distinction may be helpful between true automatism, such as sleepwalking where there is no awareness of what is occurring, and situations where there is a broad awareness of what is happening but no conscious intent to perform the individual actions.

A skilled concert pianist, whilst learning a piece of music, requires total awareness, concentration and deliberation as to the fingering of individual notes; as he becomes more and more proficient the playing is, as it were, 'handed over' to his unconscious so that finally, when in the concert hall, he is fully aware of the music that he is playing but oblivious to the individual fingerings, so that to say he 'willed' each of his actions would be incorrect.⁴¹

Riding a bicycle, driving a car, learning to type, are similar in that, in the beginning, each action is individually willed but with experience the action is performed not only without will but often indeed without awareness. This latter occurs, for example, when in driving a car, one suddenly realises that for the last few miles one's thoughts have been elsewhere. In typing a letter, if sufficiently proficient, we can lapse into daydream only to suddenly see that we are about to press an incorrect key but without sufficient time to stop the mistake being made.⁴² This last experience reinforces the interpretation of the role of consciousness as a blocking mechanism.

³⁹ Nigel Thomas 'What does implicit cognition tell us about consciousness?' *Journal of Consciousness Studies*, (1997) at p.395.

⁴⁰ Gregory notes (*op.cit.* p.112) that: "... a vast amount of our everyday activity is carried out without direct awareness."

Thomas reporting on a conference on 'blindsight' notes:

"Indeed, it would seem that much of our ordinary functioning depends on implicit cognition; very probably the lion's share of our behaviour is guided much more by 'implicit' than by conscious knowledge." [*op.cit.* at p.394]

The suggestion is that non-conscious systems exist whose function is to protect consciousness from overload and to pass inputs on to consciousness only if they become too problematic. A view which echoes Schrödinger's concept of the role of consciousness, to be discussed later in this chapter.

Thomas also notes:

"In other experiments, subjects seem implicitly to learn successful strategies for some task, whilst having no idea of what they have learned, or of why it would be relevant." [*op.cit.* p.394]

The extent of normal reliance on unconscious perception was made very clear by the case of Charles Friel, who was the subject of a BBC Horizon Documentary ('*Man who lost his body*' 16.10.1997). After a viral infection, Friel, though able to move his limbs, was left without 'proprioception' - awareness of his body. He slowly learned to walk, firstly by visualising each single movement to be performed and then by consciously performing it. Each single act had to be planned as he had no repertoire of automatic actions. It took him four months to learn to put on a sock, his simple gestures had lost all spontaneity and had to be meticulously choreographed.

⁴¹ See La Mettrie:

"This great chemist [Stahl] has wished to persuade us that the soul is the sole cause of all our movements. But this is to speak as a fanatic and not as a philosopher. ... That is to suppose that a flute player could play brilliant cadences on an infinite number of holes that he could not know, and on which he could not even put his finger!" [*op.cit.* p.136-7]

A more amusing example concerns recent research on how consumers choose between competing brands; it was found that consumers' choice was almost entirely subconscious. [Mentioned in an article, by the science correspondent of the Sunday Times (8-8-1999), which discussed recent research by a Professor Zaltman of the Harvard Business School.]

⁴² Gregory notes:

"Once the impulses are on their way, they cannot be interrupted. You know when you are going to type the wrong letter or the letters in the wrong order, and out they come, wrong; the knowledge comes too late to interrupt the planned movement." [*op.cit.* p.520]

Artistic inspiration or creative activity generally is also beyond the realm of conscious intent.⁴³ The creative idea is a 'given' as exemplified in the tradition of the artistic muse; the role of the conscious mind is limited to the working out of the implications of this given inspiration. This limited role for the conscious mind is well expressed in Schopenhauer's observation⁴⁴ that:

"We find ourselves like a hollow glass globe, from whose vacancy a voice speaks."

and Benoit's noting⁴⁵ that man, despite his pretensions, is not the artisan of either his thoughts or his emotions, and he deceives himself in seeing his conscious developed sensibility as self-sufficient.⁴⁶ This point is also emphasised by Miller who ends his essay with the observation that:

*"Experimental results from an ever-widening range of psychological functions tell the same story, that what we are conscious of is a relatively small proportion of what we know and that we are the unwitting beneficiaries of a mind that is, in a sense, only partly our own."*⁴⁷

The recognition that the locus of that which is most valuable in the human - their creativity, their source of inspiration and the groundswell of their actions - lies outside the realm of consciousness forces a reassessment of any attempt to identify 'consciousness' and 'personhood'.⁴⁸ The 'centre of gravity' of the human can no longer be defined solely in terms of in their consciousness but must acknowledge the unconscious as the source of that which is of greatest value in human endeavour. The full flowering of an individual is only possible through the capacity to access and make manifest the fruits of their unconscious.⁴⁹

Conclusion²⁻¹⁰: *The phenomena of blindsight and automaticity challenge the identification of 'mind' with 'consciousness'. Mind is a broader phenomenon than consciousness.*

Libet's Experiment⁵⁰

In 1985 Benjamin Libet performed a number of experiments in an attempt to determine the order in which

- (i) the consciousness of the intent to perform an action
- (ii) the activation of the brain area normally associated with the action, and
- (iii) the activation of the muscles necessary for the action.

occurred. The expectation was that these occurred in the order just given. The experiments were performed on subjects whose brain and arm muscles were monitored electrically, and who were told to flex their arms whenever they felt like it.

⁴³ The Encyclopaedia Britannica gives the following examples:

"The English poet Samuel Taylor Coleridge reported that he had written 'Kubla Khan' as the result of creative thinking in a dream. Having fallen asleep while reading about the Mongol conqueror, he woke to write down a fully developed poem he seemed to have composed while dreaming. Novelist Robert Louis Stevenson said that much of his writing was developed by 'little people' in his dreams, and specifically cited the story of Dr. Jekyll and Mr. Hyde in this context. The German chemist F. A. Kekulé von Stradonitz attributed his interpretation of the ring structure of the benzene molecule to his dream of a snake with its tail in its mouth. Otto Loewi, the German physiologist, attributed to a dream inspiration for an experiment with a frog's nerve that helped him win the Nobel Prize. In all of these cases the dreamers reported having thought about the same topics over considerable periods while they were awake."

⁴⁴ Quoted in Bryan Magee Confessions of a Philosopher at p.375

⁴⁵ Benoit *op.cit.* p.29.

⁴⁶ *ibid.* p.151

⁴⁷ Miller *op.cit.* p.34.

⁴⁸ *i.e.* whilst the possession of consciousness is doubtlessly a necessary condition for personhood however that is defined, it should not be thought of - as it was in Cartesian philosophy - as a sufficient condition.

⁴⁹ To such as A.H. Maslow creativity is *the* essential characteristics of the truly human [A. H. Maslow The Farther Reaches of Human Nature. p.55 *et seq.*].

⁵⁰ Libet's experiment is described in Flanagan, Consciousness Reconsidered. pp. 136-8.

It was found that the consciousness of the intention to flex their muscles occurred *after* the muscle had already begun to flex. Libet was lead to the conclusion that “*cerebral initiation of the kind studied ... can and usually does begin unconsciously.*” Paradoxically, the subjects felt that they were consciously causing their muscles to flex. In essence, Libet’s conclusion was that consciousness, though not exercising an originating power, exercised a veto power over actions which originated elsewhere. Philip Dorrell⁵¹ suggests that rather than concluding that consciousness is deluded into thinking itself responsible for behaviour that is actually performed unconsciously, the unconscious behaviour that does occur is the result of imitating previously initiated conscious behaviour. This view would see the role of consciousness as the generator of responses only in those situations which were novel in the sense that an apt and appropriate response had not been already found - a view similar to Schrödinger’s which is discussed below.

For our purposes, the conclusion to be drawn from Libet’s experiment is that actions which are paradigms of non-reflex actions are not preceded by an act of conscious will. The experiment also reinforces the distinction, suggested earlier, between ‘*reflex_{MB}*’ and ‘*reflex_{MI}*’ actions.

Conclusion 2 -11: Libet’s experiment implies that some non-reflex actions are non-intentional.

We now turn to consider some alternative philosophical perspectives on the cluster of concepts consciousness, intention, reflex and non-reflex, action.

Section 3: Philosophical challenges to the coherence of the reflex/non-reflex distinction.

Schrödinger’s view of the role of ‘consciousness’ and ‘reflex’ action

Erwin Schrödinger in his essay ‘Mind and Matter’⁵² criticised the approach of those he called the ‘rationalists’ to the subject of consciousness. These rationalists had, he suggested, argued that the study of consciousness was not a worthy subject of study because of the unprovability of propositions concerning it. Schrödinger conceded that asking whether consciousness was to be found in other than nervous processes led to unprovable speculation. Instead he suggested that an understanding of the role of consciousness could be found by first recognising that not every cerebral process was accompanied by consciousness and then by analysing those processes which were so accompanied.⁵³

Schrödinger first examined the reflexes and noted that:

*“... many reflexive processes exist that do pass through the brain, yet do not fall into consciousness at all or have very nearly ceased to do so. For in the latter case the distinction is not sharp; intermediate degrees between fully conscious and completely unconscious occur.”*⁵⁴

He argued that any succession of events involving sensations, perceptions and actions gradually drops out of consciousness when the same string of events occurs very often.⁵⁵ Consciousness of these strings only re-arises when differences to the normal established pattern occur and then it is

⁵¹ Philip Dorrell ‘The Libet Problem - Is Consciousness the Boss?’ - a lecture accessed through the internet.

⁵² Included in Erwin Schrödinger *What is Life? & Mind and Matter*.

⁵³ His suggestions were remarkably prescient in view of the current wealth of research in the area of consciousness.

⁵⁴ *ibid.* p.101.

⁵⁵ *ibid.* p.102 *et seq.*

only of these differentials. Consciousness is then required for the establishment of a response appropriate to the new circumstances.

Schrödinger suggested that consciousness is, metaphorically speaking, “... *the tutor who supervises the education of the living substance, but leaves his pupil alone to deal with all those tasks for which he is already sufficiently well trained.*”⁵⁶

He summarised his hypothesis in the words

*“Consciousness is associated with the learning of the living substance; its knowing how is unconscious.”*⁵⁷

His hypothesis accommodates automaticity with ease and Libet’s experiment presents no challenge. Gregory, who noted that much of the autonomic nervous system can be brought under voluntary control, had posed the question:

*“The fact that much behaviour is involuntary and unconscious raises such questions as: why is some behaviour voluntary, and under conscious control? It seems that high rates of information processing in unusual situations require consciousness and are voluntary.”*⁵⁸

This problem is also elegantly resolved by using Schrödinger’s hypothesis. Furthermore the strict dichotomy between animals and humans, which was such a feature of Cartesian thought falls away; humans and animals, although they have differing abilities to learn and accordingly differing levels of consciousness, are on the same continuum.

The ‘reflex action’ in Spinoza’s philosophy

Spinoza developed his philosophy partly out of a dissatisfaction with Cartesianism. Descartes had conceived of the human mind and the body as being distinct substances thus creating the necessity for an explanation of how these substances might interact. Descartes’ theory, as we have seen, was that certain bodily processes - the reflex actions - could be explained mechanistically, entirely within the confines of the body and with no involvement of the mind; whereas all other bodily actions were to be explained by the doctrine of ‘*will*’ - the mind acting on the body by means of the pineal gland.

Spinoza, in contrast, postulated that there was only one substance in the universe. This substance - called ‘*God*’ or ‘*Nature*’ - could be conceived under different aspects - called ‘*attributes*’ - of which we humans were aware of two, the mental and the physical.⁵⁹ Since these attributes were aspects of the same underlying phenomenon, it was not to be expected that they were to be explained in terms of each other. Thus the problem of interaction of mind and body encountered by Descartes, is elegantly avoided.

Any phenomenon in the universe could be viewed, and explained, either through the aspect of mind or through that of body; these being equivalent but different explanations, much as a physicist and a musician might both give different but equivalent⁶⁰ explanations of a piece of music. However, the mental aspect could not be reduced to the physical nor could the physical be reduced to the mental; the explanations move in parallel, as bodily injury has its mental parallel in pain. In particular the ‘mechanical actions’ - the reflexes - of the Cartesian system could be interpreted

⁵⁶ *ibid.* p.103.

⁵⁷ *ibid.* p.105.

⁵⁸ Gregory *op.cit.* p.66.

⁵⁹ Each ‘*object*’ being but a ‘*limited mode*’ of the universal substance.

mentally just as the non-reflex action could be interpreted physically. The fact that we utilise ideas of 'choice', 'will' and 'purpose' in explaining the non-reflex actions is:

*"... simply because purely physical explanations are not yet available; the use of these words 'will' and 'purpose' confesses that we do not in fact generally possess clear and adequate ideas of causes; they are confessions of ignorance."*⁶¹

Descartes' concept of the 'will' reflected prevailing Christian ideas of freedom and the moral responsibility of the individual for his actions. To Spinoza, such ideas of freedom were illusory; he regarded men as in bondage in so far as they are under the control of external things and 'inadequate ideas'. The Cartesian 'will' was the paradigm of such an inadequate idea:

*"... men are mistaken in thinking themselves free; and this opinion depends on this alone, that they are conscious of their actions and ignorant of the causes by which they are determined. This, therefore, is their idea of liberty, that they should know no causes of their actions. For that which they say, that human actions depend on the will, are words of which they have no idea. For none of them know what is will and how it moves the body; those who boast otherwise and feign dwellings and habitations of the soul, provoke either laughter or disgust."*⁶²

Hampshire comments⁶³ that Spinoza is not denying that there is anything within the human experience corresponding to 'will' or 'choice' for such would be absurd. Spinoza indeed recognises the conscious state of indecision and the 'choosing between alternatives' and that from this state a decision arises; what he does deny is that we are the conscious authors of this decision, despite our beliefs to the contrary.⁶⁴ To state of another 'that he could have acted otherwise' is, to Spinoza, necessarily a 'sign of the incompleteness of our scientific knowledge, or an expression of our present state of ignorance.'⁶⁵

With so many aspects of his philosophy unmentioned it is left to end this sketch by saying that Spinoza created a philosophy of extraordinary beauty and power which has a surprisingly modern resonance. This is seen particularly in its ability to accommodate many of the ideas of both contemporary science and psychology. In so far as there is one universal substance in his philosophy it follows that the rigid boundaries of objects and substances, as found in Cartesian philosophy, must yield to a more fluid view of the universe where ideas of 'process' and 'change' replace ideas of 'substance' and 'fixity' - a startlingly modern perspective when the theories of modern physics are considered. Yet it is in his treatment of the 'human bondage' to emotion, false understanding and 'inadequate ideas' and his idea of a 'lived philosophy' that his true genius becomes apparent; and if his philosophy is a source of wonder in its ability to accommodate many of the ideas of modern physics, how more so is it that his philosophy of the emotions can incorporate the insights of modern psychoanalysis.

Conclusion 2-12 : Some philosophers, for example, Spinoza and Schrödinger, have understood the complex of concepts 'consciousness / intention / reflex and non-reflex action' in a

⁶⁰ In the sense that each can be recovered from the other.

⁶¹ Stuart Hampshire, *Spinoza* p.104.

⁶² Baruch Spinoza, *Ethics*, Part 2, Note to Proposition 35 [Everyman Edition at p.64].

⁶³ Hampshire *op.cit.* p.116 *et seq.*

⁶⁴ A proposition which is vindicated by Libet's experiment.

manner radically different to the Cartesian understanding. Spinoza believes that all actions are determined by their environment and that the distinction between reflex and non-reflex actions rests simply on our present ignorance of the causes of those actions we categorise as non-reflex. Schrödinger argues that consciousness - understood as intent - is needed only if a novel situation is encountered needing a response. To him, reflex responses are simply the responses deemed adequate to a situation which has been previously encountered. They do not imply a lack of consciousness (understood as awareness) in fact they presume such a consciousness.

However, there is one modern philosopher - Daniel Dennett - also standing outside the Cartesian tradition, who has given a particularly clear and fruitful analysis of the concept of 'intention'.⁶⁶ It is to his analysis that we now turn.

Section 4: Dennett's analysis of 'intention'

Dennett locates his discussion of whether behaviour can be classed as 'intentional' in quite an abstract setting. He first considers an abstract system - *i.e.* to include any system whether it be human, animal, computer or even weather system - and considers the problem of what it means to understand - in the sense of being able to predict - the development, or unfolding, of such a system. He believes three types of attitudes or 'stances'⁶⁷ are available in confronting such a system:

- (i) a '*design stance*' - such as is adopted in relation to a computer which one has designed. One's predictions will come true provided only that the computer behaves as designed.
- (ii) a '*physical stance*' - such as is adopted when we base our predictions on the physical state of the system and the laws of nature as, for example, in the movement of a pendulum.
- (iii) an '*intentional stance*' - such as is adopted when we base our predictions on imputing intentions to a system. The intentional stance is often used when a system is too complex to permit the other stances to be adopted;⁶⁸ it is, Dennett argues, equivalent to imputing rationality to the system. Intentional activity is not the sole prerogative of persons, it is found amongst animals - Dennett considers the example of the hunter stalking a tiger, and considering what he would do if he were the tiger. It can even be applied to prediction of the behaviour of plants⁶⁹ or inanimate objects - Dennett gives the example of a chess playing computer; the earlier versions of such computers were amenable to prediction using a design stance but:

*"... today, with evolving programmes capable of self-improvement, designers are no longer capable of maintaining the design stance in playing against their own programs, and must resort, as any outsider would, to the intentional stance in trying to outwit their own machines."*⁷⁰

⁶⁵ Hampshire *op.cit.* p.116.

⁶⁶ and, by implication, reflex action.

⁶⁷ Daniel C. Dennett, *Brainstorms* especially pp. 237-42.

⁶⁸ This does not imply that it can be applied in all cases where other stances fail; for example it is not appropriate in attempting to predict the weather system [Dennett *op.cit.* p.238].

⁶⁹ as, for example, when:

"I predict that a particular plant - say a potted ivy - will grow around a corner and up into the light because it 'seeks' the light and 'wants' to get out of the shade ..." [Dennett *op.cit.* p.272]

⁷⁰ *ibid.* p.238.

Dennett considers it important that we do not attempt to ask whether a system *really* has beliefs, desires, or intentions, as such is an inappropriate question. The appropriate question relates to the *choice* of stance, and this is to be answered pragmatically by virtue of the success, or otherwise, of the stance adopted.⁷¹ If the intentional stance is the most successful then this implies that the system *has* beliefs desires and intentions; according to Dennett there is no other meaningful method of assigning the terms '*belief*', '*desire*' or '*intention*'.

What stance is appropriate to humans? Dennett argues that there is a '*tolerant assumption of rationality*' which exists normally in our dealing with our fellow humans. This presumption implies that the intentional stance is appropriate in all but the most exceptional circumstances, such as, for example, when in relation to the insane the '*design stance*' is occasionally adopted. Of the possible application of the '*physical stance*' to humans Dennett says:

*"It need hardly be added that in the area of behaviour (as opposed to the operation of internal organs, for instance) we hardly ever know enough about the physiology of individuals to adopt the physical stance effectively, except for a few dramatic areas, like surgical cure of epileptic seizures."*⁷²

Conclusion₂₋₁₃: *To assert that a human manifests only reflex behaviour is - to Dennett - to adopt a 'physical stance' to that individual;⁷³ this requires that laws of physics and chemistry are sufficient to fully predict the behaviour of that individual. It is a necessary consequence of the adoption of the physical stance that 'consciousness', 'intention', 'mind' and 'personhood' are not to be ascribed to that individual.*

Section 5: Conclusions

Questions

A number of questions were posed at the beginning of this chapter:

- (i) *'Are reflex actions well defined; and can reflex actions be clearly distinguished from non-reflex actions'?*
- (ii) *'Is an action 'reflex' if, and only if, it is 'non-intentional'?*

A third question is also fundamental to this thesis:

- (iii) *'In relation to an individual all of whose actions are judged to be reflex, what conclusions can be drawn pertaining to the complex of concepts consciousness / mind / intention / personhood'?*

As a preliminary to addressing these questions it is first necessary⁷⁴ to adopt some theoretical framework; without such a framework the questions are meaningless. Cartesian philosophy is usually the framework within which these questions are considered; however, because the Cartesian perspective is so all-pervasive in Western culture, it is often not recognised that a choice of framework is actually being made. By using other philosophical systems - such as, for example, Spinoza's and Schrödinger's - a counterpoint is provided which enables us to see that a choice is

⁷¹ Strawson makes a similar point [Individuals, p 109] in relation to judgements of the mental states of another. He argues that if we allow a gap to open between the behaviour of another and their mental state - depression in his example - this forces us to:

"... oscillate between a philosophical scepticism and philosophical behaviourism ... What we do not realise is that if this logical gap is allowed to open, then it swallows not only his depression, but our depression as well. For if the logical gap exists, then depressed behaviour, however much there is of it, is no more than a sign of depression."

⁷² *ibid.* p.239

⁷³ The possible application of the '*physical stance*' to PVS patients is considered in Chapter 10.

indeed being made. Because these questions are not *just* philosophical questions but address issues at the forefront of modern science, Schrödinger's views - in that they are those of one of the most eminent theoretical physicists of the 20th century - are worthy of especial consideration.

I will now summarise the various answers to these questions; first, as answered by Cartesian philosophy then by Spinoza, by Schrödinger, by the Classical Medical Conceptual Framework and, finally, by the Medical Conceptual Framework as it is currently found.

Answers: Descartes

The existence of a strict dichotomy between body and mind is a cornerstone of Cartesian philosophy. The mind is synonymous with 'soul', 'consciousness', 'intention' and 'will'; the existence of the mind is manifested through non-reflex actions; all other actions were purely mechanical - i.e. 'reflex_p' actions.

To answer the questions posed above:

- (i) *Theoretically*, there is a clear and unambiguous distinction between reflex and non-reflex actions; the categories are, by definition, mutually exclusive.

Practically, the situation is far from clear; for example, to Descartes, the behaviour of animals was a paradigm of reflex activity, yet even current scientific knowledge is incapable of adequately predicting their behaviour.

- (ii) It follows, as a matter of strict logical deduction, from Descartes' philosophy that an action is reflex if, and only if, it is non-intentional.
- (iii) An individual who manifest *only* reflex actions is, to Descartes, a machine - necessarily without mind, consciousness, or intention. Being just a *machine*, personhood - irrespective of its definition - is obviously excluded.

Answers: Spinoza

Spinoza, writing to a correspondent who had difficulties in accepting Spinoza's theories of the will, suggested a thought experiment. Imagine, he said, a stone set in motion by an external cause, thinking, and knowing that as far as it can, it strives to continue to move:

*"Of course since the stone is conscious only of its striving, and not at all indifferent, it will believe itself to be free, and to persevere in motion for no other cause than because it wills to. ... And this is that famous human freedom which everyone brags of having, and which consists only in this: that men are conscious of their appetites and ignorant of the causes by which they are determined."*⁷⁵

To answer our specific questions:

- (i) Non-reflex actions are simply those actions of whose causes we are presently unaware.
The reflex /non-reflex distinction is not intrinsic to actions but only mirrors our present state

⁷⁴ As discussed at the beginning of Section 1.

⁷⁵ Quoted in Genevieve Lloyd, *Spinoza and the Ethics*, at p.46.
see also Albert Einstein's comment:

"If the moon, in the act of completing its eternal way around the earth, were gifted with self-consciousness, it would feel thoroughly convinced that it was travelling its way of its own accord on the strength of a resolution taken once and for all. So would a Being, endowed with higher insight and more perfect intelligence, watching man and his doings, smile about man's illusion that he was acting according to his own free will."

from Albert Einstein *Free Will* - quoted in the promotional literature to Benjamin Libet *The Volitional Brain* [To be published September 2000].

of ignorance; as scientific research progresses, actions which were once thought to be non-reflex, will be clearly seen to be reflex.

- (ii) Non-reflex actions are usually perceived as being intentional but such views are founded on ignorance. In view of Libet's experiment - where the volunteers believed that, despite evidence to the contrary, they were responsible for the movements of their arm - Spinoza's prescience is uncanny.
- (iii) To Spinoza, whilst the individual who manifests (what are usually judged to be) only reflex actions certainly has more limited responses than other individuals, his capacity to act on intention is in reality no more or no less than other individuals. The judgement as to whether such an individual could be considered to be a 'person'⁷⁶ is unclear; it can, however, be stated that Spinoza's human ideal lies in the achievement state of 'freedom', by which he means not one whose actions have no cause - for such is impossible - but one whose actions are caused by himself alone; hence, the more an individual's actions are a response to circumstances outside of himself - *i.e.* are reflex actions - the less is he fully human.⁷⁷

Answers: Schrödinger

- (i) To Schrödinger, reflex responses are simply learned responses. A strict distinction is not to be drawn between reflex and non-reflex actions, rather they are to be viewed as different extremes on a continuum.
- (ii) The role assigned to consciousness by Schrödinger appears to be threefold; firstly, in being aware of responses which are being (unconsciously) generated; secondly, the blocking of these if they are considered inappropriate and thirdly, the generation of more appropriate responses. It could be argued that the second category envisages actions which are *both* intentional and reflex.
- (iii) A manifestation of *only* reflex actions would, to Schrödinger, imply either that they were sufficiently appropriate to the situation, or that the individual was incapable of making more appropriate responses. This inability might be caused by either informational deficiencies (those asleep cannot escape a fire) or operative reasons (those paralysed cannot escape a fire). Consciousness - understood as awareness - cannot be excluded.

To Schrödinger, the strict dichotomy between animals and humans disappears; they both lie on the same continuum; this would suggest that an individual who manifested only reflex responses would not be considered truly human because of the paucity of their response vocabulary.

Answers: Classical Medical Conceptual Framework

To Descartes, mind, consciousness, soul, and personhood were synonyms; the Classical Medical Conceptual Framework included 'brain activity' as an additional equivalence. Non-reflex actions were the outward manifestation of brain activity whereas reflex actions were the province of the spinal cord. Hitherto the Cartesian framework was a closed theoretical system, self-validating and immune from experimental challenge. However, the identification of mind (= consciousness) with brain activity, and the fact that brain activity could be independently monitored, opened a bridge with science, and caused some fundamental realignments amongst the cluster of concepts

⁷⁶ more properly 'fully human'.

⁷⁷ See G. H. R. Parkinson, Spinoza: Ethics, (2000), p.45.

'mind/consciousness/intention'. In particular the linking of consciousness with brain activity rather than with the soul dispensed with the '*all or nothing*' nature of consciousness; so that it was now possible to speak of greater or lesser degrees of consciousness. Thus Bernard Williams' criticism⁷⁸ of the Cartesian account of mind - which was recently echoed by Susan Greenfield in her suggestion that consciousness is not an 'all of nothing' condition but is more like a dimmer switch - did not apply to the Classical Medical Conceptual Framework. There were also (in relation to our specific questions) some other consequences:

- (i) It was possible to investigate, experimentally, whether the 'reflex arc' corresponding to a particular action was confined to the spinal cord, or whether it was routed through the brain. Hence, necessary and sufficient conditions for describing an action as reflex, could be *experimentally* determined.
- (ii) If the identification of mind and brain activity gave a physical embodiment to 'mind', it had the opposite effect on 'intention'. Three alternatives were possible. Either 'intention' was to be *defined* as mind activities relating to non-reflex actions⁷⁹ - in such a case the proposition that non-reflex actions are intentional is a vacuous tautology. A second possibility was that the concept of 'intention' was to be banished. A third possibility was to seek a brain correlate for intention. If this was successful it would require that a choice be made between:
 - a) a redefinition of the concept of 'reflex' so that it was no longer confined to actions routed solely through the spinal cord. This would enable the identity between non-reflex actions and intentional actions to be preserved. Or,
 - b) preserving the definition of reflex actions as those routed through the spinal cord. This would break the identity between reflex actions and non-intentional actions so that it might then become possible to speak of intentional reflex actions, or non-intentional non-reflex actions, without contradiction.

By tampering with the Cartesian scheme the concept of 'intention' was *necessarily* cast adrift.

- (i) In considering an individual who manifested *only* reflex responses two cases fall to be considered:
 - a) where the individual manifests no brain activity. In such cases there is no mind, nor consciousness, nor personhood in existence. The situation is identical to the Cartesian position, only a 'bare machine' exists.
 - b) where the individual manifests brain activity. In such cases it is logically possible to assert that consciousness and mind persist.

Answers: Medical Conceptual Framework

The incorporation of behaviour such as 'habits' into the Classical Medical Conceptual Framework presented problems but it was the phenomenon of hypnosis that wrought the greatest change. The behaviour patterns seen in hypnosis were, in outward respects, indistinguishable from what would normally be considered purposive behaviour. Hampshire notes:

"Once this is admitted, there remains no a priori justification for drawing a line, and for excluding the possibility of description and explanation in physical terms, at any particular point on the scale of complication; we may in our common sense descriptions fall back on the

⁷⁸ Williams (1978) p.284:

"... 'all or nothing account' of mind ... that a creature has a full range of conscious powers or is an automaton with no experience of any kind."

terminology of will and purpose, simply because purely physical explanations are not yet available.”⁸⁰

Yet the distinction between ‘reflex’ and ‘non-reflex’ was not abandoned; rather the category of reflex was widened so that it included such ‘unintended’ behaviour. Such reflex behaviour was no longer considered to be referable solely to the spinal cord but was seen to involve the cortex. The intent was to preserve the link between intentional and non-reflex action. Yet if this link is regarded as sacrosanct then *only one* of the concepts ‘intention’ and ‘reflex’ can be defined independently.⁸¹ In other words, either ‘reflex’ and ‘intention’ are to be defined independently - in which case the proposition ‘All reflex actions are non-intentional’ is an analytic proposition that must be established; or, just *one* of ‘reflex’ and ‘intention’ is to be defined independently - in which case the proposition ‘All reflex actions are non-intentional’ is an empty truism. Returning to our original questions:

- (i) The situation in the Medical Conceptual Framework is confused. There have been attempts to define reflex actions independently of intention - one such is as ‘stereotyped’ actions - yet such a definition cannot include behaviour under hypnosis - which is anything but stereotyped and is generally accepted as being non-intentional.

The fact that the terms ‘reflex’ and ‘non-reflex’ are no longer considered to be mutually exclusive and that reflex behaviour can now include cortical activity might suggest that the concept, whilst it may be useful as rough helpmeet, is no longer fully coherent.

- (ii) The proposition that ‘*all reflex actions are non-intentional*’ can either be an empty tautology or a proposition requiring independent confirmation. All depends on how the terms ‘reflex’ and ‘intention’ are defined. However, because of the fluidity of these concepts the status of the proposition is unclear. Libet’s experiment - which isolated behaviour which subjects believed to be intentional but which in fact was not - further confounds the relationship between the intentional and the non-reflex.
- (iii) The recognition that reflex behaviour may involve cortical activity means that no conclusion can be drawn in relation to consciousness of an individual who only manifests reflex behaviour. This conclusion is reinforced by the fact that ‘reflex’ and ‘non-reflex’ are no longer considered to be mutually exclusive categories. Libet’s experiment suggests caution in drawing any conclusion concerning the presence of intention. The recognition that certain behaviour - such as ‘unconscious cerebration’,⁸² musical improvisation and some other artistic and creative processes - which would usually be considered as quintessentially human are in fact outside conscious control - and thus lie in the domain of the reflex - cautions against acceptance of the Cartesian simplicities where the possession of personhood - in the sense of being truly human - is equated with the ability to perform non-reflex actions.

Conclusion₂₋₁₄: *Whereas the conclusions that:*

- (i) The reflex/non-reflex distinction is coherent.*
- (ii) An action is reflex if, and only if, it is non-intentional. And*
- (iii) ‘Mind’, ‘consciousness’ ‘intention’ and ‘personhood’ cannot be attributed to an individual who manifests only reflex behaviour.*

⁷⁹ They, in turn, are defined by their being not confined to the spinal cord.

⁸⁰ Hampshire *op.cit.* p.103. Hampshire was discussing the complicated behaviour of animals and sleepwalkers and he did not advert to hypnosis but the point is all the stronger for this.

⁸¹ If one considers the concept ‘non-reflex’ and ‘intentional’ as a pair. In the Classical Medical Conceptual Framework ‘reflex’ was the dominant partner; it was defined independently - by being linked with the spinal cord - and the definitions of the other concepts ‘non-reflex’ and ‘intentional’ followed by implication. In the Medical Conceptual Framework the situation is reversed, ‘non-intentional’ action was now the dominant concept.

were valid within the bounds of Cartesian philosophy; in the light of current scientific knowledge they can no longer be justified without radical amendment. The nature of such amendment is unclear.

A possible resolution of this impasse

The acceptance of Dennett's, or some equivalent, analysis of 'intention' would at least permit that concept to be used in a meaningful fashion. At present its implicit use is, essentially, as a synonym for non-reflex action; this is a logical 'sleight of hand' and cannot be justified. Adopting (rather readopting, or repossessing) such a meaning for 'intention' and using the term 'reflex' as meaning 'stereotypical response' would necessitate breaking the link between 'intentional action' and 'reflex action'. An action might then be *both* intentional and reflex⁸³ - such as, for example, the movement of a PVS patient when they scratch or move away from a painful stimulus; equally behaviour might be *both* non-reflex and non-intentional - such as, for example, behaviour under hypnosis. One conclusion that follows from this analysis is that a patient who manifests intentional behaviour is *necessarily* conscious;⁸⁴ thus the PVS patient who responds to ice on the skin is to be considered conscious.

What of the link between non-reflex behaviour and personhood⁸⁵ which was such a feature of Cartesian thought? The existence of such a link is evident in the distinction between 'person', and 'automaton', or 'zombie' - *i.e.* individuals who *only* display predictable stereotypical responses. 'Person' and 'automaton' are mutually exclusive categories. Theoretical medicine, following Descartes, had attempted to forge a link between behaviour and 'personhood' by using the concept of 'reflex action' mediated⁸⁶ through the concepts of 'consciousness' and 'willed' or 'intentional action'. I suggest that it is the *method* of linking rather than the link which is in error. In Chapter 10 I will argue that:

'It is a necessary condition for the ascription of personhood to an individual that communication, to some minimal standard, be possible with that individual.'

This, if accepted, would imply that if an attempt at communication - *the stimulus* - is met with only a predictable stereotypical response, too simplistic to be considered as communication - *the reflex* - then, if this condition is persistent and believed to be permanent, 'personhood' is lost. This would thus re-establish the link between non-stereotypical behaviour and 'personhood' but on a more secure footing.

This approach also opens up the possibility of distinguishing between '*locked-in syndrome*' and PVS in terms of 'ability to communicate' and not in terms of 'possessing consciousness' as at present.⁸⁷ This suggests a focus - *i.e.* attempting to establish communication - for the management of a patient *before* a diagnosis is made; such a focus will itself be the means of enabling the diagnosis. Furthermore it is in accord with what is *in fact* the best current medical practice⁸⁸ used in attempting to distinguish between 'PVS' and '*misdiagnosed PVS*'. Most importantly, the making of a

⁸² *i.e.* problem solving.

⁸³ reflex in the sense of 'reflex_M'. In Dennett's categorisation, if one leaves aside the complication caused by the existence of 'chaotic' systems, intentional systems are complementary to reflex - in the sense of 'reflex_P' - systems.

⁸⁴ See the earlier discussion on Dennett in Section 4.

⁸⁵ Again in the sense of 'truly human'.

⁸⁶ Through the mechanism:

'(only reflex action manifested) *implies* (consciousness and will absent) *implies* (personhood absent)'.

⁸⁷ *i.e.* within the domain of applicability of the two concepts, a patient who could communicate would be diagnosed as 'Locked-In Syndrome'; one who could not communicate, as PVS.

⁸⁸ I refer to the work of Keith Andrews which is considered in Chapter 4 when discussing the misdiagnosis of PVS.

diagnosis of PVS using these criteria would not necessitate any judgement being made on the state of consciousness of the patient and their ability to experience pain. The following chapters will argue that a reasonable doubt exists as to whether such patients can experience pain, and that there is an ethical obligation on medical carers to treat such patients as *if* they can experience pain. However, as medicine presently distinguishes between 'locked-in syndrome' and 'PVS' by asserting that the former has consciousness whilst the latter has not, the treating of PVS patients as if they could experience pain would cause considerable theoretical confusion. A focusing on the task of establishing communication would permit attempts to definitively determine patient consciousness, to be seen for the chimera that they are.

The conclusions that were established in this Chapter are:

Conclusion ₂₋₁: *There is a distinction between the medical usage of the term 'reflex' - 'reflex_M' - and its use in relation to a purely physical system - 'reflex_P'.*

Conclusion ₂₋₂: *Medically the term 'reflex' is used in two senses; as actions performed without (conscious) intention - 'reflex_{MI}' - and as actions which require only limited areas of the brain for their completion - 'reflex_{MB}'. 'Reflex_{MI}' and 'reflex_{MB}' are not necessarily equivalent concepts.*

Conclusion ₂₋₃: *In Cartesian philosophy the term 'reflex' is used to refer to the purely physical, or mechanistic responses, of a physical system. This meaning of the term 'reflex' is denoted by 'reflex_P'. Furthermore the terms 'reflex_P' and 'non-reflex_P' are mutually exclusive.*

Conclusion ₂₋₄: *In Cartesian philosophy an individual who manifests only 'reflex_P' actions lacks 'consciousness', 'mind' and 'intention'. Such an individual is not to be considered a 'person' howsoever that is defined.*

Conclusion ₂₋₅: *In Cartesian philosophy a non-reflex_P action is necessarily an intentional action.*

Conclusion ₂₋₆: *Within the Classical Medical Conceptual Framework the presence of brain activity is both a necessary, and a sufficient, condition for the ascription of consciousness. This identification 'mind' = 'brain activity' = 'consciousness' readily enables the further identification 'consciousness' = 'personhood'. However, within this framework, though an intentional action is necessarily non-reflex, a non-reflex action is not necessarily intentional.*

Conclusion ₂₋₇: *The phenomenon of hypnosis challenges the coherence of the distinction reflex/non-reflex and leads to the conclusion that, either reflex actions must be regarded as of a complexity comparable to non-reflex actions, or some non-reflex actions must be regarded as non-intentional.*

Conclusion ₂₋₈: *The categories of actions, 'reflex' and 'non-reflex', can no longer be regarded as being mutually exclusive.*

Conclusion ₂₋₉: *The cerebral cortex can no longer be regarded as the exclusive domain of non-reflex actions.*

Conclusion 2 -10: *The phenomena of blindsight and automaticity challenge the identification of 'mind' with 'consciousness'. Mind is a broader phenomenon than consciousness.*

Conclusion 2 -11: *Libet's experiment implies that some non-reflex actions are non-intentional.*

Conclusion 2 -12: *Some philosophers, for example, Spinoza and Schrödinger, have understood the complex of concepts 'consciousness / intention / reflex and non-reflex action' in a manner radically different to the Cartesian understanding. Spinoza believes that all actions are determined by their environment and that the distinction between reflex and non-reflex actions rests simply on our present ignorance of the causes of those actions we categorise as non-reflex. Schrödinger argues that consciousness - understood as intent - is needed only if a novel situation is encountered needing a response. To him, reflex responses are simply the responses deemed adequate to a situation which has been previously encountered. They do not imply a lack of consciousness (understood as awareness) in fact they presume such a consciousness.*

Conclusion 2 -13: *To assert that a human manifests only reflex behaviour is - to Dennett - to adopt a 'physical stance' to that individual; this requires that laws of physics and chemistry are sufficient to fully predict the behaviour of that individual. It is a necessary consequence of the adoption of the physical stance that 'consciousness', 'intention', 'mind' and 'personhood' are not to be ascribed to that individual.*

Conclusion 2 -14: *Whereas the conclusions that:*

- (i) The reflex/non-reflex distinction is coherent.*
- (ii) An action is reflex if, and only if, it is non-intentional. And*
- (iii) 'Mind', 'consciousness' 'intention' and 'personhood' cannot be attributed to an individual who manifests only reflex behaviour.*

were valid within the bounds of Cartesian philosophy; in the light of current scientific knowledge they can no longer be justified without radical amendment. The nature of such amendment is unclear.

Chapter 3: Judging the 'ability to feel pain'

Introduction

If functional,¹ error-free, criteria exist for determining consciousness then, from a judgement that an individual lacks consciousness, it is possible to conclude that he lacks the ability to feel pain. It is simply a matter of deduction. Equally, if functional, error-free, criteria exist for diagnosing PVS then the inference that a PVS patient cannot feel pain is immediate because lack of consciousness is a necessary condition for PVS. But, as has been shown - in Chapters 1 and 2 in relation to consciousness, and as is shown in Chapter 4, in relation to PVS - such criteria do not exist. The aim of the present chapter is to determine whether there are functional, error-free, *independent* grounds² for judging that an individual cannot experience pain.

In the course of this chapter it will be argued that 'pain judgements' - that is medical judgements on a patient's ability to experience pain - are, in principle, susceptible to error. In particular, the assertion that a PVS patient cannot experience pain, considered as an independent proposition, must be regarded as open to question. It will be further argued that 'pain judgements', although they have the appearance of being scientific statements of fact, are often surrogates for value judgements. The distinction is of importance since if such propositions are considered to be simply scientific statements then, in determining their truth, the human consequences of any such statements are of no relevance; whereas, if such propositions are considered to be value judgements, such considerations are of the essence.

The chapter is divided into six sections. Section 1 considers the scientific evidence for making 'pain judgements'; and, in particular, whether the presence of pain in PVS patients can be definitively established by some measurement of their brain or other processes. Section 2 investigates some different meanings associated with the term 'pain' and suggests that the existence of such ambiguities can distort 'pain judgements'. Section 3 gives some examples from recent medical history of situations in which it is now accepted that pain can be experienced but where the medical consensus at the time was strongly to the contrary. This suggests that the current near-unanimity of medical opinion to the effect that PVS patient cannot experience pain need not necessarily be regarded as being determinative. Section 4 considers the making of 'pain judgements' from a philosophical perspective. The analysis of the grounds used for pain judgements played a considerable role in Wittgenstein's philosophy and his arguments against the validity of a distinction between 'pain' and 'pain behaviour' are of considerable relevance to any discussion concerning pain judgements in respect of PVS patients. PVS patients exhibit 'pain behaviour' - that is the grimaces, writhing and other bodily actions which are normally considered as manifestations of pain - and, if the distinction between 'pain' and 'pain behaviour' cannot be fully sustained, the conclusion that PVS patients cannot experience pain is weakened. Section 5 considers sources which directly support the contention that PVS patients may experience pain. Section 6 seeks to draw some conclusions from the discussion.

¹ By 'functional criteria' I mean criteria that can be easily used in a clinical setting.

² i.e. not as an inference from a judgement of either lack of consciousness or of PVS.

Section 1: A scientific approach to pain judgements

There is a near-universal³ acceptance, in both medical literature⁴ and in legal cases⁵ of the proposition that PVS patients cannot feel pain.

Paradoxically, there is also a widespread acceptance in philosophical literature of the so-called 'incorrigibility' of pain judgements - *i.e.* that an assertion by an individual that they are in pain is not open to question by another. This is, of course, not to deny that it is possible to *pretend* to be in pain, but rather to claim firstly, that it is not possible for another to be mistaken about whether they themselves are in pain; and secondly, that it is not possible to definitively prove that another is lying in respect of such assertions.

The acceptance of the incorrigibility of pain judgements may suggest that such judgements are entirely private and that an independent observer can never make a definitive ruling as to whether or not another is in pain. It is, however, beyond contention that if a patient has no consciousness then they cannot experience pain. The ambiguities in the term 'consciousness' have already been mentioned,⁶ but if 'consciousness' is interpreted as '*experiential consciousness*',⁷ then the assertion that:

'If Patient X lacks 'experiential consciousness', then he cannot experience pain.'

is irrefutable. But assuming that consciousness must in some way be manifested in the brain, and absent cases where all brain activity has ceased (which does not occur in PVS), we have seen that there is no centre of the brain uniquely associated with '*experiential consciousness*'. Thus the existence of '*experiential consciousness*' is not open to experimental verification, and accordingly

³ With the exceptions of Borthwick (whose views are discussed in Chapter 4 and are summarised in Appendix B) and McQuillen and, possibly, Andrews (both of whose views are discussed later in this chapter).

⁴ [as quoted in earlier chapters]

The 1996 guidelines issued by the BMA state (at p.58):

"It is widely accepted that PVS patients are unconscious and incapable of suffering mental distress or physical pain although many reflex responses remain."

The Multi-Society Task Force on PVS state (Part 2 at p.1576):

"None of these [i.e. reflexive responses] however, can evoke the experience of pain and suffering if the brain has lost its capacity for self-awareness. The perceptions of pain and suffering are conscious experiences: unconsciousness, by definition, precludes these experiences."

As the President's Commission categorise PVS under the heading '*Permanent Loss of Consciousness*' (op.cit. p.180), it is not surprising that the issue of pain was easily resolved:

"If a prognosis of permanent unconsciousness is correct, however, continued treatment cannot confer such benefits [i.e. relief of pain]. Pain and suffering are absent, as are joy, satisfaction ..." [ibid. p.181]

The Institute of Medical Ethics Working Party on the Ethics of Prolonging Life and Assisting Death 'Withdrawal of life-support from patients in a persistent vegetative state.' *The Lancet* (1991) found that:

"Vegetative state patients are not suffering, because the mechanisms for suffering have been destroyed." [ibid. p.97]

and

"We agree with the American view that there is no remaining neurological mechanism to make pain or suffering possible, ..." [ibid.]

⁵ [as quoted in earlier chapters]

Sir Stephen Brown P. in the Bland Case stated (at p.795)

"Although Bland's body breaths and reacts in a reflex manner to painful stimuli it is quite clear that there is no awareness on his part of anything that is taking place around him ... He is fitted with a catheter which has given rise to infection necessitating surgical intervention. It is to be noted that the necessary surgical incision was made without any anaesthetic because Anthony Bland is utterly devoid of feeling of any kind." [emphasis added]

The definition of PVS given by Sir Thomas Bingham, MR, in the Bland case (at p.806):

"P.V.S. is a recognised medical condition quite distinct from other conditions sometimes known as 'irreversible coma', 'the Guillain-Barré syndrome', 'the locked-in syndrome' and 'brain death'. Its distinguishing characteristics are that the brain stem remains alive and functioning while the cortex of the brain loses its function and activity. Thus the P.V.S. patient continues to breathe unaided and his digestion continues to function. But although his eyes are open, he cannot see. He cannot hear. Although capable of reflex movement, particularly in response to painful stimuli, the patient is incapable of voluntary movement and can feel no pain. He cannot taste or smell. He cannot speak or communicate in any way. He has no cognitive function and can thus feel no emotion, whether pleasure or distress." [emphasis added]

was adopted in the Ward Case by Lynch J. in the High Court (at p.2) and by Denham J. in the Supreme Court (at p.447)

⁶ Chapter 1, Section 3.

⁷ As distinct from, say, '*executable intentional consciousness*'.

the common inference that a patient has no pain because they have no consciousness⁸ is no explanation at all. I have found confirmation of this view from Dennett, who is particularly scathing of such an assertion⁹ and suggests that it has 'the smell of a begged question' and that its 'utility evaporates if we try to construe it as an 'analytical truth'.' His argument is of particular relevance to the situation of PVS patients and is worth quoting at length:

*"The persistence of reflex responses to painful stimuli under anaesthesia is an obtrusive and unsettling fact, in need of disarming ... Yet they¹⁰ assure us that analgesia ... is complete, despite the occurrence of 'behaviour' that is held - by some schools of thought - to be well nigh 'criterial' for pain. The presence of reflexes shows that the paths between nociceptors and muscles are not all shut down. What special feature is absent? ... The short answer routinely given is: consciousness. General anaesthetics render one unconscious, and when one is unconscious one cannot feel pain, no matter how one's body may jerk about. What could be more obvious? But this short answer has the smell of a begged question ... the principle¹¹ has no particular warrant, save what it derives from its privileged position as one of the experience-organising, pretheoretically received truths of our common lore, and in that unsystematic context it is beyond testing. Until we have a theoretical account of consciousness, for instance, how are we to tell unconsciousness from strange forms of paralysis, and how are we to tell consciousness from zombie-like states of unconscious activity and reactivity? The paradigms of unconsciousness that anchor our acceptance of this home truth principle are insufficiently understood to permit us to make the distinctions we need to make in this particular instance."*¹²

Thus, we can draw the conclusion that if the goal is to establish that a PVS patient cannot experience pain, the path through attempting to establish the absence of 'experiential consciousness', is a mirage.

Conclusion₃₋₁: *The assertion that, in PVS, pain cannot be experienced because consciousness is absent, is specious.*

There may, however, be other paths; it may be that there are areas of the brain uniquely associated with the experience of pain, so that if these areas are 'inactive' or irreparably damaged we could conclude that pain could not be experienced. As applied to PVS patients this procedure might be simplified if it was possible to determine areas of the brain damage to which is uniquely associated with PVS. Because, if such was the case, it might be concluded *independently of any judgement as to patient consciousness or any further diagnostic procedure* that a diagnosis of PVS might indeed imply that a PVS patient could not experience pain. In essence, two questions are posed:

'Are there areas of the brain damage to which is uniquely associated with PVS?'

'Are there areas of the brain uniquely associated with the experience of pain?'

It is to these questions that we now turn.

⁸ Excluding cases where all brain activity has ceased which is not the case in PVS.

⁹ i.e. that a patient has no pain because they have no consciousness.

¹⁰ i.e. the anaesthetists.

¹¹ i.e. that a patient has no pain because they have no consciousness.

¹² Daniel Dennett, 'Why You Can't Make A Computer That Feels Pain' p.212-3; this essay is included in Dennett, Brainstorms to which the page references refer.

Are there areas of the brain uniquely associated with PVS?

The 'Multi-Society Task Force on PVS' reported that:

*"Neurodiagnostic tests alone can neither confirm the diagnosis of a vegetative state nor predict the potential for recovery of awareness."*¹³

and that neither computed tomographic nor magnetic resonance imaging¹⁴ nor PET scans¹⁵ nor studies of cerebral blood flow¹⁶ can locate definitive areas of damage uniquely associated with PVS.

A working party report of The Institute of Medical Ethics¹⁷ found that:

*"No available laboratory diagnostic test can indicate that a patient is permanently vegetative. Research investigation of some vegetative patients has shown a cerebral metabolic rate equivalent to that in deep anaesthesia. Computed tomography and magnetic resonance imaging only show evidence of severe brain damage, not that the cortex as a whole is out of action, and electroencephalography is unhelpful."*¹⁸

Andrews¹⁹ also agrees that neurodiagnostic tests cannot confirm the diagnosis of PVS, though his non-use of these tests was criticised by Cranford²⁰ who argued that both the 'Multi-Society Task Force on PVS' and the Royal College of Physicians had considered neurodiagnostic test to be of some use in the diagnosis of PVS.

The conclusion follows that:

Conclusion₃₋₂: *As yet, no particular areas of the brain have been identified, damage to which, or whose inactivity, is uniquely associated with PVS. Hence, even if areas of the brain were to be identified which were uniquely associated with the experience of pain, no theoretical conclusion could be drawn ruling out the possible excitation of these areas - and, presumably, the experience of pain - in PVS patients.*

Of course, it may be that if such areas were identified their level of excitation could, in individual cases, be determined *practically* by a monitoring of the patient's brain; the conclusion being drawn that, in the absence of excitation, there was no pain. Can such areas be identified?

Are there areas, or processes, of the brain uniquely associated with the ability to experience pain?

On initial consideration it might be thought that this question could be easily resolved by a, theoretically simple, experiment: all that is needed is to monitor the brain of a subject for activity whilst they simultaneously report on their experience of pain; these are then correlated so that it is subsequently possible to identify the location of '*pain centres*'. Once such '*pain centres*' were

¹³ Part 1 at p.1505.

¹⁴ *ibid.* p.1506:

"Although there are no established correlations between the results of neuroimaging studies and the development of the vegetative state or the potential for recovery, most patients who do not recover consciousness have abnormal scans."

¹⁵ *ibid.* p.1506:

"Although these studies demonstrate substantial reductions in the metabolism of glucose, there is not yet sufficient information to warrant the use of PET scanning to determine prognosis."

¹⁶ *ibid.* p.1506:

"... measurements of cerebral blood flow immediately after an acute neurologic injury does not predict a vegetative outcome in either adults or children."

¹⁷ Institute of Medical Ethics Working Party on the Ethics of Prolonging Life and Assisting Death 'Withdrawal of life-support from patients in a persistent vegetative state.' The Lancet Vol 337 Jan 12, 1991 pp. 96-98.

¹⁸ *ibid.* p.97

¹⁹ Andrews (1996) at p13.

²⁰ Cranford *op.cit.* p.5.

established, then, theoretically, the brains of PVS patients could be monitored for activity at those centres and, in the absence of activity, it would be clear that the patients were not experiencing pain.

Such experiments have indeed been carried out and have established the '*cingulate cortex*' and the '*frontal cortex*' as the prime candidates but the results were by no means definitive.²¹ The subjects involved in such tests were, necessarily, conscious - they had after all to report on their feelings of pain - and they had not suffered brain damage. It is known, however, that after injury the brain is often subject to considerable reorganisation,²² so that *even if* the 'pain centres' for conscious subjects were determined with absolute precision - which is not the case - judgements could still not be made regarding the sentience of PVS patients' ability to experience pain.

There is uncertainty as to the broad location of such 'pain centres' or even as to their existence; there is not even consensus that pain is primarily a cortical activity.²³ Indeed the very coherence of the concept of pain centre has itself been questioned. This is evidenced by the controversy between the '*specificity theory*', and the '*gate theory*', of pain, to which we next turn.

Pain research was long dominated by the '*specificity theory*' which proposed that '*pain was a specific sensation subserved by a straight-through transmission system*'.²⁴ Such theories led to attempts by neurosurgeons to cut these '*pain pathways*' in an effort to mitigate the severity of the pain experienced by some patients; however the interventions '*so frequently ended in failure*'.²⁵ Current research focuses on the '*gate control theory of pain*' - proposed by Melzack and Wall in 1965 - which suggest that there is a neural mechanism in the spinal cord which acts as a gate which, by means of complex feedback mechanisms, controls the flow of information to the brain, and that the pain mechanism itself is more complicated and more pervasive than envisaged by the '*specificity theory*'. Melzack and Wall believe that:

"... [the concept of 'pain centres'] is pure fiction unless virtually the whole brain is considered to be the "pain centre" because the thalamus, the limbic system, the hypothalamus, the brain

²¹ David Concar, [*Into the Mind Unborn* *New Scientist* 19th October 1996] mentions (at p.44) the use of PET scans to determine which parts of the brain are involved when someone experiences pain:

"When people say the stimulus is not painful you don't see these emotional areas light up."

²² Concar [*op.cit.* at p.45]; he continues:

"Sometimes, the pain they feel is increased on the side that you'd expect would be numb to pain. This could be because the brain reorganises following injury."

Gregory notes that:

"Transformation of psychological processes as new brain parts arrive at functional maturity confers a plasticity of function so that a child can partly recover from loss of brain tissue by injury or disease." [*op.cit.* p.108]

and that:

"In recent years the evidence on pain has moved in the direction of recognising the plasticity and modifiability of events in the central nervous system. Pain is a complex perceptual and affective experience determined by the unique past history of the individual, by the meaning to him of the injurious agent or situation, and by his 'state of mind' at the moment, as well as by the sensory nerve patterns evoked by physical stimulation." [*ibid.* p.574]

²³ Concar, *op.cit.* p 45:

"Some neuroscientists believe that the jury is still out on whether cortical activity really is the vital ingredient in pain. Some part of pain could be processed entirely subcortically, ... But it would be difficult to prove."

Dennett (*op.cit.* p.199-216) gives a marvellous *tour-de-force* of the '*gate theory of pain*'. The journey begins at the skin with receptors (*the nociceptors*) that respond to certain noxious events. Two types of brain fibres travel brain-wards; '*A-fibres*' believed responsible for 'stabbing' pains and enable the localisation of pain, and '*C-fibres*' believed responsible for non-localised 'deep' pains. Both A- and C-fibres meet at the midbrain gateway and output through two channels - one to the lower, phylogenetically older portion of the brain and the other to the neocortex. Dennett describes the feedback mechanisms between these outputs and their complicated onward path and uses this '*gate theory*' to help explain many of the anomalies associated with the experience of pain such as 'phantom limb', and the experience of those under morphine who are aware of feeling intense pain but of not 'minding it'. In the face of such complexity, ideas of 'pain centres' seem unduly simplistic.

Dennett's goal is to find a theoretical mechanism which will help explain the action of the different drugs used in anaesthesia and analgesia. Using the '*gate theory*' he is able to do this *without recourse to arguing that anaesthetics function by removing consciousness* - an 'explanation' which he believes to be only a sham.

²⁴ Gregory *op.cit.* p.574.

²⁵ *ibid.* p.575

*stem reticular formation, the parietal cortex, and the frontal cortex are all implicated in pain perception."*²⁶

Howard Fields and Donald Price in their essay on pain,²⁷ reached a similar conclusion though from a more philosophical perspective:

*"There are limits to what objective measurement can tell us about the pain experience ... it is not clear that it is possible to determine the site or sites in the brain where the subjective experience actually 'occurs'. In fact it is arguable whether a subjective experience has a spatial location."*²⁸

However, some believe the concept of pain centres to still have a heuristic value:

*"Meanwhile research at a neurophysiological level was going on, with much argument centred on the question whether specific pain mechanisms exist or not. Are there specific pain receptors, pain nerve fibres, and pain centres in the brain? The deep scientific and philosophical implications of this question are discussed in a concluding section. Rey believes that the specificity idea is heuristically useful and so must be retained for the moment, although it is probably invalid and may need to be replaced eventually."*²⁹

Dennett believes that there is no way of getting such 'pain centres' into the theoretical model without committing 'flagrant category mistakes'; such discussion risks confusing the personal and theoretical level of explanation³⁰ - as occurs, for example, in the reassurance given by an anaesthetist to a patient who questions 'Does it stop the pain?':

*"... his further reassurance that of course the anaesthetic does stop the pain is not yet another consequence of any theory of anaesthesia that he knows, so much as a 'philosophical' dogma"³¹ - quite reasonable, no doubt - that plays a useful role in his bedside manner."*³²

Dennett is led to conclude that our intuitions on pain are deeply, perhaps irretrievably, inconsistent and that:

*"What must be impeached is our concept of pain. A better concept is called for ..."*³³

²⁶ Quoted in Dennett *op.cit.* p.219.

²⁷ Included in Samuel Guttenplan (ed.) *A Companion to the Philosophy of Mind* pp 452-9.

²⁸ *ibid.* p.457.

²⁹ Anthony Campbell, review of Roselyne Ray's 'The History of Pain' in *The Journal of Consciousness Studies*, (1999) at p.113.

³⁰ Dennett *op.cit.* p.219.

³¹ This may appear unduly extreme yet Dennett instances cases, as does Gregory, of so-called anaesthetics which were in fact amnesiacs - so that rather than preventing pain they stopped the remembering of pain. For example, the drug *hyoscine* - known as 'twilight sleep' - has this effect and had often been given during childbirth (Gregory *op.cit.* p.24). Dennett recalls being told by a prominent anaesthesiologist "When we think a patient may have been awake during surgery, we give *scopolamine* to get us of the hook." Dennett also mentions a pharmacological textbook which uses the phrase '*obstetrical amnesia or analgesia*' as if amnesia and analgesia were much the same thing. (Dennett *op.cit.* p.210) The action of '*curare*' - which was wrongly believed to be an anaesthetic and which caused total paralysis - is discussed later in this chapter.

³² Dennett *op.cit.* p.217.

Gregory (*op.cit.* p.22-24) also acknowledges the lack of theoretical understanding of anaesthesia and consequently of pain:

"How do anaesthesia work? ... There is no common chemical structure which would suggest a specific action on some part of the brain. Instead ... all share the property of dissolving in fat ... [The] cell membrane across which an electrical potential is maintained consist of fatty molecules ... the anaesthetic ... disorders the membrane ... But if one asks, 'On what synapses, or on what cell groups of the brain, is this molecular action particularly exerted? no satisfactory answer exists. ... Detailed analysis yield a bewildering variety of effects ... It is still impossible to move convincingly from the subjective phenomena to physiological understanding ... One must recall that, despite all the advances of neuroanatomy, it is only a tiny minority of nervous pathways that can be precisely and completely described in anatomical and neurochemical detail ..."

³³ Dennett *op.cit.* p.225.

Such a radical reappraisal of the concept of pain is, for our purposes, unnecessary. A narrower conclusion, amply supported by the above analysis, is sufficient:

Conclusion 3-3: *Excepting cases where all brain activity is absent, there are no areas, or processes, of the brain that can be uniquely associated with the experience of pain to the extent that the non-activation of these areas, or the absence of these processes, would justify the conclusion that pain is not present.*

Because all brain activity is not absent in PVS patients, a further conclusion can be drawn:

Conclusion 3-4: *In PVS there are no areas, or processes, of the brain that can be uniquely associated with the experience of pain to the extent that the non-activation of these areas, or the absence of these processes, would justify the conclusion that pain is not present.*

However, Dennett's analysis permits a further conclusions of great importance for our discussion of pain judgements in relation to PVS patients. He argues that pain judgements are intimately connected with moral judgements:

*"There can be no denying (though many have ignored it) that our concept of pain is inextricably bound up with (which may mean something less than 'essentially connected with') our ethical intuitions, our sense of suffering, obligation, and evil."*³⁴

Dennett conceives of this connection, not in the simple Utilitarian sense of moral judgements following from pain judgements, but in a much more intimate way. Consider, for example, that in a Utilitarian ethic the ability to experience pain is both a necessary, and a sufficient, condition for being considered an 'Object of Intrinsic Moral Worth'.³⁵ This proposition has the *appearance* of giving a scientific, experimentally verifiable, criterion - the ability to experience pain - for ascribing moral value. Dennett's point is that this is not so; in reality the proposition is tautological. Pain judgements require a context within which they are operative; they are only applicable to certain categories of subjects - and these are the very subjects considered worthy of moral consideration. This, argues Dennett, is shown by our reluctance to accept the idea that robots³⁶ might feel pain; this reluctance stems not from a judgement on the possible internal mechanisms of robots but from a judgement that robots are not, to us, the subject of moral consideration.

Wittgenstein makes essentially the same point when he suggests that we cannot ascribe pain to a stone³⁷ but look 'at a wriggling fly and at once these difficulties vanish and pain seems able to get a foothold here.'³⁸

Further evidence for this perspective can be found in the considerable controversy³⁹ that has existed over whether animals can experience pain. The mistake here is to assume that this is a question capable of a purely scientific determination.

³⁴ *ibid.* p.197.

³⁵ This term 'Objects of Intrinsic Moral Worth' ('OMW's' for short) is explained in Chapter 1, footnote 12. The terminology is useful in discussing 'personhood' and will be considered further in Part 3.

³⁶ His essay was entitled 'Why you can't make a computer that feels pain'.

³⁷ This example is considered in Section 4.

³⁸ Wittgenstein PI-1 § 283-4:

"Only of what behaves like a human being can one say that it has pains. For one has to say it of a body, or, if you like of a soul which some body has. ... Look at a stone and imagine it having sensations ... One might as well ascribe it to a number! - And now look at a wriggling fly and at once these difficulties vanish and pain seems able to get a foothold here, where before everything was, so to speak too smooth for it."

³⁹ This will be discussed in Section 2.

Conclusion 3-5: *The ascription of pain is not amenable to a purely scientific, experimentally verifiable, determination but is intimately connected to whether the subject is deemed to be a suitable candidate for inclusion in a moral calculus (i.e. is an 'Object of Intrinsic Moral Worth').*

Applied to PVS patients, this perspective has interesting consequences. It suggests that the judgement that they are not 'persons'⁴⁰ is the logically prior proposition, and that the assessment that they cannot feel pain is a corollary of this, and not conversely. It may also account for the forcefulness with which the supposed inability of PVS patients to experience pain is often asserted; a vehemence which is all the more unjustifiable if it is accepted that appeals to a lack of consciousness are quite beside the point. However, once 'ability to experience pain' is seen to function as an implicit surrogate for 'personhood', then it is clear that the judgement of 'inability to experience pain' is playing a symbolic role and the reason underlying the forcefulness then becomes obvious.

The uncertainty implicit in 'pain judgements' has been one focus of this section. However, there are also historical reasons for recognising that 'pain judgements' - though often dogmatically asserted and brokering no opposition - can be fundamentally wrong. Descartes, for example, believed that animals could not feel pain and, up to recently, the same was believed of newborn infants. There are also examples of supposed methods of anaesthesia which, despite the protestations of patients, were incorrectly judged to preclude the experience of pain. In order to permit a fuller discussion of these examples it is first necessary to suggest some distinctions in the use of the term 'pain' and it is to this task we now turn.

Section 2: Ambiguities in the term 'pain'

It is possible, by considering one's own individual experience of pain, to disentangle some of the strands that are usually combined into the unitary judgement '*I am in pain*'. A number of distinctions assist in this.

The first distinction is that between the '*concept of pain*' and the '*unanalysed experience of pain*', which is akin to the distinction between symbol and object.

The second distinction is that between '*pain*' and '*suffering*' - 'pain' being the term appropriate to an *immediate* experience whilst '*suffering*' relates to the perception of that experience viewed against the image of 'self' considered as an continuing entity, *i.e.* possessing a past history and with future expectations.

A third distinction is that between the '*experience of pain*' and the external '*behavioural manifestations of pain*'; though Wittgenstein, for example, argues that attempts at such a distinction are misplaced. Wittgenstein's argument is considered in Section 4.

These distinctions are of importance to the debate on whether PVS patients can experience pain. For example, Wittgenstein's argument suggests that since PVS patients manifest pain-behaviour⁴¹ they must be regarded as being in pain; (however, it could be argued in response that PVS patients do not manifest '*real-pain behaviour*' but some kind of '*pseudo-pain behaviour*'; this objection will be considered in Section 4). The distinction between the 'experience of pain' and the

⁴⁰ *i.e.* that they have lost their '*personhood*'. This concept will be discussed in Chapter 10.

⁴¹ see The Ward case:

"In the Ward's case, it is also clear that she never got used to the nasogastric tube. She reacted against it by pulling it out an enormous number of times, probably well over a thousand times and probably also by way of reflex action to an unpleasant stimulus ..." [Lynch, J., High Court p.21]

'concept of pain' suggests that pain could be experienced in the absence of 'reflexive consciousness' - that is, with a lower level of consciousness than is normal - and thus operates in favour of the proposition that PVS patient can experience pain.

The distinction between the 'unanalysed experience of pain' and the concept 'pain'

The distinction suggests that, at the most basic level, the *unanalysed experience of pain* - the *feeling* of the 'burn on the hand' - can be perceived before conceptual thought intrudes. The task of conceptual thought is to compare the experience to previous experiences, and to decree that it belongs with those which were previously categorised as falling under the concept of 'pain' - *i.e.* that it be spoken of as '*painful*'. The first distinction then is between the '*feeling-pain*' and the '*concept-pain*'. Some have objected to this distinction and suggested that, in the absence of the *concept* of pain, pain is impossible.⁴² Once embarked on this path of analysis it is possible to argue that the experience - the 'burn on the hand' - can only be considered to be painful by me, if there is a *me* - a 'self' to experience the pain - but a 'self' not in the experiential sense of a 'subject of feeling' but rather a 'self' in the conceptual sense of the self/other distinction. For example, an infant does not develop⁴³ a sense of self until some 12 months old; until then he regards 'himself', 'his mother' and 'the world' as coterminous; the objection would suggest that such an infant cannot experience pain since they have not a sense of self.⁴⁴ This suggests that the correct formulation of the distinction is between '*feeling-pain*' and '*concept-self-pain*' rather than, simply, '*concept-pain*'.

This might seem an overly intellectual way to construe pain judgements, yet Descartes based his argument that animals could not experience pain - nor indeed have any 'experience' - on grounds such as these. In Descartes' view, only beings with consciousness⁴⁵ could experience pain; to him, animals were just machines, possessing no consciousness. Williams, as mentioned earlier,⁴⁶ has commented on what he considered a fundamental confusion in Descartes philosophy between '*consciousness*' and '*reflexive consciousness*':

*"An interesting case in this connection is pain. It would be generally agreed that pain is a conscious experience: one who is in pain feels something. Now it may, further, be true that a language user who is in pain will believe that he is in pain, unless perhaps he is such a reduced state that he has lost effective hold of his language use. If one possesses and can use the concept pain, its application to oneself will be elicited by ones being in pain, and in this pains importantly contrasts with wants. But non-language users can be in pain (though Descartes ... denied it); they have no concept of pain they can apply to themselves, and to them we cannot in all seriousness ascribe in addition to their pain, a belief that they are in pain."*⁴⁷

Williams argues that this confusion easily leads to the erroneous suggestion that if reflexive consciousness is absent then so is consciousness and also the ability to experience pain. The confusion is that between 'experiencing something' and 'experiencing that something as pain' - the latter obviously requiring use of the concept 'pain' and hence a 'reflexive consciousness'. The

⁴² This was Descartes' view and is discussed later in this section. Some medical practitioners, who argue that a newborn baby cannot feel pain, also rely on this ground as do some who suggest that animals cannot experience pain; these views are examined in Section 3.

⁴³ As argued, I believe, by Piaget.

⁴⁴ and, *a fortiori*, that a foetus could not experience pain.

⁴⁵ By which he meant the capacity to reason conceptually.

⁴⁶ Chapter 1, footnote 92.

⁴⁷ Williams, *Descartes*, p.82.

refusal to accept the distinction between the 'experience of pain' and the 'concept of pain' leads to the conclusion that experience cannot occur without language; this would imply the bizarre conclusion that a child brought up without language, but who is otherwise normal - as in the so-called 'enfant sauvage' cases⁴⁸ - is necessarily⁴⁹ incapable of experiencing pain. The line of reasoning would also imply, for example, that an infant could not be conscious of its first steps without knowing that its movements were to be properly categorised as *steps* (in contrast to, say, hops). An even more striking thought experiment is to imagine a desert nomad who one day sees snow - a phenomenon utterly unknown to him and which had never before occurred in that desert. The experience cannot be encompassed within his existing language and is so foreign to it that it cannot even be hinted at. Must we then be forced to say that - in the absence of a capacity to describe it - the feeling of snow on his skin did not happen?

It may be possible to argue against the distinction from another direction - that the immense difference that we attribute to the distinction between pain and pleasure lies not in the experiences themselves, but rather in the construction that we place upon them; such a construction would necessarily be conceptual. This position is put forward by Alan Watts:

*"What we feel is to an enormous and unsuspected degree dependent on what we think, and the basic contrasts of thought ordinarily strike us as the basic contrasts of the natural world. We therefore take it for granted that we feel an immense difference between pleasure and pain. But it is obvious in some of the milder forms of these sensations that the pleasure or the pain lies not so much in the feeling itself as in the context. There is no appreciable physiological difference between shudders of delight and shudders of fear ... but the context of the feeling changes its interpretation, depending on whether the circumstances which arouse it are for us or against us."*⁵⁰

But this is really an argument, not against the inability to experience in the absence of language but, against assuming that our methods of categorisation have any universal validity. In fact Watt's contention *presupposes* that the experience is separable from its categorisation and may be explained by a further distinction - that between 'pain' and 'suffering'.

⁴⁸ These are cases of children, such as the 19th century documented example known as the 'The Wild Boy of Aveyron' [discussed in Chapter 10] who grow up in the company of animals but in the absence of humans.

⁴⁹ Singer in his essay 'Do Animals Feel Pain?' states:

"There is a hazy line of philosophical thought, deriving perhaps from some doctrines associated with the influential philosopher Ludwig Wittgenstein, which maintains that we cannot meaningfully attribute states of consciousness to beings without language. This position seems to me very implausible. Language may be necessary for abstract thought, at some level anyway; but states like pain are more primitive, and have nothing to do with language... Human infants and young children are unable to use language. Are we to deny that a year-old child can suffer? If not, language cannot be crucial."

This shows, I believe, a fundamental misunderstanding of Wittgenstein's views, in particular his 'Private Language Argument'. The 'PLA' is considered in Chapter 10.

[Singer's article 'Do Animals Feel Pain?' is an excerpt from his book Animal Liberation and is available on the internet at <http://www.envirolink.org/arrs/index.html>]

⁵⁰ Alan Watts, Nature, Man & Woman, at p.86.

The distinction between 'pain' and 'suffering'

'Pain' can be distinguished from 'suffering', by noting that the term 'suffering' is used to refer to the experience of pain when viewed against one's past 'life story' and future plans and expectations; 'pain' refers to the unanalysed experience itself.⁵¹

The distinction is one that is not commonly used; usually when we speak of our pain, we are conscious of the actual experience - our stinging cheek, having been just slapped across the face - and the implication for us of that experience, both now (our dignity is affronted), in the future (the slap may have caused injury so we will have future pain or it may mean that certain relationships will be affected) and in the past (we may have to rewrite our 'life stories'); hence, usually our 'pain' and 'suffering' are conflated.

Watt's observation - on the enormity of the difference between 'pain' and 'pleasure' judgements - is accounted for in noting that it is the *context* that turns an experience firstly into a 'pain' and thence into a 'suffering' and the 'immense difference' is not so much between 'pain' and 'pleasure' as between 'suffering' and its counterpart.

The distinction between 'pain' and 'suffering' permits the conclusion that, though the absence of reflexive consciousness is a bar to 'suffering', it is no bar to the experiencing of 'pain'. Furthermore, it would follow that - if the absence of conceptual abilities was accepted - neither animals nor newborns⁵² nor older infants experience 'suffering' though they may well experience 'pain'.

Conclusion₃₋₆: *It is possible to draw a distinction between the 'pain', the 'concept of pain' and 'suffering', and to conclude that, though the possession of reflexive consciousness is a precondition for experiencing pain 'as pain' or for suffering, it is not so for the experience of pain itself.*

Section 3: Examples of reversals of a consensus that pain cannot be experienced.

Historically, the question of whether animals can experience pain has been contentious. Descartes, for example, believed that animals were unable to feel pain; though the consensus, in modern times, is that they can. However, it is not only philosophers who disputed the ability of certain categories of individuals to experience pain; these controversies did - and still do - occur in medicine. For example, up to quite recently it was believed that newborn infants were incapable of experiencing pain, and there is currently a controversy as to the developmental stage required of the foetus for it to begin to feel pain. There have also been disputes over whether certain medical procedures could rightly be called anaesthetic or were, in fact, just amnesiac; some arguing that the difference didn't matter.⁵³

In this section I examine these controversial pain judgements firstly, in relation to animals; secondly, in relation to newborn infants and foetuses; thirdly in relation to certain anaesthetic practices. The relevance of these examples is that they show that the existence of a near-

⁵¹ Charlotte Joko Beck, *Everyday Zen*, p.191:

"I'd like to draw a distinction between pain and suffering. Pain comes from experiencing life just as it is, with no trimmings. We can even call this direct experiencing joy. But when we try to run away and escape from our experience of pain, we suffer."

⁵² Though it is difficult to see whether an infant's fear of abandonment should be classified as being 'pain' or 'suffering'.

⁵³ Article by Emma Burns entitled 'Does a foetus feel pain?' [The Times 28th March 2000]:

"Do unborn babies feel pain? If so, from which week? And - horrifying though it may be to imagine such suffering, does it matter in the long term, given that the experience will not be remembered?"

The practice of giving amnesiacs in conjunction with anaesthetics is discussed later in this section.

unanimity in medical opinion on the impossibility of pain being experienced - as happens currently in relation to PVS patients - is no guarantee as to its truth.

Animals

The close relationship between judging an individual as having the '*ability to feel pain*' and being an '*object of intrinsic moral worth*' has already been noted, and is particularly well exemplified in discussions concerning an animal's ability to experience pain, where the relationship is so close that any denial that animals can feel pain is considered tantamount to a denial of the existence of moral obligations to animals. If these questions are conflated then the status of pain judgements - *i.e.* whether they are scientific or ethical propositions or some admixture of both - is itself unclear. In an attempt to separate out the scientific issues from the ethical, I wish to categorise arguments on the ability of animals to feel pain as either '*fact driven*' or '*value driven*'. The argument is '*fact driven*' when it is a scientifically based investigation of the brain and general physiology of an animal, in an attempt to directly establish the existence of pain. In contrast, it is '*value driven*' when in establishing the ability of animals to experience pain *any* reliance is placed on animals being objects of moral worth; in such cases 'pain judgements' are being derived indirectly from a prior value judgement.

I wish to argue, echoing Dennett, that all 'pain judgements' are value driven, *i.e.* that they are never amenable to a *purely* scientific determination. Once the 'fact driven' arguments are shown to be inconclusive, then this contention is established by default.

'Fact driven' arguments.

A review of a recent study on pain suggests that "[Pain's] near-universality suggests that it must be a basic neurological phenomenon, yet it is still possible to argue about whether pain is felt by non-human organisms, and if so by which of them."⁵⁴ Many have suggested that pain is necessarily a cortical activity, but even this is in doubt. Dr Vivette Glover, the director of the Foetal and Neonatal Stress Research Centre at Queen Charlotte's and Chelsea Hospital, has pointed out that:

*"Frogs and fish do not have a cerebral cortex, yet most people would say that they could not be sure that frogs ... and fish don't feel anything."*⁵⁵

A recent study⁵⁶ on the hunting of deer which attempted to determine whether the deer felt pain was so heavily criticised that it is being withdrawn; this particular study also seems to have equated bodily stress with pain, bodily stress being scientifically a more manageable concept. Other studies have also had difficulty in finding a scientific correlate of pain; in one study⁵⁷ those with the '*greatest rise in the stress hormone cortisol in their saliva*' were considered to be in the greatest pain.

These examples are eloquent testimony to the difficulty of fully incorporating the concept of animal pain into a scientific theory. Indeed, it is arguable that it is theoretically *impossible* because the concept of pain - like consciousness - is itself not amenable to a scientific investigation; some

⁵⁴ Campbell *op.cit.* p.113.

⁵⁵ Burns *op.cit.*

⁵⁶ It has been reported that Patrick Bateson, an authority on animal behaviour at Cambridge University - whose report on the stress suffered by deer whilst being hunted, led to a National Trust ban on stag hunting - has admitted that the validity of his findings needs to be tested by further research.

[In an article entitled 'Staghunt scientist admits his doubts', The Times, January 24th 1998].

⁵⁷ Dr. Glover [as quoted in Burns *op.cit.*].

physical correlate is required - whether stress level, or whatever - and whereas scientific results can be generated for the correlate, the correlation *itself* can never be immune from challenge.⁵⁸ This is particularly so if the ability to communicate is either non-existent (as in the case of animals) or is permanently lost (as in the case of PVS patients).

'Value driven' arguments

Descartes attempted to justify the proposition that animals cannot feel pain on the grounds that they were just machines. Though this has the initial appearance of being a factual or scientific proposition, it is not so. It rests on a distinction, crucial to Descartes, between the *value* of animals and that of humans - humans have language and reason (or, more concisely, 'souls'), animals have not. There is no *demonstration*⁵⁹ that 'animals are machines', nor are any arguments offered - as later considered by Dennett - that '*machines cannot feel pain.*'⁶⁰ If Descartes' argument was implicitly theological, others have offered a more explicit theological justification, suggesting, for example, that since all suffering is a consequence of Adam's sin and since animals are not descended from Adam they cannot feel pain.⁶¹

Returning again to the relationship/identity between '*ability to feel pain*' and being an '*object of moral worth*', Descartes and the Church theologians considered that the absence of 'souls' in animals logically implied humans owed no moral obligations to animals - that animals were not '*moral objects*' - and the proposition that animals could not feel pain was by way a *logical inference* from this. Bentham sought to reverse the implication by suggesting that:

*"The question is not, Can they reason? nor Can they talk? but Can they suffer?"*⁶²

He sought to derive the moral worth of animals by a logical inference from the 'fact' of animal suffering.⁶³ But is it a '*fact*' that animals experience pain?

Do animals feel pain?

Singer, in an attempt to establish that animals do feel pain, noted the similarity of the behaviour, and of the nervous system, of animals and humans. However, this of itself, was obviously not conclusive and he was forced to fall back on arguments such as:

*"The overwhelming majority of scientists who have addressed themselves to this question agree ..."*⁶⁴

Marian Stamp Dawkins has attempted a more rigorous approach. Her aim is to unravel the '*bowl of spaghetti-like reasoning*' that is normally used as an ethical basis for the treatment of animals.⁶⁵ She has suggested that an animal can be said:

"... [to be] suffering if it is being kept in conditions that it would work hard to get out of, if given the chance."

⁵⁸ See the discussion in Chapter 1 (p.37) on the use of eye-movement as a criterion for 'dreaming' and the suggestion that this is tantamount to a redefinition of 'dreaming'.

⁵⁹ As, for example, one would attempt to demonstrate to one who had never seen, nor heard of, a tape recorder that it was a machine.

⁶⁰ The suggestion that machines might feel pain seems extreme yet it is worth remembering that La Mettrie, a contemporary of Descartes, implicitly accepted this in that he considered humans as just machines.

⁶¹ Attributed to Malebranche; see: [Internet Encyclopaedia of Philosophy](#) 'Animal Rights'.

⁶² Quoted in Singer, *A Companion to Ethics* at p.348.

⁶³ Neglecting, for the moment, the distinction between 'pain' and 'suffering'.

⁶⁴ see Singer, '*Do Animals Feel Pain?*'

⁶⁵ Paul Gribble '*Cognitive Science and Animal Rights*' [internet source]

This definition creates its own difficulties. Consider a minute organism endowed with negative phototaxis *i.e.* which avoids light.⁶⁶ If we place such an organism close to a light it will tend to move away from it - can we say of such an organism that it suffers? Consider another example; there is no conceptual difficulty in designing a robot,⁶⁷ susceptible to damage by heat, which would be programmed to avoid heat whenever possible. Could we say of such a robot that it suffers? Dennett tried to confront this question directly in his essay *'Why you can't make a computer that feels pain'*. His conclusion was that our concept of pain is inextricably linked with moral considerations; robots to us, are not worthy of moral consideration and thus cannot feel pain.

Animal pain - some implications for PVS patients

This discussion on animal pain has shown that 'pain judgements' cannot be fully separated from judgements of moral worth. The moral worth - or '*personhood*' - of PVS patients is considered in a subsequent chapter where it is defined in such a way as to uncouple the link between the personhood of PVS patients and their ability to feel pain. It is then possible to consider a PVS patient as being able to experience pain without this in any way determining the personhood of the PVS patient. This would thus overcome - what I have already suggested as - the reason for the resistance of medical profession to treating PVS patient as being able to experience pain, namely, that to do so would be tantamount to a determination of their personhood, and would imply that PVS patients were persons with the same rights to treatment and care as other persons - a situation difficult to justify in times of scarce resources.

The ability of newborn infants to experience pain

A recent editorial in The New Scientist noted that:

*"Until the 1980s, surgeons operated on newborn babies without giving them opiate-like painkillers, believing that these were not necessary."*⁶⁸

Dr John Wyatt, a consultant neonatal paediatrician, commenting on the findings of the Rawlinson Commission on foetal ability to experience pain has said - in a passage which is redolent of current attitudes to PVS patients - that:

*"Until 10 years ago it was widely believed by scientists and clinicians that newborn babies were incapable of feeling pain. The obvious physiological reactions that babies demonstrated to invasive procedures, such as crying and grimacing, were thought to represent reflex responses. It was common medical practice to perform major surgery with drugs that ensured that the baby couldn't move but gave little or no pain relief."*⁶⁹

But confusion did not cease ten years ago, it is still evident. The "The Multi-Society Task Force on PVS", for example, state:

⁶⁶ Gregory *op.cit.* p.519.

⁶⁷ This example was given by Gribble *op.cit.*

⁶⁸ Entitled '*Cool heads in a hot climate*'; The New Scientist 19th October 1996 at p.3

See also Burns *op.cit.*:

"Until 1985 it was assumed that not merely fetuses but also newborn babies were incapable of feeling pain. Then research emerged showing that newborns given painkillers during surgery were more likely to thrive than those who were not. By 1993 it was accepted that this was because they can and do suffer and should be treated accordingly. Now the focus has switched to fetuses,"

⁶⁹ Dr John Wyatt, article entitled '*Foetal Pain*' [The Guardian 23rd October 1996].

*"Newborns may have the potential to experience pain and suffering. Infants over several months of age are consciously aware and capable of suffering."*⁷⁰

This clearly indicates the existence of doubts on the ability of newborns to feel pain, doubts which are not shared by the President's Commission:

*"Thus infants whose lives are destined to be brief are owed whatever relief from suffering and enhancement of life can be provided, including feeding, medication for pain, and sedation, as appropriate."*⁷¹

Differences in current practice⁷² with regard to the need to anaesthetise male infants prior to circumcision is also a manifestation of the confusion in this area. The confusion is not restricted just to the pain receptivity of newborn infants but extends also to considerably later stages in the infant's development. For example, Stuart Derbyshire, a research fellow in the Department of Rheumatology at Hope Hospital in Salford, argues that conscious experience depends on social interaction and self-awareness, and that it is only well after birth that the awareness of pain develops as a 'consequence of self-observation and efforts to articulate and cope with emotion provoking situations'. He states further that:

*"Whether the cortex does or does not light up is neither here nor there ... the ability to feel pain flows not just from circuits of neurones in the brain ... [but] from the impact of memories and life events on those brain circuits. In short, a foetus cannot feel because it has no experience of life."*⁷³

The distinctions, discussed earlier, between the 'experience of pain', the 'concept of pain' and 'suffering' could have been profitably used by Derbyshire!

Foetal pain

In view of such differing opinions on the pain receptivity of newborns, it is not surprising that the situation with regard to foetal pain is even more confused.

The Royal College of Obstetricians and Gynaecologists, acknowledging the scientific evidence that the development of the nervous system - which, they argue, might enable a foetus to feel pain - begins at around 26 weeks, recently⁷⁴ issued guidelines on the use of painkillers when carrying out procedures involving the foetus. The British Medical Association welcomed⁷⁵ the guidelines, saying that even if there was no incontrovertible evidence that foetuses feel pain, they 'may help to relieve the anxiety of the parents and health professionals'. At present the UK Medical Research Council is reviewing the current state of knowledge of foetal awareness; its 'Foetal Pain Expert Group' is expected to report early in 2001.⁷⁶

⁷⁰ Part 2 p.1577 [emphasis added].

⁷¹ President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research. 'Deciding to Forego Life-Sustaining Treatment' at p 220.

⁷² A study (which I have not consulted) by Gideon Korean in The Lancet; February 28, 1997 discusses the differences in current medical practice.

Burns (*op.cit.*) also addressed the question of male circumcision:

"Pain suffered at or soon after birth seems to leave its mark. Dr Vivette Glover, the director of the Foetal and Neonatal Stress Research Centre at Queen Charlotte's and Chelsea Hospital, West London, says: "Baby boys circumcised in their first week cried more at their inoculation jabs at four to six months than a control group did, indicating a long-term alteration of their pain response."

⁷³ The Guardian 23rd October 1996.

⁷⁴ The Irish Times 25th October 1997.

⁷⁵ The Times 25th October 1997.

⁷⁶ Burns *op.cit.*

However, a new study by Professor Nicholas Fisk and Dr Glover, as yet unpublished, is expected to urge a lowering of this threshold. Dr Glover says:

*"It is overstated to say there is no possibility of foetal sentience before 26 weeks. We know too little about the physiological basis of consciousness, about the anatomical development of the foetus, and about what is functioning when ... We cannot measure pain in the foetus. All we can do is guess. My best guess is that the foetus may feel pain from 20 weeks, and may feel something from 17 weeks."*⁷⁷

But Neil McIntosh - Professor of Child Life and Health at the neonatal unit of the University of Edinburgh and who sat on the Royal College of Gynaecologists Working Party - says:

*"The evidence suggests that until 26 weeks the connections between the lower brain and the cortex,⁷⁸ which we like to think of as the mammalian seat of consciousness and sentience, do not occur. There is a difference between having a response to pain and feeling pain."*⁷⁹

This shows yet again the need for distinguishing between having 'pain' and having 'pain and knowing it as 'pain'!

Infant and foetal pain - some implications for PVS patients

These developments are of interest to the treatment of PVS patients because:

- (i) they explicitly endorse the principle that, in case of doubt as to whether pain is being experienced, carers should anaesthetise.⁸⁰
- (ii) the reasons given⁸¹ by many of those who oppose the treating of foetuses as being receptive to pain is further evidence of the suggested link between 'pain judgements' and judgements as to personhood.
- (iii) they highlight the incongruity between the treatment of PVS patient and foetuses in respect of pain - the possibility that foetuses may experience pain is now being tentatively accepted unlike the situation in regard to PVS patients.

An article by Michael McQuillan,⁸² Professor of Neurology in Georgetown University, is of particular interest in relation to this last point as he explicitly asks why uncertainty can be acknowledged in one situation, but not the other.

In speaking of infant pain, he expresses surprise that some hold:

*"... so firmly to the view that infants do not experience pain that surgery would be performed without anaesthesia."*⁸³

⁷⁷ *ibid.*

⁷⁸ *ibid.* Dr Glover had noted (as mentioned earlier) that pain may not be exclusively an activity of the cerebral cortex. "... frogs and fish do not have a cerebral cortex, yet most people would say that they could not be sure that frogs and fish don't feel anything."

⁷⁹ Burns *op.cit.*

⁸⁰ Chapter 5 examines how doubt should be resolved in medical decision making; it urges the acceptance of such a principle, as does Dr Glover:

"We are all guessing. In my view, we should err ... on the safe side, and treat the foetus as though it does feel things from 20 weeks." (see Burns *op.cit.*)

⁸¹ Concar *op.cit.* (p.40):

"One senior pain specialist said 'Having never spoken to a foetus I can't say what it feels. But I'm deeply suspicious of the motives of people who ask me.' History shows he is right to be. Whether foetuses feel pain has always been bitterly contested by opponents and proponents of abortion ..."

⁸² Michael P McQuillan, 'Can People Who Are Unconscious or in the 'Vegetative State' Perceive Pain?' *Issues in Law & Medicine* (1991). The article is also considered in Section 5.

⁸³ *ibid.* p.381. See also the Bland case (p.795):

"It is to be noted that the necessary surgical incision was made without anaesthetic because Anthony Bland is utterly devoid of feeling of any kind."

He considers that observations both of cardiovascular changes and of facial expressions - by using a system of coding facial expression of infants - permits the drawing of valid inferences on the perception of pain by infants. He then poses the rhetorical question:

"If such measures are accepted as evidence that pain perception is present in a normal neonate, can they be rejected in the neonate born without a brain (the infant with anencephaly⁸⁴) or in the adult in a 'persistent vegetative state' ?⁸⁵

McQuillan concludes:

"Although by definition the unconscious patient cannot tell you that he perceives pain, available data suggest that he may; therefore you cannot know that he doesn't."⁸⁶

This conclusion, he notes, has prompted some to recommend talking to comatose patients. This is in agreement with one of the conclusions of this thesis, namely that PVS patients should always be treated as *if*⁸⁷ they were conscious.

Pain under anaesthesia

Whilst the uncertainty of pain judgements may be understandable in relation to animals and the newborn, it is less clear how such uncertainty could exist in relation to normal adults during anaesthesia. Surely, we feel, these questions are easily resolvable.

Dennett's answers by considering⁸⁸ the example of the drug 'curare' and its use as an anaesthetic. Curare was a poison used by South American Indians into which they dipped their blow-pipe darts and which paralysed their enemies. Its active ingredient was isolated and introduced into medical research in the 1930's and some doctors began to use it as a general anaesthetic in major surgery. It is, in fact, a paralytic that produces total paralysis and limpness of all the voluntary muscles but which has no anaesthetising properties. Dennett takes up the story:

'The patients were, of course, quiet under the knife and made not the slightest frown, twitch or moan, but when the effects of the curare wore off, complained bitterly of having been completely conscious and in excruciating pain, feeling every scalpel stroke and simply paralysed and unable to convey their distress. The doctors did not believe them.'⁸⁹

Eventually a doctor submitted himself as a subject and convinced his colleagues that curare had no anaesthetic properties.

Lest it be thought that such anaesthetic 'mistakes' belong only to a bygone era, Dennett recounts⁹⁰ the current practice of giving amnesiacs in addition to anaesthetics so that even if anaesthetic is not fully effective the patient will not remember the pain. Furthermore, there have recently been numerous media reports of studies (I have not had the opportunity to consult the originals) on deficiencies in anaesthetic practices:

where it seems, bizarrely, that the non-use of an anaesthetic by the medical carers became - to the legal professionals - proof that pain was absent.

⁸⁴ Jennett and Plum (1972 at p.736) note, from observations on anencephalic infants, that an appreciable range of activity and responsiveness is possible in the absence of a cortex.

⁸⁵ McQuillan *op.cit.* p.382.

⁸⁶ *ibid.* p.383.

⁸⁷ 'as if' in the sense of 'not knowing' rather than in the sense of 'pretending'. This does not imply (see Chapter 10) that they should always be treated as if they were 'persons'.

⁸⁸ Dennett *op.cit.* p.209.

⁸⁹ *ibid.* p.209.

⁹⁰ *ibid.* p.210.

- (i) a report⁹¹ from the Institute for Anaesthesiology in Munich that patients are, in about 1% of operations, to some degree aware. Of those who were aware, 17% were in severe pain and 73% recalled their surgeons conversations. This latter phenomenon was also the topic of a paper recently presented to the British Association for the Advancement of Science Studies⁹² which examined reports of patients being able to recall remarks made in their presence whilst they were supposedly anaesthetised.
- (ii) a report⁹³ from Johns Hopkins University which estimates that no more than four patients in every 10,000 are conscious during anaesthesia.
- (iii) an observation by Dr. Tom Stuttford the medical correspondent of The Times, that the anaesthetising properties a barbiturate/muscle mixture - similar to that used in carrying out executions in the US - are limited in their effect:
*"Barbiturates/muscle relaxants act as anaesthetic, but many a patient, when anaesthetised, although still and incapable of communication, is conscious of what is going on. A suicidal person may appear asleep, but be aware of a suffocating inability to breathe."*⁹⁴

Anaesthesia - some implications for PVS patients

The 'Multi-Society Task Force on PVS' argued that PVS patients lack awareness because they evinced low metabolic rates:

*"... comparable to those reported during deep general anesthesia in normal subjects whom all would agree are unaware and insensate."*⁹⁵

In view of the difficulties just enumerated this argument is less than compelling!

Conclusions

The general conclusions that I wish to draw from this section are:

Conclusion 3-7: *'Pain' is not open to a purely scientific analysis. At best, correlates of pain can be studied but the validity of the correlation is not fully amenable to a scientific determination. This is particularly so when the ability to communicate is either non-existent (as in the case of animals) or is permanently lost (as in the case of PVS patients).*

This conclusion reinforces the earlier *Conclusion* 3-5.

Conclusion 3-8: *Experience has shown that unanimity of medical opinion on the impossibility of pain being experienced is no guarantee of truth. Thus, the current near-unanimity of medical opinion that PVS patients cannot experience pain should not be regarded as decisive.*

⁹¹ The Sunday Times 22nd March 1998, Medical Notes, quoting a report from the British Journal of Anaesthesia.

⁹² As reported in The Times 16th August 1999.

⁹³ Hopkins Internet Health report 'Awake Under Anaesthesia' April 15th 1998.

⁹⁴ 'Final moments of old friend who 'died on end of needle'- an article concerning Dutch euthanasia practices [The Times 26th Feb 2000].

⁹⁵ Part 1 p.1502. McQuillen - offering a view contrary to the 'Multi-Society Task Force on PVS' - says:

"Infants, whose cognition can only be inferred by motor movements not unlike those manifested by the patient in the 'vegetative state,' have cerebral metabolic rates in excess of healthy adults. This is so in the very regions with regard to which it is inferred, in the 'vegetative state,' that cognition is lost because the metabolic rate is low."
 [op.cit. p.375]

It may be urged that medical science has now progressed to such an extent that errors such as have been described, could no longer occur. This belies the lesson of history which is that each medical generation has believed in 'certainties' which succeeding generations have unmasked. Surely the correct lesson is that future medical generations will regard the currently accepted 'certainties' with the same tolerant bemusement which we accord to the theories of yesteryear.

Section 4: Wittgenstein: a philosophical approach to pain judgements.

Wittgenstein believed that the origin of many philosophical problems lay in language,⁹⁶ either in its misuse - through inattentiveness to subtleties of meaning - or in being bewitched by its form.⁹⁷ His remedy was to sift the various connotations of terms, identify shades of meaning, excavate problems - much as an archaeologist might explore ruins - so that foundations, hitherto unsuspected, might be uncovered and scrutinised in the cool light of day. He believed that:

*"... some of the greatest achievements in philosophy could only be compared with taking up some books which seemed to belong together, and putting them on different shelves; nothing more final about their positions than that they no longer lie side by side."*⁹⁸

His goal was not that the problem would, in a traditional sense, be solved but that it would 'disappear', as when, for example, a problem was eventually seen as originating in an assumption that the existence of a grammatical similarity between certain propositions, mirrored a deeper, structural, unity. His belief was that once the inappropriateness of the assumptions implicit in our use of language was made patent, a philosophical problem dissolved and 'the fly was let out of the bottle.'⁹⁹

Pain judgements play an important role in Wittgenstein's philosophy. There are many occasions in his writings, particularly when discussing the 'Private Language Argument',¹⁰⁰ where their status is analysed. This is because pain judgements straddle the boundary between the observable and 'the mental', a region which has generated many philosophical problems. Also the confusion generated by the assumption that similar grammatical structures mirror a deeper 'reality', is particularly evident in discussing 'pain judgements'. Consider, for example, the propositions:

P_1 - 'I have a pain.'

P_2 - 'I have a hand.'

P_3 - 'John has a pain.'

These all have the same grammatical structure - 'X has a Y' - yet Wittgenstein denied that 'I have a pain' is an instance of 'X has a pain' although 'John has a pain' undoubtedly is.¹⁰¹ This implies that P_1 and P_3 do not share the same deeper structure. Wittgenstein also argued that P_1 and P_2 have only superficial similarities; he suggested that, unlike the statement 'I have a hand' - where before making the assertion I can examine my hand and assure myself that I do indeed have one - 'I have a pain' is not the result of any such examination. Wittgenstein regarded the statement

⁹⁶ Wittgenstein defined philosophy with the phrase:

"Philosophy is a battle against the bewitchment of our intelligence by language."

[Wittgenstein, PI-1 § 109.]

⁹⁷ As in the belief that behind every noun there is an 'object'.

See also Wittgenstein:

"We fail to get away from the idea that using a sentence involves imagining something for every word." [PI-1 § 449]

"... reach the conclusion that the sensation itself is a nothing - Not at all. It is not a something, but not a nothing either! ... We have only rejected the grammar which tries to force itself on us here." [PI-1 § 304]

⁹⁸ Wittgenstein, *The Blue Book* (p.44); quoted in Flew *op.cit.* p.34.

⁹⁹ Wittgenstein PI-1 § 309: *"What is the aim of your philosophy? - To shew the fly the way out of the fly-bottle."*

¹⁰⁰ The 'Private Language Argument' will be discussed in Chapter 10.

'I have a pain' as more an avowal - like a cry - than a proposition. Thus I could not doubt my being in pain, nor could I say that 'I know that I am in pain'¹⁰² no more than in saying 'ouch', I could doubt, or know, 'ouch'. Because P_1 and P_3 share only a superficial structure, it is necessary, when discussing Wittgenstein's analysis, to distinguish between '1st person pain judgements' (pain judgements made by a person about themselves) and '3rd person pain judgements' (pain judgements made by a person about another). But before considering these differing pain judgements it is first necessary to consider some other aspects of Wittgenstein's concept of pain.

Some aspects of Wittgenstein's concept of pain

Wittgenstein's concept of 'pain' is neither solely an 'inner', nor solely an 'outer' phenomenon but straddles both perspectives. In this it resembles Strawson's concept of 'person'¹⁰³ but differs from, for example, Descartes' which is based solely on an 'inner' investigation.¹⁰⁴ Other philosophers have sought to base the concept of person solely on an 'outer' investigation - by considering, for example, external behaviour or brain development. Strawson, however, insists that both dimensions - the inner and the outer - are vital to a definition of personhood. Similarly Wittgenstein, in his discussion of pain, denies that it is a purely inner phenomenon - *i.e.* that it is a purely private sensation known only to its 'subject' - and denies that pain is a purely external phenomenon to be fully captured by external behaviour; he insists that it shares aspects of both. Because of this complexity, it is useful in examining Wittgenstein's concept of pain, to do so from a number of different directions. The polarity inner/outer is first adopted and the 'inner' perspective on pain is contrasted with the 'outer'; then a 1st person / 3rd person polarity is adopted and 1st person pain judgements are contrasted with 3rd person pain judgements.

Wittgenstein's concept of pain - the 'inner/outer' polarity

Pain - not solely an inner phenomenon

Wittgenstein, in asking the question as to how a person learns the names of sensations, or pains, is led to enunciate his '*Private Language Argument*'. This argument - by considering the impossibility of determining whether a sensation which one now has, was the *same* as a previous sensation, which one had named 'S' - seeks to show the impossibility of either sensations (such as pain) or of their naming, being inherently private. Wittgenstein's conclusion is that 'pain' is not a name privately assigned to a sensation privately discovered but a tool whose meaning is given through social interaction; the idea of pain as being a private entity, is a '*grammatical fiction*'.¹⁰⁵

A comparison of the proposition 'I am in pain' with the proposition 'I promise to do X' is instructive.¹⁰⁶ If one too readily allows a distinction between my saying to someone 'I promise to do X' and my state of inner assent, so that only I can know with certainty my inner state (the statement

¹⁰¹ Kenny (1973) p.199.

¹⁰² Wittgenstein regarded 'knowing' as involving a true description of a state of affairs: 'I am in pain' is not such a description of a state of affairs rather it is part of the state of affairs - see Kenny (1973) p.201.

¹⁰³ Strawson's concept of 'person' is discussed in Chapter 10.

¹⁰⁴ Steiner eloquently describes the Cartesian position:

* "For Descartes, truth is determined and validated by certainty. Certainty, in turn, is located in the ego. The self becomes the hub of reality and relates to the world outside itself an exploratory, necessarily exploitative way. As knower and user, the ego is predator. For Heidegger, on the contrary, the human person and consciousness are not the centre, the assessors of existence. Man is only a privileged listener and respondent to existence." [op.cit. p.31]

* "It is not in respect of "I am" that we most readily and most assuredly seize on the nature of being (here Heidegger differs fundamentally from the "egoism" of Descartes ...)" [ibid. p.51]

¹⁰⁵ Glock op.cit. p.57.

¹⁰⁶ Fogelin op.cit. p.171.

'I promise to do X' being a report of this) then the very meaning of 'to promise someone' is undermined. Equally, to refuse to make the distinction excludes the possibility that I am lying. The conclusion to be drawn is that the concept 'promise' has *necessarily* a public component and that the phrase 'I promise to do X' is best construed as an utterance (*i.e.* more as a constituent of a public performance which is integral to the concept of promise) than as a proposition (*i.e.* a report of some inner happening). Similar considerations apply to a purported distinction between 'anger' and 'anger-behaviour'.¹⁰⁷

A corollary of this analysis is that 'pain' *necessarily*¹⁰⁸ has a public component; though this is not to deny that, *on occasions*, pain manifestations may be suppressed.

Pain - not solely an outer phenomenon

It has been suggested that Wittgenstein was a behaviourist¹⁰⁹ but, whilst there are aspects of his thought that can be accommodated within behaviourism, some aspects cannot. For example, Wittgenstein's contentions that:

- (i) it does not make sense for me to attempt to verify the proposition 'I am sad' by an examination of my behaviour;¹¹⁰
- (ii) that I can *imitate* being sad;
- (iii) that the term 'behaviour' is not restricted to facial expressions and gestures but also includes what people say;

all militate against interpreting Wittgenstein's philosophy as being purely behaviourist. However, these caveats all relate to '*1st person pain judgements*'; it seems that, with regard to '*3^d person pain judgements*', the contention that Wittgenstein was a behaviourist is more easily defended, though even here qualification may be required.¹¹¹

Wittgenstein's concept of pain - the '*1st person/3^d person*' polarity

1st person 'pain judgements'

The relevance of behaviour

Wittgenstein's position is that the statement 'I am in pain' cannot be *doubted* by me nor *known* by me although I may well be lying. To say 'I am in pain' is a more sophisticated expression of, and essentially akin to, a child's scream of pain. Furthermore my behaviour is not relevant to my stating 'I am in pain' - in the sense that I do not verify my behaviour before making the statement. However, if I am precluded from manifesting *all* behaviour, this may need qualification; Wittgenstein had speculated on whether it was possible to imagine being in pain and yet utterly immobile - 'turned to stone'; this thought experiment will be considered below.

¹⁰⁷ In saying:

"We do not laugh because we are happy - we are happy because we laugh."

William James suggested that the exterior expression of an emotion *was* the emotion itself. (I am unable to locate the reference for this quotation.)

¹⁰⁸ Glock *op.cit.* p.55.

¹⁰⁹ *ibid.* p.55.

"Behaviourism ... holds that attributing mental states, processes or events to people really amounts to making statements about their actual behaviour or disposition to behave."

Behaviourism has various guises - as the belief that either mental phenomenon do not exist; or, that mentalist terminology should be avoided as not verifiable; or, that propositions which involve such mentalist terminology are semantically equivalent to propositions about behaviour and should be replaced by such.

¹¹⁰ *ibid.* p.56

¹¹¹ This is discussed below.

The relevance of language.

Singer has suggested¹¹² that Wittgenstein considered the ability to use language as crucial to the ability to experience pain. This misrepresented Wittgenstein's position as can be seen by considering his explanation of how a child learns the word 'pain' - *i.e.* that he learns to utter the word 'pain' as an alternative form of behaviour to, for example, crying. To suggest that language use was necessary to pain experience would imply that when the infant was crying - prior to learning the word pain - he was not, in fact, in pain!

Wittgenstein's position is that language use, though not necessary for experiencing 'anger' and 'pain',¹¹³ is necessary for expressing some psychological states such as 'hope'.

3rd person 'pain judgements'

It has been suggested¹¹⁴ that Wittgenstein's treatment of ascriptions of psychological concepts to third persons, is straightforwardly behaviourist; and that to ascribe mental phenomenon to others is *logically* connected¹¹⁵ with behaviour. I suggest that this is an oversimplification, and that in asking the question "*Is X in pain?*" there are, in fact, *two* questions and these need to be distinguished. These questions are:

- (i) "*Is X a suitable candidate for a pain judgement?*" - *i.e.* does he belong to the class to whom pain is (normally) ascribed?
- (ii) "*If X is a suitable candidate, is X in pain?*"

Wittgenstein had posed a particular 'thought experiment', which is helpful in the attempting to elucidate these questions; he had asked:

*"Couldn't I imagine having frightful pains and turning to stone while they lasted?"*¹¹⁶

This question is of interest because it seeks to clarify whether it is possible to imagine pain existing *in the absence of all behavioural expression*.

Wittgenstein's stone experiment: Pain in the absence of all behavioural expression

Norman Malcolm examines Wittgenstein's thought experiment in his essay '*Turning to Stone*'.¹¹⁷ He regards it as a convenient device for *totally* eliminating any human behaviour from the discussion of pain. Wittgenstein used the first person singular in describing his experiment - *i.e.* he adopted the perspective of the person metamorphosed into stone, and not that of an observer of the stone; Malcolm considers this to be significant:

¹¹² Singer in his essay 'Do Animals Feel Pain?' states:

"There is a hazy line of philosophical thought, deriving perhaps from some doctrines associated with the [as mentioned philosopher Ludwig Wittgenstein, which maintains that we cannot meaningfully attribute states of consciousness to beings without language. This position seems to me very implausible. Language may be necessary for abstract thought, at some level anyway; but states like pain are more primitive, and have nothing to do with language... Human infants and young children are unable to use language. Are we to deny that a year-old child can suffer? If not, language cannot be crucial."

[this was quoted earlier at footnote 49]

¹¹³ Wittgenstein, PI-2 (i):

"One can imagine an animal angry, frightened, unhappy, happy, startled. But hopeful? And why not?"

¹¹⁴ Glock *op.cit.* p.56-7.

¹¹⁵ Where by 'logical connection' is meant a conceptual and not empirical connection.

¹¹⁶ Wittgenstein PI-1 § 283.

¹¹⁷ This essay is included in Malcolm Wittgensteinian Themes pp 133-145.

*"The fantasy of turning to stone can get a solid grip on one's imagination only if it is presented in the first person singular."*¹¹⁸

And the reason is that:

*"... I don't employ any criteria in my own case."*¹¹⁹

When viewed as a '1st person problem' there appears to be no difficulty in ascribing pains to the stone:

*"If another person ... touched my body he would perceive that it had the hardness and coldness of stone. He would think that I had lost sensation and consciousness: but he would be wrong!"*¹²⁰

The experiment can, however, also be considered as a '3rd person problem'. It can be approached from the perspective of an imagined observer of the stone who might ask 'Can't I conceive that this man I see lying here in frightful pain should turn to stone, and his pain continue?' To this question, Malcolm responds:

*"It would be difficult to take this supposition seriously. Why? Because we would realise that our normal criteria for attributing either pain or the absence of pain to another person would not be applicable to a stone figure."*¹²¹

Wittgenstein is even more forthright:

*"Only of what behaves like a human being can one say that it has pains. For one has to say it of a body, or, if you like of a soul which some body has. ... Look at a stone and imagine it having sensations. One says to oneself: How could one so much as get the idea of ascribing a sensation to a thing? One might as well ascribe it to a number! - And now look at a wriggling fly and at once these difficulties vanish and pain seems able to get a foothold here, where before everything was, so to speak too smooth for it. And so, too, a corpse seems to us quite inaccessible to pain. - Our attitude to what is alive and to what is dead, is not the same. All our reactions are different. - If anyone says: 'That cannot simply come from the fact that a living thing moves about in such-and-such a way and a dead one not,' then I want to intimate to him that this is a case of transition 'from quantity to quality'."*¹²²

It might appear that the conclusion to be drawn from the stone experiment is that:

'Though 1st person pain judgements can be made in the absence of all behavioural expression, 3rd person pain judgements cannot.'

Indeed this seems to be the conclusion drawn by Malcolm.¹²³ Wittgenstein analysis is more subtle; he resolves the problem not in terms of behaviour - but firstly in terms of the possibility of empathy - i.e. possible in respect of a fly but not in respect of a stone; and only then in terms of the behaviour - the wriggling fly.

¹¹⁸ *ibid.* p.140.

¹¹⁹ *ibid.* p.140.

¹²⁰ *ibid.* p.135.

¹²¹ *ibid.* p.140.

¹²² Wittgenstein, PI-1 § 283-4.

¹²³ Malcolm *op.cit.* p.140:

"The face and limbs of a stone man cannot be twisted with spasms of pain ..."

I suggest that, of these, the possibility of empathy is primary and indeed in certain cases determinative. To see that this is so, recollect Dennett's discussion of curare.¹²⁴ A doctor had been told by his patients that they had been in pain during surgery though they had been 'anaesthetised' with curare. His medical colleagues dismissed the possibility of pain; but he had begun to believe the patients' reports and decided to submit himself to the procedure. The patient, during surgery, was utterly immobile and thus exhibited *no* behaviour. Was not that doctor (and subsequently his colleagues) capable of ascribing pain in the absence of *all* behaviour? Indeed, not only in the absence of all *behaviour* but in the absence of all *action*¹²⁵ on the part of the patient. This example shows that behaviour, and indeed action, is not a necessary condition for the ascription of pain.

Let us try to draw some conclusions on the relationship between pain and behaviour in respect of third party pain judgements. This relationship is often perceived as being a choice between saying that pain judgements are *logically* connected with the exhibition of pain behaviour or that the connection is *contingent*. The choice that is offered is between:

- (i) 3rd party pain judgements are *logically* connected with the exhibition of pain behaviour, where this is interpreted as meaning that pain cannot be ascribed in the absence of pain behaviour. And
- (ii) There is no logical connection between pain judgements and pain behaviour, so that in no case are we bound to infer pain from behaviour or conversely absence of pain from lack of behaviour. Pain and pain behaviour often do occur together but there is no reason why they must. Kenny describes this view in the words:

*"Pain and its expression seem no more essentially connected than redness and sweetness: sometimes what is red is sweet, and sometimes not."*¹²⁶

This is an illusory dilemma and it was Wittgenstein's main contribution to this debate to point out that this is so. There is a third position, which is best described by saying:

- (i) 3rd party pain judgements are *necessarily* connected with the exhibition of pain behaviour in the vast majority of cases. This is *logical* connection between the concepts not a contingent connection¹²⁷ for if the connection was contingent then it would be possible to imagine circumstance where the connection was absent in the generality of cases; but this - as argued by Wittgenstein - would imply that the concepts of 'pain' and 'pain judgements' were incoherent.
- (ii) Because the requirement only relates to the vast majority of cases; this implies that neither concept can be reduced to the other. It cannot be asserted that pain behaviour is a sufficient condition for the ascription of pain - for to do so is to ignore the fact that pain behaviour can be a pretence;¹²⁸ neither is it a necessary condition - for to do so is to ignore,

¹²⁴ Discussed in Section 3.

¹²⁵ The distinction between '*behaviour*' and '*action*' will be discussed shortly.

¹²⁶ Kenny (1973) p.183.

¹²⁷ Ruddick (*op.cit.* at footnote 5) comments:

"[Wittgenstein's] general attack on the views that psychological terms are to be thought of as names for private sensations, rather than as tools whose meaning is given by uses in what he called 'forms of life', 'the stream of life'." This metaphor of pain being a 'tool' is helpful because tools are something which are *generally* used for a purpose; for example, a screwdriver is a tool for turning screws not because it must be always used for such a purpose - it can be used for opening pain tins - but because it is generally so used. To say then that the connection between '*being a screwdriver*' and '*being capable of turning screws*' is contingent is a misdescription in that it suggests that there is no necessary relationship between these concepts.

The idea of pain being a 'tool' is clearly brought out in a quotation of Wittgenstein's:

"A child discovers that when he is in pain for instance, he will get treated kindly if he screams; then he screams, so as to get treated that way. This is not pretence. Merely one root of pretence." [Quoted by Ruddick *op.cit.* at footnote 7]

¹²⁸ See last quotation in footnote 127. This distinction permits a gap to be opened up between the 'pain' and the 'pain behaviour' (the scream).

for example, the patient paralysed by curare. Thus pain can be ascribed in the absence of behaviour.

Let us now resume the earlier discussion which suggested that the question '*Is X in pain?*' consisted of two questions

- (i) "*Is X a suitable candidate for a pain judgement?*" - i.e. does he belong to the class to whom pain is (normally) ascribed?
- (ii) "*If X is a suitable candidate, is X in pain?*"

It is convenient to examine these questions separately.

"Is X a suitable candidate for a pain judgement?"

Dennett, in considering whether a robot could feel pain, was led to conclude that pain was not a purely empirical concept but embodied ideas of value, and that since a robot was, to us, not an object of moral value it could not be said to be in pain. Wittgenstein is led to a similar conclusion which is that to say of a machine that it thinks, or is in pain, is a category mistake.¹²⁹ He argues that the question of whether '*X is thinking*' or '*X is in pain*' is not *solely* an empirical question.¹³⁰ In Part 2 of the Philosophical Investigations he goes further, and says:

*"I believe that he is suffering ... [implies that] my attitude towards him is an attitude towards a soul ... [and] the human body is the best picture of the human soul."*¹³¹

Robert Fogelin expresses the underlying idea by saying:

*"... my ascription of a pain to another expresses my feelings towards him: my pity or sympathy"*¹³²

so that a *capacity to engender empathy* is a necessary condition for pain ascription. I suggest that this condition is the key to 'dissolving' some of the difficulties associated with the making of 'pain judgements' in relation to PVS patients. I suggest furthermore that this is what is meant by saying that an individual possesses consciousness.¹³³ The importance of acknowledging this equivalence is that consciousness - as we have seen in Chapter 1 - wears the mask of being a scientific concept and carries the suggestion that its ascription is open to experimental verification;¹³⁴ 'capacity to engender empathy' has no such pretensions.

Conclusion 3-9: *The question 'Is X in pain?' consists of, in fact, two questions:*

- (i) "*Is X a suitable candidate for a pain judgement?*" - i.e. does he belong to the class to whom pain is (normally) ascribed?

¹²⁹ Glock *op.cit.* p. 157.

¹³⁰ Wittgenstein PI-1 § 359-60:

"Could a machine think ? - Could a machine be in pain? ... But a machine surely cannot think! - Is that an empirical statement? No. We only say of a human being and what is like one that it thinks."

¹³¹ Wittgenstein PI-2 p.178.

¹³² Fogelin *op.cit.* p.198.

¹³³ Wittgenstein suggests that imagining the people around him lack consciousness is equivalent to saying they lack souls. [PI-1 § 420-422].

¹³⁴ Wittgenstein saw an unbridgeable gulf between consciousness and brain processes so that no monitoring of brain processes can enlighten us as to questions of consciousness.

"The feeling of an unbridgeable gulf between consciousness and brain-processes: how does it come about that this does not come into the consideration of our ordinary life? This idea of a difference in kind is accompanied by slight giddiness, - which occurs when we are performing a piece of logical sleight-of-hand."

[PI-1 § 412].

see also PI-1 § 392:

(ii) "If X is a suitable candidate, is X in pain?"

Conclusion₃₋₁₀: A candidate for a pain judgement is an appropriate candidate if it has the capacity to engender empathy, or, equivalently, if it possesses consciousness. The term 'capacity to engender empathy' is to be preferred in that it - unlike the term 'consciousness' - lays no claim to a spurious scientific rigour.

These conclusions are perhaps sufficiently contentious to require the citing of further authority: Rush Rhees, for example, says:

*"When I say the dog is in pain I am not describing what the dog is doing, any more than I describe what I am doing when I give expression to pain. It is more like an expression of pity. At any rate, feeling pity, trying to ease him and so on - or perhaps turning away from the sight - is all part of believing that he is in pain. And to say that I was obviously justified in that - or maybe that I was mistaken - is a different sort of thing from saying that I was justified or mistaken in believing that he had a fracture."*¹³⁵

Let us now turn to the second question:

"If X is a suitable candidate, is X in pain?"

It was suggested earlier that Wittgenstein's argument implied that since PVS patients manifest pain-behaviour¹³⁶ they must be regarded as being in pain. This conclusion could be avoided by attempting to make a distinction between 'real-'pain behaviour' and 'pseudo-'pain behaviour' (i.e. as manifested in PVS patients).¹³⁷ But there is an obligation on one who suggests such a distinction, to produce adequate criteria. To simply assert that:

'pseudo-'pain behaviour' = pain behaviour as manifested by PVS patients

is a logical sleight of hand which seeks to overcome a factual ignorance by means of a definition.¹³⁸ J. L. Austin's admonition is apposite:

*"... we make a distinction between 'a real x' and 'not a real x' only if there is a way of telling the difference between what is a real x and what is not. A distinction which we are not in fact able to draw is - to put it politely - not worth making."*¹³⁹

How then could such a distinction be made?

A possible distinction between 'real-'pain behaviour' and 'pseudo-'pain behaviour'

Passmore summarises the argument for the distinction between 'behaviour' and 'pseudo-behaviour' or, more simply, 'actions' as follows:

"The analysis [in discussing pain] oscillates between science and grammar."

¹³⁵ Rush Rees Discussions of Wittgenstein p.59.

¹³⁶ For example,

"In the Ward's case, it is also clear that she never got used to the nasogastric tube. She reacted against it by pulling it out an enormous number of times, probably well over a thousand times and probably also by way of reflex action to an unpleasant stimulus ..." (Lynch, J. The High Court p.21)

¹³⁷ Compare with the statement:

"She is receiving regular small doses of the sedative Chloral. If she does not receive that she cries 'as if in pain' though the carers are unsure where the pain originates."

This statement was included in a medical report submitted to the court in the case of baby C [Re C (a minor)(wardship: medical treatment)] [1989] 2 AllER 782 at p.785].

¹³⁸ Lest it be thought that this argument applies equally to those who urge a distinction between 'real-'pain behaviour' and 'pretend-'pain behaviour', this latter distinction is justified by the expectation that the difference will be manifested in some way in the subject's subsequent behaviour. If, in the vast majority of cases, such subsequent manifestation did not occur, then the distinction could not be made.

¹³⁹ J. L. Austin, Sense and Sensibilia, p.77.

*"... there is a distinction between motions of the body, such as the knee reflex, and activities of the person, or 'behaviour'. Behaviour can never be defined in terms of movements of the body, since the very same set of movements can be present in quite different kinds of behaviour. ... The physiologist can explain the motions of a body in terms of causes, but he cannot explain human behaviour. Indeed behaviour has no causes."*¹⁴⁰

It is clear that the concept 'behaviour' is not a purely scientific concept; 'behaviour' is not simply equivalent to a collection of specific actions; it has additional connotations. Wittgenstein's distinction between 'human' and 'automaton' is ploughing the same furrow, and suggests that the distinction between 'behaviour' and a 'set of physically equivalent actions' is not empirical but is again based on value, on the possibility of empathy, or in having an attitude to that other as towards a 'soul'. Imagine a human body writhing and grimacing; the observer - seeing the body as human (i.e. a 'suitable case' for a pain judgements) - allows the response 'he is in pain' to flow naturally. Next, the observer is told that, in reality, the body is a corpse whose muscles were being electrically stimulated to mimic pain behaviour; immediately the response 'he is in pain' ceases as being no longer appropriate. Is it inappropriate because it is 'pseudo pain behaviour', or because the subject was a corpse? Would it be different if the subject was an actor? This seems mere word play; the important observation is that the judgements, and the reversals of judgement, followed naturally the flow of empathy, and furthermore that this flow of empathy is not a static phenomenon. It is capable of being changed either way. That it is capable of being engendered, is shown by the curare example; that it is capable of being destroyed, is shown by the corpse example. The role of behaviour is simply that 'appropriate' behaviour considerably facilitates this initial flow of empathy.

Conclusion³⁻¹¹: *Ascribing pain to an individual who has been deemed a suitable candidate for such ascription, is greatly facilitated if the behaviour of that individual resembles human pain behaviour; the presence of such behaviour is, however, neither necessary nor sufficient; the determining factor for the ascription of pain is the presence of empathy.*

There is a well-nigh irresistible temptation to imagine that we can somehow 'go behind' the behaviour of the subject to some 'true' experience of pain and thus resolve all doubts. This, to Wittgenstein, is impossible:¹⁴¹

"... Wittgenstein repeats that in the language game with 'pain' there is no comparing of pain with its picture. We are tempted, he says, to say that it is not merely the picture of pain-behaviour which enters into the game but also the picture of pain. That is we feel that in order to use 'He is in pain' we need not only a sample of pain-behaviour as a paradigm for comparison with his behaviour, but also a sample of pain for comparison with his pain. ... If I were to construct a table linking pictures with words, in order to help me learn the meaning of

¹⁴⁰ Passmore *op.cit.* p.513; he later notes (in a footnote to a discussion on Austin):

"Austin's work has been particularly interesting to moral and legal philosophers, who have suggested that it is a 'descriptive fallacy' to suppose that, for example, in calling something good we are describing it or that in saying that somebody did something we are describing the person's bodily movements, as distinct from ascribing responsibility to him." [*ibid.* p.598]

¹⁴¹ see also Kenny (1973) p.183:

"To try to connect 'pain' with pain in isolation from unlearned pain-behaviour would be to try to insert language between pain and its expression. This, Wittgenstein thinks, is absurd."

*'pain', the table would not contain pictures of pain ... linked with 'pain': the pictures would have to be pictures of pain-behaviour"*¹⁴²

Furthermore, to Wittgenstein, any attempt to appeal to consciousness - or lack of consciousness - is equally futile. Consciousness is a psychological term, to apply it to a third party we must consider *only* their behaviour and if the patient is manifesting pain-behaviour - and is therefore in pain - they cannot be considered to have lost their consciousness. This is reminiscent of the Dennett argument¹⁴³ that any appeal to lack of consciousness was nothing other than a 'question-begging' exercise.

Conclusions: Wittgenstein and pain judgements

Wittgenstein's arguments force a complete reorientation of the discussion on the making of pain judgements; away from what can best be called 'pseudo-science' and towards the primacy of the ethical issues *i.e.* the question of the stance to be adopted to this 'other'. At first sight this conclusion may seem implausible, but this response is, I suggest, evidence of the extent to which we have become bewitched by mock science and the illusion that pain is a '*scientific*' concept. It brings to mind Jaspers' vision of the role of philosophy as one which frees man '*from scientific superstition, i.e. from false absolutes and pseudo-knowledge.*'¹⁴⁴ A recent example - taken from a documentary on discrimination by the medical services, against Down Syndrome patients - may help clarify the point at issue; in this example the mother of a Down Syndrome child was told by nursing staff that her son needed no pain relief after an operation because '*Down children don't feel pain.*'¹⁴⁵ The nurse doubtlessly felt her judgement was well founded and that it could be justified scientifically. It is interesting to note how such pseudo-science is sufficient to *prevent* the flow of empathy which would naturally result in a judgement that the child was in pain; this is a phenomenon that also occurs in relation to PVS patients.

Wittgenstein's analysis also provides an elegant resolution of the problem of animal pain. Now the solution is seen to lie *not* in a search for a scientific determination of whether animals feel pain - for such is a search for a mirage - but in the possibility of empathy existing between the person making the judgement and the animal in question (recognising, of course, that the presence, or absence, of empathy is not a static condition but is subject to being influenced by intellectual argument).

Wittgenstein and PVS patient pain judgements

If we accept that PVS patients manifest a pain-behaviour - such as the grimaces and writhing often commented on in the legal cases - must we conclude that the PVS patients are in pain? Judgements as to lack of consciousness or inability to experience pain, based on examination of brain states are, as we have seen, beside the point because they are *necessarily* inconclusive.

Hacker interprets Wittgenstein's position as implying that:

¹⁴² *ibid.* p.197-8

¹⁴³ Dennett, *Brainstorms* p.212-3.

¹⁴⁴ Kaufmann *op.cit.* p.172.

See also Jaspers' statement:

"As a physician and psychiatrist I saw the precarious foundation of so many statements and actions, and beheld the reign of imagined insights, e.g. the causation of all mental illness by brain processes (I called all this talk about the brain, as it was fashionable then, brain mythology; ...), and realised with horror how, in our expert opinion, we based ourselves on positions which were far from certain, because we had always to come to a conclusion even when we did not know, in order that science might provide a cover, however unproved, for decisions the state found necessary."
[Kaufmann *op.cit.* p.170 emphasis added]

“... to see another writhing and groaning after being injured is to know ‘directly’ that he is in pain, it is not an inference ...”¹⁴⁶

Can this be directly translated to pain judgements for PVS patients? I suggest that all depends on the existence of empathy; if it exists then the pain judgements follow - as Hacker describes it - ‘directly’; if empathy does not exist then the pain judgement is blocked.

It has often been noted that the relatives of PVS patients are *convinced* that the patient is in pain; however, on the medical side there is an even greater conviction that such patients are *not* in pain; how can these be reconciled? Does the introduction of the concept of ‘empathy’ help in their resolution?

One way to attempt to reconcile the medical and lay perceptions is to seek to draw a distinction between ‘real’ pain behaviour and that manifested by PVS patients. If such a distinction is possible then it could be argued that the lay observers were simply not being sufficiently perceptive, and that what they interpreted as pain behaviour was in fact not so. This is the approach adopted by the ‘Multi Society Task Force’ who state:

“Conscious (i.e. learned) responses to pain differ measurably from the reflexive decorticate or decerebrate postural responses¹⁴⁷ that usually characterise a persistent vegetative state.”¹⁴⁸

Now the complete thrust of Wittgenstein’s argument is that the recognition of ‘pain-behaviour’ does not require any special expertise, it flows naturally from our common humanity. The patient’s doctors have no special competence in this area, indeed the judgements of the patient’s family - in so far as they are more familiar with the patient - should carry greater weight. Whilst, no objection can be made to an analysis of various patterns of behaviour so that a distinction can be drawn between the behaviour manifested by PVS patients - ‘*pain_{PVS} behaviour*’ - and by others - ‘*pain behaviour*’ this brings us nowhere nearer resolving the question of PVS patients pain.

And the role of empathy in reconciling the medical and lay perceptions? To the layman, the observation of the grimaces and writhing of the patient immediately generate empathy; the perception that the PVS patients is in pain follows ‘directly’. To the medical observer - in so far as they accept that the proposition ‘*PVS patients lack consciousness*’ is a scientifically determined fact - the flow of empathy is *necessarily* blocked. Once their state of being ‘in thrall’ is broken - as, for example, by showing the inadequacy of the supposed scientific demonstration - then a gap opens up and the flow of empathy can be restored. The crucial point is that pain judgements are not *wholly* scientific propositions: the precondition for a ‘pain judgements’ is that the subject is an appropriate subject for the ascription of pain - this is a question of *attitude*¹⁴⁹ and is not open to a scientific determination (a corollary of this is that such judgements cannot be either true or false); once the subject is deemed a fitting subject then criteria for the ascription of pain can be clarified; a judgement that a subject is in pain can then be made and - in so far as it satisfies the criteria - it can be meaningfully asserted to be either true or false.¹⁵⁰

¹⁴⁵ A recent television documentary entitled ‘Access All Areas: The Down Syndrome’ (Channel 4, 7th March 1999).

¹⁴⁶ Hacker *op.cit.* p.41.

¹⁴⁷ Jennett and Plum (1972 p.735) argued against the use of the terms ‘*decerebration*’ and ‘*decortication*’ in relation to PVS patients:

“Both decerebration and decortication might be taken to imply a specific structural lesion: such terms are unsuitable for bedside diagnosis, when the nature of the lesion can seldom be accurately predicted and never proved.”

¹⁴⁸ Part 2 p.1576.

¹⁴⁹ The concept of ‘attitude’ as used in Wittgenstein’s philosophy is examined in Chapter 10, Section 3; see also Chapter 11 Section 1(8) for a summary of the discussion.

¹⁵⁰ To clarify this, consider the ascription of pain to infants (being infants, the problem of ‘pretence’ can be ruled out); let it be accepted that grimacing in such infants is a criterion of pain. Next, given an anencephalic infant who is grimacing - is it

Section 5: Academic support for the proposition that PVS patients may experience pain.

I wish to cite three authors in this context: William Ruddick who, in an article entitled '*Do Doctors Undertreat Pain?*',¹⁵¹ argues that doctors have - and are trained to have - a certain 'blindness' to pain particularly when it has no diagnostic value; Michael McQuillen who, in an article '*Can people who are unconscious or in the 'vegetative state' perceive pain?*',¹⁵² directly confronts (and accepts) the possibility that PVS patients can experience pain; and lastly Keith Andrews who, in some remarks in a paper entitled '*Patients in the persistent vegetative state: problems in their long term management*', also acknowledges the possibility that PVS patients can feel pain.

Ruddick 'Do Doctors Undertreat Pain?'

Ruddick's paper does not seek to establish that doctors routinely ignore pain; rather he takes this as an obvious, and accepted, given and seeks to explain it. His explanation is twofold; doctors 'forget' patient pain through either:

- (i) a '*psychological 'forgetting' of pain*', which is primarily self-protective and helps the doctors distance themselves from the pain they often produce. By their attitudes to the patient and their use of language, they discount the pain that a patient may experience, and they rationalise this discounting by various stratagems - '*patients exaggerate*', '*they're cry babies*' or '*they have regressed to childhood*'. Or,
- (ii) a '*conceptual forgetting of pain*'. This, he suggests, has its roots in the self-definition of modern medicine as being curative and life-preserving and only incidentally involved in the relief of pain. Doctors are taught to regard pain as a useful symptom for diagnosing disease; they are not to respond to pain by relieving it, but to respond by observing it and exploring it, even at the cost of accentuating the pain.

Ruddick distinguishes a *lay concept of pain*, where the appropriate response is to attempt to relieve the pain, from a *new clinical concept of pain* where the appropriate response is to observe that pain. In physicians the lay concept of pain (as a solely private sensation) has been replaced by the clinical concept which supposedly gives them a capacity for sophisticated inferences from outward behaviour. He considers the question as to whether the clinician concept of pain is a more precise concept than the lay concept to be misplaced; they are essentially different concepts calling forth different responses.

Ruddick's analysis suggests that physicians would tend to ignore pain when it was no longer useful as a diagnostic tool; he gives the examples of terminally ill patients, or those in chronic pain with no discoverable organic cause, being told '*I'm afraid there is nothing more that we can do for you!*'. His analysis also suggests that the pain of a patient, who was unable to communicate their pain, would become clinically 'nonexistent'. This in turn implies that a physician operating with such

in pain? The first question to be resolved is '*Is an anencephalic infant a suitable subject for the ascription of pain?*' - i.e. 'Do we believe that such an infant can be in pain?' or 'What is our attitude to such an infant?' - this question cannot be resolved by scientific means; if our attitude is that such infants cannot be in pain then that is the end of the matter; if our attitude is that they *can* be in pain, then we can ask *are* they in pain - it may be that what we had assumed to be a 'grimace' was in fact a 'smile' - the question of pain ascription is then open to discussion.

The problem posed by the possibility of an individual 'pretending' to be in pain requires that the criteria for pain ascription cannot be defined *simply* in terms of behaviour but need further elaboration; note however, that the question of pretence in relation to pain can *only* arise in relation to one who is thought capable of experiencing pain.

¹⁵¹ *Bioethics*, (1997).

¹⁵² *Issues in Law and Medicine*, (1991).

a clinical concept of pain would be more likely to discount the possibility of a PVS patient experiencing pain.

McQuillen 'Can people who are unconscious or in the 'vegetative state' perceive pain?'

McQuillen, a neurologist, in discussing the commonly accepted theories of pain concludes that the experiencing of pain is not primarily a cortical activity but is regulated subcortically, and that:

*"... pathways sufficient for the perception and modulation of pain need not rise nor descend to levels generally thought necessary for consciousness."*¹⁵³

McQuillen speaks of the 'will-o-the-wisp' nature of the concept of consciousness and quotes (with approval) Hughlings Jackson:

*"... [t]here is no such entity as consciousness; we are from moment to moment differently conscious."*¹⁵⁴

The removal of the dichotomy 'conscious / unconscious' - either by using Hughlings Jackson's perspective, or by regarding 'consciousness' as a 'dimmer-switch' - allows a more fruitful debate of issues concerning consciousness. However, McQuillen's article, in common with most medical discussions, suffers from forcing the terms 'conscious' and 'unconscious' to carry too many shades of meaning whilst simultaneously using them as contrasting terms; and thus leading to semantic paradoxes¹⁵⁵ which would have been obviated had a more appropriate terminology been used.

McQuillen mentions¹⁵⁶ a study on the existence of implicit memory subsequent to anaesthesia; this study found that 70% of patients required no analgesia after major surgery when a series of positive suggestions were read to them at the end of the operation and whilst they were supposedly unconscious. He also notes¹⁵⁷ a study of patients who had recovered from coma; this study found that eight of fifteen patients who had recovered consciousness after head injury reported a variety of recollections including that of pain. These results argue strongly that some level of consciousness be attributed to these states.

McQuillen's observations on infant pain judgements have already been noted¹⁵⁸ as has his observation concerning PVS patients:

*"If such measures are accepted as evidence that pain perception is present in a normal neonate, can they be rejected in the neonate born without a brain (the infant with anencephaly) or in the adult in a 'persistent vegetative state'?"*¹⁵⁹

¹⁵³ McQuillen *op.cit.* p.383.

¹⁵⁴ *ibid.* p.374.

¹⁵⁵ Such as:

"Although by definition the unconscious patient cannot tell you that he perceives pain, available data suggest that he may; therefore you cannot know that he doesn't." [*ibid.* p.383]

¹⁵⁶ *ibid.* p.382.

¹⁵⁷ *ibid.*

¹⁵⁸ In Section 3.

¹⁵⁹ McQuillen *op.cit.* p.382.

Some comments by Andrews

As can be seen in the following passage, Andrews acknowledges the possibility that a vegetative patient may experience pain:

*"Very few patients in the persistent vegetative state are so severely brain damaged that they demonstrate no response, and most respond to pain by either withdrawing or grimacing ... If there is no cortical function then we assume that the patient cannot be aware of the distress. While recognising that a withdrawal response to pain is a basic reflex which has a functional value ... it is more difficult to see how facial grimacing in response to pain stimulation of the leg can have a useful reflex purpose ... "Is it possible that we have given too little thought to a patient's lower brain functions as part of the person we are caring for? I have seen only one patient in the persistent vegetative state die of starvation (because oesophageal stricture prevented reinsertion of a nasogastric tube) ... She took 3 weeks to die and became more alert, constantly awake, and agitated - presumably due to the release of brain stimulating chemicals in response to hypoglycaemia. It is one thing to state that she could not have felt any distress because she had a damaged cortex, it is another to be fully convinced (and to convince her carers) that there really was no suffering."*¹⁶⁰

Conclusion₃₋₁₂: There is some academic support for the proposition that PVS patients can experience pain.

Section 6: Conclusions: 'Pain judgements' and the PVS patient.

- * It is necessary to distinguish between 'the ability to experience pain' and 'the ability to experience pain knowing it to be pain'; it then follows that an assertion that an individual lacks the capacity for reflective thought does not imply that they cannot experience pain.
- * Secondly, 'pain' is *primarily* an ethical and not a scientific, concept; it is closely allied with the capacity to engender empathy and, in these respects, it resembles the concept of 'consciousness'.
- * Thirdly, the assertion that, because an individual lacks consciousness, he lacks the ability to experience pain, is specious.¹⁶¹

Some, more specific, conclusions are possible:

- (i) A determination that 'X is in pain' first requires an answer to the question 'Is X a suitable individual - i.e. of the right type - for the ascription of pain?'; this question relates, essentially, to the *attitude* adopted to X's type - i.e. whether or not empathy could exist towards X.
 - a) If answered negatively, the discussion is concluded; the question is not a scientific question and is not capable of rational determination.¹⁶²
 - b) If answered positively then the question 'Is X, in fact, in pain?' can be asked.

¹⁶⁰ Andrews (1993) at p.1601[emphasis added].

¹⁶¹ In Dennett's words 'has the smell of a begged question' (see: Brainstorms p.212).

¹⁶² Thus, one either believes that animals can experience pain or one does not; the existence of pain cannot be scientifically demonstrated; see Wittgenstein [PI-1 § 284]:

"Look at a stone and imagine it having sensations ... And now look at a wriggling fly and at once these difficulties vanish and pain seems to be able to get a foothold here, ..."
[A fuller version of this quotation was given earlier at p.100]

It follows that the existence of empathy to individuals of X's type is a necessary but not sufficient condition for the ascription of pain to X.

(ii) Assuming that X is of the type to whom pain is normally ascribed, the question as to whether X is, in fact, in pain can be approached in either of two ways: either by clarifying the criteria for the ascription of pain to such an individual and seeing whether they are, in fact, fulfilled; or by attempting to find brain states which correlate with the experience of pain¹⁶³ and seeing whether such brain states are, in fact, present in X's case.

- a) The criteria for the ascription of pain to such individuals are normally expressed in term of the overt¹⁶⁴ behaviour; however, the presence of such behaviour is neither necessary nor sufficient for the ascription of pain.
- ▶ It is not sufficient because of the possibility that the behaviour is a pretence (e.g. a child or an actress pretending to feel pain).
 - ▶ It is not necessary because an individual may be immobile (e.g. locked-in syndrome patient) and yet be in pain.

Attempts to distinguish '*real pain behaviour*' from '*pseudo pain behaviour*' - with pain behaviour as manifested by PVS patients being suggested as an example of the latter - are inappropriate because they depend on the assumption that the manifestation of pain behaviour is both a necessary, and a sufficient, condition for pain ascription. This assumption is incorrect. The assertion that the pain behaviour manifested by PVS patients is pseudo pain behaviour and that, accordingly, PVS patients do not experience pain is specious.

- b) If pain is conceived of as a phenomenon which must be manifested in the brain then - although pain itself is not accessible scientifically - it may be theoretically possible to establish correlations between the activity of certain areas of the brain (called '*pain centres*') and the experience of pain.
- ▶ To date, no such pain centres have been identified; indeed, doubt has been cast on the very coherence of the concept. The current understanding is that if the concept is to be used, it must be applied to the *whole* brain, so that only in the absence of *all* brain activity can it be stated that pain is not being experienced.
 - ▶ Because some brain activity is present in PVS patients, the conclusion that PVS patients do not experience pain is not justified.
 - ▶ *Even if at some future time* such pain centres were to be identified, then there are theoretical reasons why such identification could only be applicable to patients who have the ability to communicate; this is because the correlation can *only* be established for such patients. It may be possible to extend these results to patients who lack the present¹⁶⁵ ability to communicate by comparing the theoretical predictions with the patient's subsequent reports of their experiences; however, because of the difficulty¹⁶⁶ of distinguishing between 'pain' and the (true, or false) 'memory of pain', such correlation is open to doubt.

In patients - such as PVS patients - who never recover the ability to communicate these difficulties would appear to be theoretically insurmountable particularly because, in

¹⁶³ In turn these can, of course, become criteria for ascribing pain.

¹⁶⁴ i.e. other than by the examination of brain states.

¹⁶⁵ i.e. at the time the pain judgements are being made.

cases of brain damage, there can be considerable reorganisation of the functions of the brain. Hence, there does not appear to be even a *theoretical* possibility of establishing whether PVS patients experience pain.

- (iii) Attempts to justify the assertion that 'PVS patients cannot experience pain' on *scientific* grounds - such as a supposed lack of consciousness or results of the examination of brain states or by distinguishing between pseudo pain behaviour and 'true' pain behaviour - are not sustainable. The judgement that PVS patients cannot experience pain, springs from adopting the attitude that such patients are not fit subjects for the ascription of pain; pseudo scientific 'justifications' for such assertions are of a *negative* importance in that, if unchallenged, they destroy the possibility of the empathy which naturally arises on observing the behaviour of such patients, being sustained.
- (iv) There have been many historical examples where a consensus of medical opinion has existed - supposedly based on scientific grounds - on the inability of some to experience pain, but where this opinion has subsequently been accepted as being erroneous (e.g. the ability of newborn infants to experience pain is now widely accepted); accordingly, the fact that there presently exists a medical consensus that PVS patients cannot experience pain, is no guarantee that such patients cannot experience pain; indeed, there is some evidence that the consensus is weakening.
- ▶ Whilst writing the conclusions to this thesis a recent Editorial in the journal Anaesthesia has come to hand which argues that anaesthesia should be routinely given to patients who are classified as being brainstem dead, when their organs are being removed;¹⁶⁷ this adds considerable weight to the proposal in this thesis that PVS patients should be treated as if they are conscious and can experience pain.

The conclusions that were established in this Chapter are:

Conclusion 3.1: *The assertion that, in PVS, pain cannot be experienced because consciousness is absent, is specious.*

Conclusion 3.2: *As yet, no particular areas of the brain have been identified, damage to which, or whose inactivity, is uniquely associated with PVS. Hence, even if areas of the brain were to be identified which were uniquely associated with the experience of pain, no*

¹⁶⁶ As evidenced in the current practice of giving amnesiacs in addition to anaesthetics prior to some surgical procedures. (See Section 3 above).

¹⁶⁷ See Young PJ, Matta BF, Editorial: 'Anaesthesia for organ donation in the brainstem dead - why bother?' Anaesthesia, (2000).

A report in the Guardian [entitled 'Transplant row over pain rule' (19-8-00)] contains an especially intriguing example of medical practitioners being 'philosophical': in the report, Giles Morgan [President of the Intensive Care Society and the author of the original guidelines] is quoted as saying:

"In simple terms, if you are dead, you are dead and so dead people don't require anaesthesia ... That is a fact. If you aren't dead, you shouldn't be having your organs taken away."

Morgan compared the brainstem to the fuse board of a house. Without it nothing functions. Even so, he said, he would not preclude the possibility that one small bulb somewhere would flicker: *"It is disorganised random electricity. The whole brain is functionally disintegrating."* Morgan continued:

"Nobody knows what it is like to be dead. We can't tell, so we are giving it our best shot."

[Morgan's philosophical justifications are no less 'weighty' than many of the justifications offered for the assertion that PVS patients cannot feel pain considered earlier in this Chapter.]

The Guardian article mentioned that many anaesthetists believe that the Royal Colleges had - in classifying brainstem deaths as 'dead' - created a philosophical and ethical fudge in their haste to start heart transplants in Britain in the 1970's.

theoretical conclusion could be drawn ruling out the possible excitation of these areas - and, presumably, the experience of pain - in PVS patients.

Conclusion ₃₋₃: *Excepting cases where all brain activity is absent, there are no areas, or processes, of the brain that can be uniquely associated with the experience of pain to the extent that the non-activation of these areas, or the absence of these processes, would justify the conclusion that pain is not present.*

Conclusion ₃₋₄: *In PVS there are no areas, or processes, of the brain that can be uniquely associated with the experience of pain to the extent that the non-activation of these areas, or the absence of these processes, would justify the conclusion that pain is not present.*

Conclusion ₃₋₅: *The ascription of pain is not amenable to a purely scientific, experimentally verifiable, determination but is intimately connected to whether the subject is deemed to be a suitable candidate for inclusion in a moral calculus (i.e. is an 'Object of Intrinsic Moral Worth').*

Conclusion ₃₋₆: *It is possible to draw a distinction between the 'pain', the 'concept of pain' and 'suffering', and to conclude that, though the possession of reflexive consciousness is a precondition for experiencing pain 'as pain' or for suffering, it is not so for the experience of pain itself.*

Conclusion ₃₋₇: *'Pain' is not open to a purely scientific analysis. At best, correlates of pain can be studied but the validity of the correlation is not fully amenable to a scientific determination. This is particularly so when the ability to communicate is either non-existent (as in the case of animals) or is permanently lost (as in the case of PVS patients).*

Conclusion ₃₋₈: *Experience has shown that unanimity of medical opinion on the impossibility of pain being experienced is no guarantee of truth. Thus, the current near-unanimity of medical opinion that PVS patients cannot experience pain should not be regarded as decisive.*

Conclusion ₃₋₉: *The question 'Is X in pain?' consists of, in fact, two questions*
(i) "Is X a suitable candidate for a pain judgement?" - i.e. does he belong to the class to whom pain is (normally) ascribed?
(ii) "If X is a suitable candidate, is X in pain?"

Conclusion ₃₋₁₀: *A candidate for a pain judgement is an appropriate candidate if it has the capacity to engender empathy, or, equivalently, if it possesses consciousness. The term 'capacity to engender empathy' is to be preferred in that it - unlike the term 'consciousness' - lays no claim to a spurious scientific rigour.*

Conclusion ₃₋₁₁: *Ascribing pain to an individual who has been deemed a suitable candidate for such ascription, is greatly facilitated if the behaviour of that individual resembles human pain behaviour; the presence of such behaviour is, however, neither necessary nor sufficient; the determining factor for the ascription of pain is the presence of empathy.*

Conclusion 3-12: *There is some academic support for the proposition that PVS patients can experience pain.*

Chapter 4: PVS, Locked-In Syndrome and an alternative definition of PVS

The aim of this chapter is to examine the definition of PVS with the emphasis on clarifying its *differential* definition (*i.e.* the criteria which enable PVS to be distinguished from other conditions with which it might be confused) rather than its *absolute* definition (*i.e.* a set of necessary and sufficient conditions for diagnosing PVS), the former being the more problematic. The 'Guillain-Barré' Syndrome - also known as the 'Locked-In' Syndrome - is a condition which very closely resembles PVS and one with which it is easily confused. The criterion often advanced as enabling these conditions to be distinguished is the possession of consciousness (it is said to be present in Locked-In Syndrome but absent in PVS). However, this criterion is problematic because, as has been seen in Chapter 1,¹ there is no scientific method of determining the presence, or absence, of consciousness.² Because of these difficulties the distinction between PVS and Locked-In Syndrome is especially important and it is a particular focus of this chapter.

In discussing the definition of a medical condition such as PVS or Locked-In Syndrome, not only are the theoretical aspects of the definition of importance - *i.e.* whether it is a logically coherent definition and whether the set of criteria offered to distinguish it from related conditions, is a complete set - but the practical aspects of the definition are also of significance - *i.e.* Is it *useable* in a clinical setting? Assuming a definition is theoretically sound, then a good indicator of its practical utility is to be found in the rate of misdiagnosis associated with its use. As is seen later in this chapter, the rate of misdiagnosis associated with PVS is alarmingly high - of a magnitude similar to that to be expected if diagnosis was made by the tossing of a coin.³ This alone indicates that the difficulties associated with the definition of PVS are substantial. These difficulties are the concern of this chapter and are considered in detail in later sections; however it is advantageous - before becoming enmeshed in detailed argument - to have some wider overview of the magnitude of the problem. To assist in this I wish to first recap on an earlier conclusion and then to quote from two doctors, Keith Andrews and Michael McQuillen, both eminent practitioners in the field of PVS.

As to the conclusion: In an earlier chapter⁴ the question was asked as to whether there were any areas of the brain, damage to which was uniquely associated with PVS. The conclusion of that discussion was that:

Conclusion₃₋₂: *As yet, no particular areas of the brain have been identified, damage to which, or whose inactivity, is uniquely associated with PVS.*

Thus, in the search for a definition of PVS, one obvious and apparently promising avenue of exploration has, as yet, been unfruitful.

As to the medical authorities: Andrews begins his paper 'Managing the persistent vegetative state' by testifying to the problematic nature of PVS:

¹ see: Conclusion₁₋₄ *There is no neurological test which will determine PVS patient consciousness.*

Conclusion₁₋₆ *There are theoretical limits to the determination of necessary and sufficient conditions for the ascription of consciousness. Any attempt by science to assert that particular criteria are both necessary and sufficient for ascribing consciousness is unwarranted.*

² Absent cases where brain activity has ceased. However, as there is no cessation of brain activity in cases of PVS, this proviso is not relevant to the present discussion [see Chapter 1].

³ That is the differential diagnosis between PVS and the conditions which it most closely resembles, is only marginally better than if the diagnosis was made by some random process.

⁴ Chapter 3, Section 1.

*"The persistent vegetative state is one of the least understood conditions in rehabilitative medicine."*⁵

McQuillen is equally dissatisfied with the current understanding of PVS. He emphasises that PVS is just a *syndrome* - i.e. just a collection of symptoms without any necessary theoretical unity. There may be no one underlying pathology or, indeed, there may be many such pathologies which future research may succeed in disentangling. At all events, being a syndrome,⁶ it is not to be expected that PVS is, at present, amenable to a fully coherent theoretical analysis. Unfortunately, in ethical and legal discussions⁷ PVS is treated as a coherent, well defined, condition. In such discussions it functions as a *gateway* concept, meaning that once it is diagnosed, certain ethical and legal consequences - such as that the tube feeding of such patients is a 'medical treatment' and that the withdrawal of such treatment is permissible - are generally deemed appropriate. These consequences would not be considered appropriate had PVS not been diagnosed. Thus, in times when medical resources are regarded as scarce, it should not be unexpected that the ambiguities surrounding the definition of PVS - which at other times would be deplored - can now be seen to be of benefit and be made to serve economic ends. McQuillen has not commented on the economic reasons for this tendency but has noted its existence:

*"In recent years, some researchers have emphasised the essentially clinical nature of the 'vegetative state' and have attempted to extend its limits to include the end stage of any chronic, progressive, neurodegenerative disorder at one end of life and to compare it with anencephaly at the other. Such a comparison has obvious pragmatic impact on any discussion of the ethical consequences of the syndrome but is flawed from the start, since the syndrome is just that: a 'set of symptoms which occur together,' by no means precise, easily recognised or even well accepted."*⁸

A further cause of the difficulties encountered in discussing PVS, is the use of an inappropriate terminology.⁹ Andrews adverts to this difficulty:

*"The term"¹⁰ is unfortunate. Many people understate 'persistent' to mean 'permanent' - that is, a statement of final outcome rather than a statement on the present state."*¹¹

This difficulty is compounded when, as has occurred,¹² the term 'permanent' is explicitly used.

Maurice O' C. Drury - who was himself a medical doctor and a pupil of Wittgenstein's - believed that the choice of appropriate terminology was especially important in medical discussions because of the danger that from:

"... unsystematic nomenclature suppositions are drawn, which then become presumptions and only too easily pass over into established truths. I would say that the chief danger of an

⁵ Andrews (1992) at p.486.

⁶ That is a collection of symptoms that occur together without any well understood theoretical reason for such coincidence.

⁷ These are explored in Part 2 of this thesis.

⁸ McQuillen *op.cit.* at p.375

⁹ If in a particular context, a terminology has connotations which have not been independently established in that context, then it can be said to be '*inappropriate*' because it creates a tendency to use the connotations as if they had been independently established.

¹⁰ i.e. persistent.

¹¹ Andrews (1992) at p. 486.

¹² As in the President's Commission Report; see section 2 of this Chapter.

*unsystematic nomenclature is the danger of regarding its classification as mutually exclusive and completely exhaustive.”*¹³

The importance of the role of terminology in the discussion of PVS is also a theme of this chapter.

This chapter comprises six sections. Section 1 discusses the definition of PVS given by Jennett and Plum in their 1972 paper which first identified the condition and named it as such. Subsequent formulations of the definition are considered in Section 2. Section 3 draws some conclusions from studies on the extent of misdiagnosis of PVS. (The studies themselves are considered in Appendix A.) Section 4 considers Chris Borthwick’s criticism of the coherence of the concept of PVS. (Some of Borthwick’s papers relevant to the discussion are summarised in Appendix B.) It will be suggested that Borthwick’s criticism is not sufficiently far-reaching and that the conceptual problems lie much deeper than he suggests. An alternative definition of PVS emerges out of the foregoing analysis and this is discussed in Section 5. The conclusions of the chapter are stated in Section 6.

Section 1: The original definition of PVS

An article by Jennett and Plum,¹⁴ published in 1972, was the first to name the syndrome ‘Persistent Vegetative State’ as such. This syndrome, after its acute stage had passed, was characterised by:

- * *“... the absence of function in the cerebral cortex as judged behaviourally;”*¹⁵
- * *“The eyes are open and may blink to menace, but they are not attentive; ... It seems there is wakefulness without awareness.”*¹⁶
- * *“A significant grasp reflex often appears, ... sometimes fragments of coordinated movements may be seen such as scratching...”*¹⁷
- * *“Grunting or groaning may be provoked by noxious stimuli, but most of these patients are silent; they neither speak nor make any meaningful response to the spoken word.”*¹⁸

Jennett and Plum recognised that the term ‘Persistent Vegetative State’ primarily:

*“... describes behaviour, and it is only data about behaviour which will always be available”*¹⁹

In their view the:

*“... essential component was the absence of any adaptive response to the external environment, the absence of any evidence of a functioning mind ...”*²⁰

¹³ Drury *The Danger of Words* at p.3. He also points out the danger - which is again highly relevant in the present context - of being mesmerised by the theoretical structures of our analysis and blind to existential reality:

“And so the hypothesis which is our own useful creation, dazzles our view of things. We fail to see much that the hypothesis doesn’t include; we extend the limits of our hypothesis into regions of phantasy. Reality which lies before us at every moment is replaced by the abstract picture we have ourselves created.” [op.cit. p.100]

¹⁴ Bryan Jennett and Fred Plum, ‘Persistent Vegetative State after Brain Damage - A Syndrome in Search of a Name.’ *The Lancet*, (1972).

¹⁵ *ibid.* p.734.

¹⁶ *ibid.*

¹⁷ *ibid.*

¹⁸ *ibid.*

¹⁹ *ibid.* p.736.

Such patients were:

*"... incapable of communication and without hope of recovery as social human beings."*²¹

The Jennett and Plum article was seminal and has had a considerable influence on the subsequent debate on PVS. The authors displayed a precision in their use of language which is seldom found in the subsequent discussion. They were aware of the danger of drawing unjustified inferences and were scrupulous in their choice of terminology, being fully conscious of the subtle implication of inappropriate terminology. Subsequent discussions on PVS have often concentrated on the supposed '*lack of consciousness*' of the PVS patient yet a careful reading of the Jennett and Plum paper shows a different emphasis. To more easily permit these differing shades of meaning to be discussed, it is useful to make the following distinctions:

PVS _{BEH}	to denote a definition of PVS made solely in behavioural terms.
PVS _{COM}	to denote a definition of PVS where the emphasis is on the inability to communicate.
PVS _{MTL}	to denote a definition of PVS where 'mentalist' terms - such as lack of consciousness - are used

The distinction between PVS_{BEH} and PVS_{COM} might seem otiose in that communication - whether by word or gesture, or more primitively by blinking 'one for yes, two for no' - is necessarily behavioural, yet it is possible to imagine a patient who displayed 'purposive' behaviour - say, in his reaching towards a cup - but with whom it was not possible to establish any communication; the distinction is also of importance in that a definition in terms of communication is 'dynamic' - it points therapeutic intervention in a definite direction, that is towards establishing communication; in contrast, a definition in terms of behaviour is 'static' because once behaviour has been observed a diagnosis can be made with no internal, or theoretical, pressure for ongoing review.

The immediate problem is to determine which of PVS_{BEH}, PVS_{COM} or PVS_{MTL} best fits Jennett and Plum's analysis.

The definitional strategy that best describes the Jennett and Plum approach

The peripheral role of PVS_{MTL}

Surprisingly in view of subsequent developments, it is not the PVS_{MTL} definition that is most central. Certainly the authors at one point use the term '*mindless*'²² but it is immediately qualified with the phrase '*as best can be judged behaviourally, the cerebral cortex is not functioning*'. The phrase '*lack of consciousness*' is not used; the closest the authors come to such a terminology is when they speak of a '*profoundly altered consciousness*'²³ and when they state that "*It seems that there is wakefulness without awareness.*"²⁴ At another point the authors speak of actions being 'reflex' though they note that '*to the inexperienced observer...[such actions]...may even be regarded as purposeful or voluntary*'.²⁵ Although this description does have '*mentalist*' connotations, an alternative formulation - '*their responsiveness is limited to primitive postural and*

²⁰ *ibid.*

²¹ *ibid.*

²² *ibid.*

"What is common to all patients in this vegetative, mindless state is that, as best can be judged behaviourally, the cerebral cortex is not functioning..."

²³ *ibid.* p.734.

²⁴ *ibid.* [emphasis added]

²⁵ *ibid.*

reflex movements of the limbs.'²⁶ - is also used by Jennett and Plum; the latter phrase is used as logically equivalent to the former and it is without any mentalist connotations. Thus, although there is a use of a mentalist terminology, it is a superficial use which masks an underlying behaviourist framework. Indeed the authors show a strong desire to stress the behaviourist base of their definition; this is evidenced in the following passage:

*"... the immediate issue is to recognise that there is a group of patients who never show evidence of a working mind. This concept may be criticised on the grounds that observation of behaviour is insufficient evidence on which to base a judgement of mental activity: it is our view that there is no reliable alternative available to the doctor at the bedside, which is where decisions have to be made."*²⁷

One further use of 'mentalist' terminology is when Jennett and Plum state (in speaking of 'Locked-In Syndrome' patients):

*"Such patients are entirely awake, responsive and sentient, although the repertoire of response is limited to blinking, and jaw and eye movements. One patient ... signals by Morse code using blinks and jaw movements ..."*²⁸

Though the distinction between Locked-In Syndrome and PVS is formulated using a mentalist terminology ('awake', 'sentient') these concepts again play only a peripheral role; the important feature permitting the distinction is the '*blinking*' or '*signalling*'. This permits the conclusion to be drawn:

Conclusion 4-1 : *The definition of PVS and the distinction between it and Locked-In Syndrome given by Jennett and Plum is capable of being formulated either in a 'mentalist' (PVS_{MTL}) or behaviourist (PVS_{BEH}) terminology or in terms of an inability to communicate (PVS_{COM}). The mentalist formulation is peripheral.*

We next examine which of the other possibilities - i.e. PVS_{BEH} or PVS_{COM} - is the more fundamental to Jennett and Plums' analysis.

Which of PVS_{BEH} or PVS_{COM} is the more fundamental?

Certainly the initial impression on reading Jennett and Plum's article is that 'patient behaviour' is the more important diagnostic criterion - the poverty of the behavioural responses are adverted to more often than is the inability to communicate. Against this, it could be argued that the inability to communicate is the more fundamental as is shown by, for example, the following passage:

*"... [vegetative patients] were described as incapable of communication and without hope of recovery as social human beings. ... All the patients are speechless and also fail to signal appropriately by eye movements, although they sometimes follow moving objects ..."*²⁹

The primacy of ability to communicate as a diagnostic criterion is particularly evident in relation to the distinction between PVS and Locked-In Syndrome, because the difference between PVS and 'locked-in syndrome' patients - which is so slight when stated in behavioural terms - show their true

²⁶ *ibid.* [Discussed in the synopsis.]

²⁷ *ibid.* p.737.

²⁸ *ibid.* p.736.

²⁹ *ibid.*

importance *only* when interpreted as communication. Furthermore Jennett and Plum speak of the wisdom of making:

*“... an absolute distinction between patients who do make a consistently understandable response to those around them, whether by word or gesture, and those who never do.”*³⁰

The making of an ‘understandable response’ is better accommodated in a framework where ‘ability to communicate’,³¹ rather than observed behaviour, is the focus of primary concern; these points suggests PVS_{COM} as the more fundamental.

There are, however, arguments in favour of regarding PVS_{BEH} as the more fundamental. The most important of these is that there are other medical conditions characterised by prolonged unresponsiveness and a definition of PVS in terms of ‘inability to communicate’ might foster confusion; it is this argument which is advanced by Jennett and Plum when they state:

*“Such patients are best described as in a persistent vegetative state, which should be clearly distinguished from other conditions associated with prolonged unresponsiveness. What is common to these patients is the absence of function in the cerebral cortex as judged behaviourally; ...”*³²

In order that the risk of confusion can be more clearly assessed, it is of interest to briefly describe these other ‘diseases of responsiveness’.³³ Those which most closely resemble PVS are ‘Akinetic Mutism’, ‘Locked-In Syndrome’ and ‘Apallic Syndrome’.

Akinetic Mutism

This term was coined by Cairns in 1941 to describe:

*“... an intermittent disturbance of consciousness in an adolescent girl with a craniopharyngioma. She lapsed into this state three times in nine months and each time she recovered when the cyst was aspirated. Cairns commented on the eyes being open, apparently attentive and ‘giving the promise of speech’.”*³⁴

The term ‘presents considerable semantic problems’³⁵ not least because akinesia and mutism do not always occur together. Furthermore, the mutism may only be relative:

*“Cairn’s patient would answer in whispered monosyllables, whilst other reported patients would use sign language to communicate.”*³⁶

‘Akinetic Mutism’ is, however, better described as a disease of *limited* responsiveness either in time or in extent, rather than unresponsiveness. Hence, if ‘an inability to communicate which is believed to be permanent’ was taken as a necessary condition for diagnosing PVS then this would permit PVS to be distinguished from ‘Akinetic Mutism’ because in the latter the inability to communicate is either not present or, if present, is not believed to be permanent.

³⁰ *ibid.* p.737.

³¹ Interpreted in a wide fashion and not restricted to verbal communication.

³² *ibid.* p.734.

³³ These are discussed by Jennett and Plum at pp 734-5.

³⁴ *ibid.* p.735.

³⁵ *ibid.*

³⁶ *ibid.*

Locked-In Syndrome

In this syndrome patient response is 'limited to blinking, jaw and eye movements.'³⁷ By using such movements the patient can communicate by a system similar to Morse Code; their condition is thus readily distinguishable from PVS *provided* this is defined in terms of 'inability to communicate'.

Apallic Syndrome

This is a term proposed by Kretschmer in 1940 to describe patients who are 'open-eyed, uncommunicative and unresponsive'.³⁸ Jennett and Plum believe that the term 'apallic':

*"... seems to us more to confuse than to clarify the issue under discussion."*³⁹

Jennett and Plum's discussion on this condition is unsatisfactory in that it is not clear whether they consider Apallic Syndrome to be a clinically different condition from what they term PVS, or the same condition but with an inappropriate name.

An inappropriate name? Other than the criticism of the term 'apallic' just mentioned Jennett and Plum also criticise the term because it 'assumes an unproved pathology',⁴⁰ and because it contributes to the 'unnecessarily arcane jargon that often makes neurology needlessly difficult for others to understand'.⁴¹

A different condition? Jennett and Plum seek to distinguish Apallic Syndrome from PVS because:

1. Partial forms of Apallic Syndrome are possible. The 'full form' is characterised by an isoelectric E.E.G. whereas in PVS, though:

*"Initially the E.E.G. may be isoelectric, considerable activity and even alpha rhythm may be found once the state has lasted many months."*⁴²

Jennett and Plum do not discuss the partial forms in any detail.

2. Recovery may be possible from Apallic Syndrome whereas in considering PVS:

*"Certainly we are concerned to identify an irrecoverable state, ..."*⁴³

The use of the term 'near-PVS' in recent years - it has been used to refer to the Ward case⁴⁴ - considerably weakens the first objection, as does Jennett and Plum's acknowledgement that:

"Although we would not deny that a continuum must exist between this vegetative state and some of the others described, it seems wise to make an absolute distinction between patients

³⁷ *ibid.* p.736

³⁸ *ibid.* p.735. Jennett and Plum, in discussing this condition, state:

"Attempts have been made to produce apallic cats by making brain stem lesions ... These experiments are most interesting in showing the amount of complex activity which eventually returns after extensive lesions; surgical decerebration of infant monkeys is likewise followed by the return of a considerable repertoire of responsive motor behaviour, and observations on anencephalic humans surviving for some weeks reinforce the view that an appreciable range of activity and responsiveness is possible in the absence of a cortex."

This would appear to add further support to Conclusion 1-2 which stated 'There is no area of the brain, and no specific brain activity, that is uniquely associated with the possession of consciousness.' However, Jennett and Plum do not accept that conclusions relevant to the debate on PVS can be drawn from such experiments. They state, in a surprisingly dogmatic manner and without explicit justification, that:

"However, none of this evidence bears on the problem of mental function in adult man..." [op.cit. p.736]

³⁹ *ibid.* p.736

⁴⁰ *ibid.*

⁴¹ *ibid.*

⁴² *ibid.*

⁴³ *ibid.* p.735

⁴⁴ The Ward case, High Court, at p.2.

"The Ward is ... in a condition which is nearly, but not quite, what in modern times has become known as persistent or permanent vegetative state."

who do make a consistently understandable response to those around them, whether by word or gesture, and those who never do.”⁴⁵

Their second objection is the root of many of the difficulties encountered in discussing PVS because in attempting to identify an *irrecoverable* condition they conflate ideas of prognosis and diagnosis.

Is PVS an irrecoverable condition?

It could be argued that Jennett and Plum, rather than accurately defining a particular syndrome and then clarifying the prognosis for this syndrome by systematic observation, appear to approach the problem in the reverse order.⁴⁶ The authors, whilst acknowledging an uncertainty as to how long the condition must persist before it can be declared permanent, state that they are concerned to identify an irrecoverable state.⁴⁷ The suggestion that ‘irrecoverability’ should be incorporated into the definition of PVS introduces a profound logical confusion into the discussion of PVS, and this confusion considerably exacerbates the problem of misdiagnosis.⁴⁸ It resurfaces in the BMA discussion of misdiagnosis of PVS⁴⁹ - the BMA explicitly incorporate ‘irrecoverability’ into the definition of PVS and this has as a necessary consequence that if PVS patients recover then they must, *as a matter of logic*, have been misdiagnosed. This approach leaves unsolved the problem as to what the (supposedly) PVS patients, who in fact recovered, had actually been suffering from.⁵⁰ Jennett and Plum’s analysis would seem to suggest that they were suffering from Apallic Syndrome, however their criticism of the name ‘apallic’ and their unwillingness to suggest an alternative (*i.e.* different from PVS) would suggest otherwise.

Conclusion^{4.2} : *The Jennett and Plum discussion of PVS is unsatisfactory in that in attempting to identify an irrecoverable condition, it ignores the position of those who recover from a condition which at the time of diagnosis was indistinguishable from PVS.*

These difficulties arise from precisely the problem warned against by O’C. Drury:

“[T]he chief danger of an unsystematic nomenclature is the danger of regarding its classification as mutually exclusive and completely exhaustive.”⁵¹

Returning now to the question of which of PVS_{BEH} or PVS_{COM} is the more fundamental, the following conclusions can now be drawn in relation to the definition of PVS and its possible confusion with other conditions of unresponsiveness:

Conclusion^{4.3} : *According to Jennett and Plum, the diseases of responsiveness that might be confused with PVS are ‘Akinetic Mutism’, ‘Locked-In Syndrome’ and ‘Apallic Syndrome’.*

⁴⁵ *ibid.* p.737.

⁴⁶ The reasons for the reversal of normal procedure is surely to be found in the socio-economic implications of prolonged treatment of PVS patients, implications of which the authors were not unaware. They state [*op.cit.* p.737]:

“Certainly the indefinite survival of patients in this state presents a problem with humanitarian and socioeconomic implications which society as a whole will have to consider.”

⁴⁷ *ibid.* p.735.

⁴⁸ This is discussed in Section 3.

⁴⁹ This is discussed in the Section 2.

⁵⁰ The case of Andrew Devine, which is discussed in Section 3, is an example of such a situation.

⁵¹ M. O’C. Drury *op.cit.* p.3.

'Akinetic Mutism' is better described as a disease of limited responsiveness rather than unresponsiveness; 'inability to communicate' is either not present or, if present, is not believed to be permanent. In 'Locked-In Syndrome' communication is possible though by a primitive means. 'Apallic Syndrome' is a condition which, in so far as it differs from PVS, is characterised by the inability to communicate not being permanent.

Jennett and Plum's reluctance to base the definition of PVS on inability to communicate is understandable if what was being suggested was a definition of PVS grounded *solely* in terms of inability to communicate. This, however, is not what is being suggested in advocating PVS_{COM}; what is being advocated is that 'inability to communicate' be considered a *necessary* condition within a background context of primitive postural movements.⁵² Within such a context, the Locked-In Syndrome patient can be distinguished from the PVS patient simply by the ability to communicate. A further advantage of using a definition of PVS based on ability to communicate is that the problem of defining 'near-PVS' (supposedly conscious PVS-like patients), and the distinction between it and PVS, disappears.⁵³

Conclusion 4-4: *If, within a context where a patient exhibits only primitive postural movements, PVS is defined in terms of an inability to communicate believed to be permanent (i.e. PVS_{COM}), then it can be readily distinguished from Locked-In Syndrome and the other conditions of unresponsiveness outlined by Jennett and Plum. Furthermore such a definition allows 'near-PVS' and 'PVS' to be assimilated into the one condition.*

Before leaving Jennett and Plum's analysis the question of whether they consider PVS to be a discrete medical condition or to be a syndrome, must be addressed. This issue was mentioned briefly in the introduction to this chapter and McQuillen's views were quoted.⁵⁴

PVS - a syndrome or a specific medical condition?

Jennett and Plum clearly describe PVS as a 'syndrome'⁵⁵ - that is a collection of symptoms without necessarily any internal or structural cohesion between them. Surprisingly - in that the authors do not believe that a 'partial PVS' is possible - they acknowledge that PVS is not discrete from such as the 'locked-in syndrome', but forms part of a continuum.⁵⁶ This aspect of their analysis seems to have been forgotten by many later commentators who, in seeing consciousness as an 'either/or' condition, and in asserting its absence in PVS patients and its presence in 'locked-

⁵² A PVS patient - whether defined on grounds of PVS_{BEH} or PVS_{MTL} - cannot communicate; thus, inability to communicate is a necessary condition for PVS *howsoever defined*; what is at issue is not the necessity of the condition but the advisability of making its existence explicit. It is a corollary of this approach that 'possession of consciousness' be no longer used as the criterion for differentiating PVS from Locked-In Syndrome; if this were not so then those patients who had lost the ability to communicate but were still conscious would be neither 'PVS' nor 'Locked-In Syndrome'. (These question are discussed further in the later sections of this chapter.)

⁵³ in that the ability to communicate to a specific level is a yes/no condition, unlike the possession of consciousness. [Susan Greenfield, for example, has described consciousness as being analogous to a dimmer switch rather than an on/off switch.] This is discussed further in Section 5.

⁵⁴ McQuillen *op.cit.* p.375:

"In recent years, some researchers have emphasised the essentially clinical nature of the 'vegetative state'... but [this] is flawed from the start, since the syndrome is just that: a 'set of symptoms which occur together,' by no means precise, easily recognised or even well accepted."

⁵⁵ *ibid.* p.736.

"We propose this as the most satisfactory term to describe this syndrome ..."

⁵⁶ *ibid.* p.736

"Although we would not deny that a continuum must exist between this vegetative state and some of the others described, it seems wise to make an absolute distinction ..."

in syndrome' patients, appear to deny this continuum. McQuillen and Andrews are notable exceptions to this tendency. Andrews states:

*"PVS is not a concrete diagnosis. It's a continuum from a coma through different levels of vegetative state. We cannot think of being in a vegetative state as a black-and-white situation."*⁵⁷

Conclusion^{4,5}: *A further reason for rejecting the assertion that consciousness is necessarily absent in PVS patients, is to be found in the fact that PVS is a syndrome rather than a unitary, theoretically coherent, medical condition; and that it lies on a continuum of conditions at one end of which is the Locked-In Syndrome.*

Section 2: Definitions of PVS subsequent to that of Jennett and Plum

This section considers definitions of PVS given by:

1. The President's Commission for the study of ethical problems in medicine (1983).⁵⁸
2. The Multi-Society Task Force on PVS (1994).⁵⁹
3. The Institute of Medical Ethics working party on the ethics of prolonging life and assisting death: 'Withdrawal of life-support from patients in a persistent vegetative state' (1991).⁶⁰
4. The British Medical Association (BMA) guidelines on treatment decisions for patients in persistent vegetative state (1996).⁶¹

The first two of these are reports by American authorities and the others by British.

The emphasis in this section is on the actual definition of PVS given by these authorities with particular reference to firstly, the question of how the possible consciousness of PVS patients is resolved, and secondly, to how PVS is distinguished from related conditions and especially the Locked-In Syndrome. The terminology used in the reports is also examined for any tendency to hinder clarity of discussion particularly in relation the misdiagnosis of PVS and to the possibility of PVS patients recovering from their condition.

The President's Commission for the study of Ethical Problems in Medicine

The President's Commission discussed PVS under the heading '*Permanent Loss of Consciousness*'. They justified this decision by saying:

*"The term needed for the discussion in this Report was selected to include deep coma and vegetative state but to exclude patients with partial impairments of consciousness. 'Permanent Loss of Consciousness' accomplishes this."*⁶²

They justified the term '*unconsciousness*' in stating that:

*"The term 'vegetative state' denotes unconsciousness with persistent brain-stem functions ..."*⁶³

⁵⁷ discussing the case of Andrew Devine (see Section 3). Dr Andrews was quoted in an article in The Times March 27th 1997 entitled '*Joy for parents as Hillsborough victim 'talks' back*'.

⁵⁸ President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research (1983).

⁵⁹ The Multi-Society Task Force on PVS:

- 'Medical Aspects of the Persistent Vegetative State' (First of Two Parts) *The New England Journal of Medicine* (1994):

- 'Medical Aspects of the Persistent Vegetative State' (Second of Two Parts) *The New England Journal of Medicine* (1994).

⁶⁰ Institute of Medical Ethics Working Party on the Ethics of Prolonging Life and Assisting Death 'Withdrawal of life-support from patients in a persistent vegetative state.' *The Lancet* (1991).

⁶¹ BMA Guidelines on Treatment Decisions for patients in Persistent Vegetative State; *Medico-Legal Journal of Ireland* (1996).

⁶² President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research (1983).

p.174.

⁶³ *ibid.*

The possibility of patients diagnosed as PVS being conscious is resolved by a sleight of hand - surely a case of the tail wagging the dog.⁶⁴

PVS and the possibility of recovery

The President's Commission considered the term '*permanently*'⁶⁵ to be synonymous with '*lasting ... indefinitely without change; as opposed to temporary.*' They rejected '*persistent*' because it could apply to situations which are not permanent; they rejected '*irreversible*' because of its association with coma though they recognised that it might be beneficial because it '*focuses on the prognostication of therapeutic possibilities*'; they rejected '*judged to be permanent*' because, although it focused on the probabilistic nature of the judgement, it was unwieldy.⁶⁶

Opting for the term 'permanent' as the name for a condition which is not necessarily so, may seem to be a matter of 'mere' terminology - something of no consequence. This is not so; such inept nomenclature may well have serious consequences as can be seen by considering its effect on the family of a PVS patient especially in circumstances where the withdrawal of treatment is being discussed.⁶⁷

PVS and consciousness

The question '*Can a PVS patient have some level of consciousness?*' is also neatly resolved because if, by definition, a PVS patient suffers from a '*permanent loss of consciousness*' then who but the foolhardy would have the temerity to ask such questions?

The distinction between PVS and the Locked-In Syndrome

Distinguishing between PVS and 'locked-in syndrome' is also disingenuously resolved because '*locked-in syndrome*' patients are obviously not permanently unconscious whereas PVS patients have been defined to be so.⁶⁸

Terminology

The linguistic rigour of Jennett and Plum has disappeared. The choice of terminology might seem a trifling matter of 'mere convention'; that it is not such can be seen by noting that a choice of inappropriate terminology permits questions such as:

'Can a PVS patient have some level of consciousness?'

'Can a PVS patient experience pain?' or indeed

'Can a PVS patient recover?'

to be 'resolved' by a definitional *fiat*. Such attempts must be exposed for the 'question begging' that they are.

⁶⁴ or the name resolving the question.

Jennett and Plum had considered, and rejected, the use of the term '*unconscious*' in relation to PVS patients:

"Once past the acute stage these patients are neither unconscious nor in a coma in the usual sense of these terms which imply a sleep-like insensibility." [op.cit. p.734]

⁶⁵ They acknowledged the uncertainty implicit in any empirical judgement which they recognised to be:

"... especially serious in predictions about unconsciousness because the evidence ... is still quite limited. The overall number of patients is small, and most cases have not been carefully studied or adequately reported." [op.cit. p.176 footnote]

The awareness of such levels of uncertainty did not, however, diminish their enthusiasm for the term '*permanent*' even though such a term connotes quite a different state of affairs to that which exists; indeed the term may, because of its connotations, become a self fulfilling prophecy.

⁶⁶ *ibid.* p.176.

⁶⁷ A scenario highlighting the possible misleading effects of such terminology, is given in Section 6.

⁶⁸ Neither '*locked-in syndrome*' nor '*Guillain-Barré syndrome*' feature in the index to the report.

Conclusion⁴⁻⁶: *The President's Commission for the study of ethical problems in Medicine chose a definition of PVS and a terminology for its discussion which effectively precluded the consciousness of PVS patients or their possibility of recovery being questioned.*

A terminology which by the use of a linguistic subterfuge, precludes the asking of valid questions cannot but be abjured; it is reminiscent of Lewis Carroll's 'Alice in Wonderland':

"When I use a word," Humpty Dumpty said, in a rather scornful tone, "it means just what I choose it to mean - neither more nor less."

"The question is," said Alice, "whether you can make words mean so many different things."

"The question is," Humpty Dumpty said, "which is to be master - that's all."

The Multi-Society Task Force on PVS⁶⁹

The definition of PVS

The Multi-Society Task Force defined the vegetative state by giving the following diagnostic criteria:⁷⁰

- "(1) no evidence of awareness of self or environment and an inability to interact with others;*
 - (2) no evidence of sustained, reproducible, purposeful, or voluntary behavioural responses to visual, auditory, tactile, or noxious stimuli;*
 - (3) no evidence of language comprehension or expression;*
 - (4) intermittent wakefulness manifested by the presence of sleep-wake cycles;*
 - (5) sufficiently preserved hypothalamic and brain-stem autonomic functions to permit survival with medical and nursing care;*
 - (6) bowel and bladder incontinence; and*
 - (7) variably preserved cranial-nerve reflexes⁷¹ and spinal reflexes.*
- The distinguishing feature of the vegetative state is an irregular but cyclic state of circadian sleeping and waking unaccompanied by any behaviourally detectable expression of self-awareness."*⁷²

⁶⁹ The deliberations of the "The Multi-Society Task Force on PVS" have been considered earlier where the evidence for their assertions that PVS patients had no level of consciousness and could not experience pain, were considered. [see Chapters 1 and 3]

The emphasis in this section is on:

i) how the Task Force distinguished between 'locked-in syndrome' and PVS; this distinction is crucial to any discussion of misdiagnosis.

ii) their recommendations on terminology which also impacts on the discussion of misdiagnosis.

⁷⁰ These criteria have been adopted, in a slightly amended form, in a report by Grubb *et al* 'Doctors' views on the management of Patients in Persistent Vegetative State: A European Study'. This report lists (at p.11) the amended set of criteria as:

- "1. No evidence of awareness of self or environment.*
- 2. All responses are reflex in nature*
- 3. No meaningful or voluntary response to stimulation (visual, auditory, gustatory, olfactory or tactile)*
- 4. No evidence of language comprehension or expression*
- 5. Intermittent sleep-wake pattern*
- 6. Variable preserved cranial nerve reflexes*
- 7. Sufficient preserved hypothalamic and brainstem autonomic function to permit prolonged survival with medical and nursing care."*

⁷¹ (pupillary, oculocephalic, corneal, vestibulo-ocular, and gag)

⁷² Part 1 p.1500.

Terminology.

'Permanent' versus 'persistent'

The Task Force retreated somewhat from the terminology used by 'The President's Commission'⁷³ and drew a commendable distinction between 'persistent' and 'permanent':

*"The adjective 'persistent' refers only to a condition of past and continuing disability with an uncertain future, whereas 'permanent' implies irreversibility. Persistent vegetative state is a diagnosis; permanent vegetative state is a prognosis."*⁷⁴

A distinction which, as we shall see, seems not to have been fully accepted by the BMA Guidelines and which causes considerable difficulties in the analysis of cases of misdiagnosis.

'Severe disability' as a synonym for loss of personhood

The Task Force suggested that sufficient research data was available⁷⁵ on the prognosis of recovery to allow judgements to be made, with a high level of confidence, on the likelihood of a particular patient not recovering consciousness:

*"... or that if consciousness were recovered, the patient would be left severely disabled."*⁷⁶

The conjunction of these two outcomes is of interest. It has been pointed out by Andrews⁷⁷ that the prognosis after a skiing accident may well be that *'the patient would be left severely disabled'* yet such would hardly be considered sufficient reason for 'treatment withdrawal'; something more than *'severe disability'* is involved here and is not being addressed. I suggest that it is the specific nature of the disability and its effect on the mental and social capabilities of the 'recovered' patient that underlies this discussion; disabilities so great that the 'personhood'⁷⁸ of the patient be considered to be lost. The unwillingness of the Multi-Society Task Force to directly confront the issue of loss of personhood is to be regretted for many reasons but most importantly because of the deep offence that is caused to people who suffer from *'severe disability'* but whose personhood is not in question.

Often attempts are made, by using the concept of *'quality of life'*, to distinguish between the severity of various disablements so that at one end of the scale, disablement is regarded as so severe *'that life is no longer worth living'*. These *'quality of life'* judgements are considered in Part 2 of this thesis where it is argued that *'absolute quality of life'* judgements - i.e. judgements that the 'totality' of a patient's life is such *'that life is no longer worth living'* - are ethically impermissible. However, in Part 3 of this thesis it is argued that an individual who is deemed to have permanently lost their ability to communicate has lost their personhood. It is this loss of ability to communicate that is crucial rather than disability *per se*. Bringing the concept of personhood centre stage allows

⁷³ i.e. permanent vegetative state.

⁷⁴ *ibid.* p.1501. However, they do use the term 'permanent' but in a more restricted sense:

"A wakeful unconscious state that lasts longer than a few weeks is referred to as a persistent vegetative state ... A patient in a persistent vegetative state becomes permanently vegetative when the diagnosis of irreversibility can be established with a high degree of clinical certainty ... We believe there are sufficient data on the prognosis for neurologic recovery to allow us to distinguish between persistent and permanent vegetative states." [Part 1, p.1501]

and

"On the basis of these probabilities, a persistent vegetative state can be judged to be permanent 12 months after a traumatic injury in adults and children; recovery after this time is exceedingly rare and almost always involves a severe disability." [Part 2, p.1575]

⁷⁵ at the time of writing i.e. 1994.

⁷⁶ Part 1 p.1501.

⁷⁷ Andrews (1993a) p.1600.

⁷⁸ The concept of 'personhood' is discussed in Chapter 10.

a resolution of the PVS problem without the necessity for devaluing the lives of those who are disabled.

PVS and consciousness⁷⁹

The opening sentence of the Task Force's discussion of the definition of PVS speaks of the 'complete unawareness' of PVS patients.⁸⁰ Two paragraphs later this criterion becomes lack of 'behaviourally detectable expressions of self-awareness'.⁸¹ Subsequently, however, the Task Force does distinguish between these concepts, and acknowledge the possibility that a patient may be conscious whilst not manifesting 'conscious behaviour':

*"A false positive diagnosis of a persistent vegetative state could occur if it was concluded that a person lacked awareness when, in fact, he or she was aware. Such an error might occur if a patient in a locked-in state (i.e. conscious yet unable to communicate because of severe paralysis) was wrongly judged to be unaware. Thus, it is theoretically possible that a patient who appears to be in a persistent vegetative state retains awareness but shows no evidence of it. In the practice of neurology, this possibility is sufficiently rare that it does not interfere with a clinical diagnosis carefully established by experts."*⁸²

The Task Force shed no light on how the 'rarity' of this condition could conceivably be established, nor on how the use of such a term could be reconciled with the high level of misdiagnosis.

Conclusion 4-7: *The Multi-Society Task Force on PVS acknowledge the possibility that patients who appear to be in a persistent vegetative state might retain awareness but show no behavioural manifestation of this. The Task Force asserts, without giving theoretical ground for such an estimate, that such cases are 'rare'.*

The distinction between PVS and the Locked-In Syndrome

Let us take the above quotation as authority for the existence of a group of patients who are aware but exhibit no 'conscious behaviour' - let us call them the 'frozen-aware'.

The 'frozen-aware'

Concerning this category one might ask whether they should be classified as 'PVS' or as 'locked-in syndrome' patients or be regarded as a separate category. The Multi-Society Task Force report, as we have seen, categorises such patients as being 'locked-in syndrome' patients. This has the important consequence that the 'locked-in syndrome' can no longer be defined behaviourally. The standard assertion - as mentioned, for example, by Jennett and Plum - that 'locked-in syndrome' patients are responsive⁸³ though in a limited fashion must be abandoned; yet this very assertion is made by the Multi-Society Task Force - they give the criterion 'eye movement

⁷⁹ The terms 'consciousness' and 'awareness' are used interchangeably in the Multi-Society Task Force report; see Part 1 p.1500.

⁸⁰ Part 1 p.1500:

"The vegetative state is a clinical condition of complete unawareness ... accompanied by sleep-wake cycles ... [it] may be transient ... or permanent."

⁸¹ Part 1 p.1500:

"The distinguishing feature of the vegetative state is an irregular but cyclic state of circadian sleeping and waking unaccompanied by any behaviourally detectable expression of self-awareness."

⁸² p.1501.

⁸³ Jennett and Plum p.736:

preserved as a characteristic of the Locked-In Syndrome.⁸⁴ We shall examine the Task Force's definition of the Locked-In Syndrome shortly; but first note that there are two other possibilities. The 'frozen aware' could be categorised as being PVS or as comprising a category distinct from both PVS and the Locked-In Syndrome.

The 'frozen aware' - are they PVS?

Could the 'frozen aware' have been categorised as PVS? If so, then the assertion that PVS patients necessarily lacked awareness could no longer be sustained, and the conclusion that some PVS patients are conscious - and, presumably, can experience pain - must be accepted.

The 'frozen aware' - are they a distinct category?

Could the 'frozen aware' have been considered as forming a third category distinct from PVS and Locked-In Syndrome? If this were done then this new categorisation could only be sustained at a theoretical level as it would be utterly devoid of diagnostic criteria that could be used in a clinical setting; such a possibility would render an already difficult situation even more confused.

Considering the difficulties faced by medical professionals in attempting a diagnosis of conditions such as PVS, it might seem unduly pedantic to introduce such distinctions. My defence is that an examination of the problem of categorising the 'frozen aware' permits a more useful conceptual framework to emerge for discussing PVS and 'locked-in syndrome', than exists at present. In order to set the groundwork for this argument⁸⁵ let us examine how the Multi-Society Task Force define the Locked-In Syndrome.

The definition of 'locked-in syndrome' adopted by the Multi-Society Task Force

The Multi-Society Task Force use the term 'Locked-In Syndrome' to refer to:

*"... a state in which consciousness and cognition are retained but movements and communicate are impossible because of severe paralysis of the voluntary motor system."*⁸⁶

This patient, with whom communication is impossible, becomes - *within that very same paragraph* of the report - able to communicate by eye movements:

*"Patients with this syndrome can usually establish limited communication through eye-movement signals."*⁸⁷

Such imprecision in the use of the term '*communication*' bodes ill for clarity of discussion. However, such imprecision is *crucial* to defending the stance adopted by the Multi-Society Task Force because it permits the 'frozen aware' to be classified as being Locked-In Syndrome. If 'ability to communicate' was a necessary criterion of being categorised as Locked-In Syndrome then the frozen aware could not be so classified.

What then are the necessary criteria for diagnosing Locked-In Syndrome?

We are told simply that:

"Such patients [i.e. 'locked-in syndrome' patients] are entirely awake, responsive and sentient, although the repertoire of response is limited to blinking, and jaw and eye movements."

⁸⁴ Part 1 p.1502, Table 1.

⁸⁵ An alternative definition of PVS is set out in Section 5.

⁸⁶ Part 1 p.1502

⁸⁷ *ibid.*

*"Diagnosis of the locked-in syndrome is established by clinical examination."*⁸⁸

This is the one definitive statement in the treatment of Locked-In Syndrome; certainly support may be garnered from other directions:

*"Brain imaging may show isolated ventral pontine infarction, and nerve conduction studies may demonstrate severe peripheral neuropathy. Positron-emission tomographic (PET) scans have shown higher metabolic levels in the brains of patients in the locked-in state than in patients in a persistent vegetative state. Electroencephalograms, evoked responses, and single-photon-emission computed tomograms do not distinguish reliably between the locked-in and vegetative states."*⁸⁹

Thus they are left with one practical criterion to distinguish between PVS and 'locked-in syndrome', namely PET scans. However, the Task Force members themselves are clearly aware of the limitations of PET scans as a diagnostic tool; the report states:

*"Although these studies demonstrate substantial reductions in the metabolism of glucose, there is not yet sufficient information to warrant the use of PET scanning to determine prognosis."*⁹⁰

Furthermore, their recommendations for future research projects note that:

*"A confirmation of the absence of evoked activity on the PET scan would also help defend the assertion that patients in a persistent vegetative state are completely unaware and insensate."*⁹¹

Earlier in this thesis⁹² it was shown that, in the view of various authorities on PVS, PET scans are of, at best, limited usefulness in the diagnosis of PVS. McQuillen, for example, states that the inference drawn from PET scans:

*"... is that cognitive function is lost because the regional cerebral metabolic rate for glucose is less than half the normal value."*⁹³

McQuillen points out that because the comparable rate for infants '... whose cognition can only be inferred by motor movements not unlike those manifested by the patient in the 'vegetative state',⁹⁴ is in excess of healthy adults, such inferences must be treated with caution. Andrews did not use PET scans in his study on the misdiagnosis of PVS; which is, in itself, eloquent testimony to their inconclusiveness.⁹⁵

Thus, the inclusion by the Multi-Society Task Force of the 'frozen-aware' cases within the 'locked-in syndrome' category necessitated the abandonment of any definitive practical criterion for distinguishing between PVS and 'locked-in syndrome' in favour of retaining a definitive theoretical criterion namely 'lack of consciousness'. The 'possession of consciousness' thus becomes the primary diagnostic criterion with 'ability to communicate' secondary. This reverses the original order

⁸⁸ *ibid.*

⁸⁹ *ibid.* [emphasis added]

⁹⁰ Part 1 p.1506

⁹¹ Part 2 p.1578

⁹² Chapter 3 Section 1.

⁹³ McQuillen *op.cit.* p.375

⁹⁴ *ibid.*

⁹⁵ Andrews (1996)

used by Jennett and Plum where - as I have argued in Section 1 - 'ability to communicate' is the primary criterion and 'possession of consciousness' is at best secondary.

Conclusion 4-8: *The Multi-Society Task Force acknowledge the existence of patients who are aware but show no behavioural manifestations of awareness [the 'frozen aware']. In categorising these patients as cases of Locked-In Syndrome, rather than PVS, the coherence of the criteria used to diagnose Locked-In Syndrome is damaged.*

Further evidence of the confusion implicit in the Task Force's analysis of the distinction between PVS and Locked-In Syndrome is evident when - in arguing that PVS patients have no awareness - they seek to buttress their case by stating:

*"Almost all such patients [i.e. PVS patients] have some degree of motor activity and eye movement that would be capable of signalling conscious perception of pain if such existed."*⁹⁶

The Task Force seem oblivious to the contradiction implicit in this statement, because if such a patient could signal by eye movement then, by definition, they would no longer be PVS but be 'locked-in syndrome'.⁹⁷ Their statement continues, achieving something of a *volte-face*:

*"In rare cases, it may be difficult to distinguish a persistent vegetative state from a severe locked-in state. Under such unusual circumstances, a patient may not be able to express behavioural responses to painful stimuli ... the absence of response cannot be taken as proof of the absence of consciousness."*⁹⁸

As to the theoretical reasons for believing that such cases of misdiagnosis are rare the report is silent. Section 3 of this chapter will show that misdiagnosis of PVS, far from being 'rare' and 'unusual' is so common as to approach the norm.

The Institute of Medical Ethics working party on the ethics of prolonging life and assisting death

PVS and the possibility of recovery

The report of the working party has already been mentioned⁹⁹ as has their conclusion that:

*"No diagnostic test can indicate that a patient is permanently vegetative. ... The diagnosis therefore depends on careful clinical observation over several weeks."*¹⁰⁰

Despite this conclusion the report did not hesitate to state that:

*"Patients in a persistent vegetative state have permanently lost the function of the cerebral cortex."*¹⁰¹

They discussed the withdrawal of life-supporting medical treatment from patients:

⁹⁶ Part 2 p.1576.

⁹⁷ Jennett and Plum [op.cit. p.736]:

"This term [locked-in syndrome] was coined by Plum and Posner to describe the ... mute but fully alert state. ... Such patients are entirely awake, responsive and sentient, although the repertoire of response is limited to blinking, and jaw and eye movements. One patient ... signals by Morse Code, using blinks and jaw movements ..."

⁹⁸ Part 2 p.1576.

⁹⁹ in Chapter 3 Section 1.

¹⁰⁰ Institute of Medical Ethics Working Party on the Ethics of Prolonging Life and Assisting Death 'Withdrawal of life-support from patients in a persistent vegetative state.' The Lancet (1991) at p. 97.

*“... whose condition has been diagnosed with certainly as permanent.”*¹⁰²

By adopting such a terminology the possibility of a PVS patients recovering, is explicitly denied.

PVS and the Locked-In Syndrome

The working party did not discuss the Locked-In Syndrome.

PVS and consciousness

The working party's view on the possibility of PVS patients being conscious is implicit in their statement, just quoted, that such patients have permanently lost the function of the cerebral cortex. It is also implicit in their statement on the possibility of such patients experiencing pain:

*“Vegetative state patients are not suffering, because the mechanisms for suffering have been destroyed.”*¹⁰³

In a further quotation which culminates in a marvellously surrealistic non-sequitor:

*“We agree with the American view that there is no remaining neurological mechanism to make pain or suffering possible, and that good oral hygiene can be maintained by appropriate nursing care after food and fluids have been withdrawn.”*¹⁰⁴

Terminology

The working party considered that the reluctance of some families to agree to treatment withdrawal in cases of PVS, was based on an unfounded optimism:

*“... a view which may be encouraged by some carers. ... the working party believes it is unfair and unkind to allow such optimism to be sustained.”*¹⁰⁵

The report urges professional bodies to publicly acknowledge the appropriateness of treatment withdrawal in cases of PVS;¹⁰⁶ not to withdraw treatment from PVS patients could be to the detriment of other patients:

*“The economic and social consequences of indefinite treatment of vegetative patients may also mean that the ... resources they receive ... are denied to other patients who could benefit.”*¹⁰⁷

The working party's unqualified use of the term 'permanent' in its discussion of PVS appears to be a tactic designed to diminish such 'unfounded optimism'; however, it also functions as a denial of the fact that PVS is not necessarily permanent and that it is prone to a high level of misdiagnosis.¹⁰⁸

¹⁰¹ *ibid.* p.96 [emphasis added]

¹⁰² *ibid.* [emphasis added]

¹⁰³ *ibid.* p.97

¹⁰⁴ *ibid.*

¹⁰⁵ *ibid.*

¹⁰⁶ *ibid.* p.98

¹⁰⁷ *ibid.* p.97

¹⁰⁸ The term 'permanent' can be used in at least two senses, which can be best explained by considering the following examples:

(i) *“He lives permanently in Ireland”*

(ii) *“The car is uninsured because it is permanently off the road.”*

In the first example the use of the term “permanent” is not invalidated by an occasional holiday abroad; whereas in the second example the use is invalidated by the occasional trip to town.

The first use allows occasional exceptions; it could be described as the statistical meaning and is denoted by 'permanent_s'.

The second use permits no exceptions; it could be described the logical meaning and is denoted by 'permanent_t'.

Conclusion⁴⁻⁹: *The use by the Institute of Medical Ethics of the term 'permanent' in relation to PVS whilst omitting any reference the possibility of recovery, or to the high level of misdiagnosis associated with that condition, is disingenuous.*

Attempts to 'adjust' the truth, whether explicitly or by more subtle means, so that certain aims be more readily accomplished bespeaks a paternalism which cannot be justified irrespective of how well-meaning the intent, or how 'good' the goals. In that the 'Institute for Medical Ethics' is the author of such attempts, it is to be especially deplored.

The British Medical Association Guidelines

The BMA Guidelines noted the distinction made by the Royal College of Physicians between 'continuing vegetative state' and 'permanent vegetative state',¹⁰⁹ however, the BMA decided not to adopt that terminology:

*"For the present time at least, the BMA retains the term 'persistent' rather than 'permanent' but continues to keep the arguments and the evidence under review."*¹¹⁰

All, however, is not as it seems. The BMA position in relation to the naming of PVS is best explained by contrasting it with that of the Multi-Society Task Force. The Task Force, as mentioned earlier,¹¹¹ considered that:

*"Persistent vegetative state is a diagnosis; permanent vegetative state is a prognosis."*¹¹²

and that:

*"On the basis of these probabilities, a persistent vegetative state can be judged to be permanent 12 months after a traumatic injury in adults and children; recovery after this time is exceedingly rare and almost always involves a severe disability."*¹¹³

In the previous section a distinction was introduced¹¹⁴ between two uses of the term 'permanent'; the first is where occasional, perhaps rare, exceptions are allowed; this was called the statistical use and was denoted by *permanent_s*. The second use is where no exceptions are permitted; this was called the logical use and was denoted by *permanent_t*. The Multi-Society Task Force clearly uses the term 'permanent' in the sense of *permanent_s*. Next, consider a patient diagnosed as PVS who, after 12 months in that condition,¹¹⁵ recovers; according to the Multi-Society Task Force analysis, although the *prognosis* for this patient was incorrect, the *diagnosis* of PVS is not invalidated. The situation is theoretically no different from that of a patient who was correctly diagnosed as having a broken ankle and who was told that it would take 6 weeks to heal whereas in fact it took 8 weeks. Let us now attempt to outline the BMA analysis.

Though the BMA noted that:

The term 'permanent' was used in the sense of *permanent_s* by the Multi-Society Task Force; it was used in the sense of *permanent_t* by The Institute of Medical Ethics working party, by the President's Commission (although they equivocated) and by the BMA Guidelines which are discussed in the next subsection.

¹⁰⁹ where the former term describes a patient's diagnosis prior to confirmation of the permanence of the condition.

¹¹⁰ *ibid.* p.58

¹¹¹ See page 125.

¹¹² *ibid.* p.1501.

¹¹³ Part 2 p.1575.

¹¹⁴ At footnote 108.

¹¹⁵ At which stage the Multi-Society Task Force would classify such a patient as being *permanently* in a persistent vegetative state.

and that it:

*"... has consistently recommended that the diagnosis of irreversible PVS should not be considered confirmed (and therefore treatment not withdrawn) until the patient has been insentient for 12 months."*¹¹⁷

These guidelines speak of a 'diagnosis' and of 'irreversible PVS'; these terms need further examination. On a first reading, the guidelines appear to be essentially equivalent to the Multi-Society Task Force recommendations with the term 'irreversible' used in place of 'permanent'; it is possible to suggest that they are even more 'liberal' in that the use of the term 'irreversible' is not automatically permitted after 12 months of being diagnosed as PVS but requires further clinical confirmation. On this interpretation, though 'irreversible PVS' is spoken of as a diagnosis, it is in reality a prognosis, and although 'irreversible' is equivalent to, or even stronger than, 'permanent' in its connotations it should be understood in the sense of *permanent_s* rather than *permanent_L*. This however is not the BMA's position:

*"An enduring cause for concern, however, have been the intermittent reports of alleged 'recovery' from PVS. In the BMA's view, recoveries, where they can be verified, indicate an original misdiagnosis."*¹¹⁸

It is indeed difficult to find a coherent interpretation of the BMA position.¹¹⁹ Had the passage just quoted spoken of alleged recovery from 'irreversible PVS' then, though the terminology used might be open to criticism, the BMA's position would have been tenable. It would have been that within the condition 'PVS', a subgroup of patients can be defined who never recover; such patients are said to suffer from 'irreversible PVS'; if one of such patients recovered then this might indeed be described as a case of 'misdiagnosis' - however the misdiagnosis would relate to 'irreversible PVS' and not to PVS. There is evidence for such an interpretation elsewhere in the guidelines as, for example, when the BMA speaks of other discrete conditions within the broad ambit of the PVS condition itself:¹²⁰

*"... recognises that distinction can be drawn between different categories of PVS patients depending on factors such as patient's age ..."*¹²¹

But such an interpretation is in effect a rewriting of the guidelines in an attempt to impose coherence. The guidelines do not speak of recovery from 'irreversible PVS' being a misdiagnosis, they speak of recovery from PVS *simpliciter* being a misdiagnosis.¹²² Furthermore it is not open to

¹¹⁶ *ibid.* p.58.

¹¹⁷ *ibid.*

¹¹⁸ *ibid.*

¹¹⁹ See also BMA (1999a) Withholding and Withdrawing Life-prolonging Medical Treatment : Guidance for decision making. 3C.18.1:

"Patients in pvs have a permanent and irreversible lack of awareness of themselves or their surroundings and no ability to interact at any level with those around them."

¹²⁰ The guidelines suggest that the PVS condition itself is discrete:

"It considers PVS to be sufficiently discrete and extreme that its management can be defined, without raising implications for other categories of severe handicap." [op.cit. p.58]

This suggestion runs counter to both Jennett and Plum, and Andrews, who regard PVS as forming a continuum with other conditions. The BMA suggestion seems designed more to allay fears of a 'slippery slope' than to describe a clinical reality.

¹²¹ *ibid.* p.58.

¹²² That PVS *simpliciter* is an irrecoverable condition is also implied by:

"[PVS] results from severe damage to the cerebral cortex, resulting in irreparable destruction of tissue in the thinking, feeling part of the brain." [op.cit. p.58]

It is surprising that the BMA have not recommended that post-mortems be routinely performed on PVS patients so that such assertions might be verified; they *'are currently considering the merits of this proposal.'* [op.cit. p.59]

suggest that the adjective 'irreversible' is implied by the context, because the passage on misdiagnosis, just quoted, occurs *before* any mention of irreversibility.

In a short document which was written for the guidance of medical practitioners such ambiguity is inexcusable. The guidelines incorporate not only 'permanence' but 'permanence_L' into the definition of PVS, but unlike the President's Commission or The Royal College of Physicians, not into the title; in doing this, although arguably sticking to the letter of the recommendation of the Task Force that the distinction between 'diagnosis' and 'prognosis' not be blurred, they entirely miss its point.

Jennett and Plum in their 1972 paper sought to identify an irrecoverable state,¹²³ and certainly such an identification would ease considerably the ethical and socio-economic problems¹²⁴ associated with the management of PVS patients. They were, however, of the opinion that medical science was not yet sufficiently advanced to permit such prognosis and that, until then, '*persistent*' was a more appropriate term than either '*permanent*' or '*irreversible*'. Their intention was:

- * to find a criterion to distinguish between PVS and 'locked-in syndrome'; this they found, despite some appearances to the contrary, in the 'ability to communicate'.
- * to find criteria which when applied to those diagnosed as PVS, would permit the original presenting condition to be partitioned into two distinct conditions - 'permanent PVS', which was an irrecoverable condition, and 'non-permanent PVS' which presumably would, in time, be given a different name, so that it would then be possible to speak of all PVS as permanent.

It is important to recognise that the goal of the analysis suggested by Jennett and Plum would envisage *three* competing medical conditions being identified:

- * Locked-In Syndrome
- * 'Permanent' PVS
- * 'Non-permanent' PVS

The BMA have attempted to achieve the goal set by Jennett and Plum by a definitional *fiat*. This is a double subterfuge in that they have not only attempted to incorporate permanent_L into the definition of PVS - so that it then becomes possible to state that recovery from PVS is logically impossible - but they have left those who having been diagnosed as PVS and then recovered in a state of diagnostic limbo. The question '*What would have been the correct diagnosis for such patients?*' uncovers the Achilles heel of the BMA analysis. The BMA in its guidelines, offers no answer; in fact it does not even acknowledge that there is a question. In order to have a term to describe such patients, let us say that they were suffering from '*pseudo-PVS*.' Is '*pseudo-PVS*' a new condition, or an existing condition? What are the diagnostic criteria for '*pseudo-PVS*'? Not surprisingly there are none. '*Pseudo-PVS*' plays a role similar to that of the imaginary debtor in fraudulent bookkeeping: it allows the books to be 'balanced' and all inconvenient anomalies to 'disappear'. If the Task Force encountered difficult waters in its insistence that the 'frozen-aware' suffered from 'locked-in syndrome', then the BMA has truly muddied these waters; because, in the absence of creating a new diagnostic category, the only possible category open for '*pseudo-PVS*' patients - since they are, by definition, not PVS - is the Locked-In Syndrome. The source of the

¹²³ Jennett and Plum [op.cit. p.735]:

"Certainly we are concerned to identify an irrecoverable state, although the criteria needed to establish that prediction reliably have still to be confirmed. Until then '*persistent*' is safer than '*permanent*' or '*irreversible*'..."

¹²⁴ *ibid.* p.737:

"Certainly the indefinite survival of patients in this state presents a problem with humanitarian and socioeconomic implications which society as a whole will have to consider."

confusion in the BMA position is the logical error - warned against by Drury - of unjustifiably assuming that a classification is 'mutually exclusive and completely exhaustive'.¹²⁵

Some consequences of the BMA's redefinition of PVS

- * The coherence of the definition of Locked-In Syndrome is seriously eroded. The hallmark of the condition - the ability to communicate by eye blinks - must be relinquished because this ability is manifested neither in the 'pseudo-PVS' nor in the 'frozen aware'. How then should the Locked-In Syndrome be defined? This was not addressed by the BMA in its guidelines, and there is no obvious solution. It seems that by attempting to solve one problem another, even greater one, has been created.
- * The description of PVS as 'irrecoverable' becomes the justification for treatment withdrawal. As a consequence, the scientific investigation of whether the condition is, in fact, irrecoverable become impossible. A self-fulfilling, self-validating, process has been set in motion.
- * A further consequence of the BMA position is that any attempt to conduct research amongst recovered 'PVS' patients in an attempt to resolve the question of whether PVS patients have any level of consciousness, or can experience pain, is immediately invalidated on *a priori* grounds because such patients were, by definition, misdiagnosed; they were not PVS. Accordingly whether they were conscious or felt pain, is of no relevance to the question of whether PVS patients are conscious or can experience pain.
- * By means of the linguistic device adopted by the BMA, a medical professional could unhesitatingly assert that recovery from PVS was *logically* impossible. He could then unequivocally recommend treatment withdrawal. Such word play would also permit the BMA to state that *never* has a PVS patient recovered. This last proposition wears the mask of a meaningful proposition but is in fact no more than a tautology. The President's Commission spoke of the '*permanent*' vegetative state but allowed for cases of recovery from PVS; the BMA analysis has, by a subterfuge, reached precisely the opposite conclusion.

Conclusion ⁴⁻¹⁰ *The suggestion by the BMA Guidelines that patients who recovered, having been previously diagnosed as PVS, were to be classified as cases of misdiagnosis is destructive of honest debate. Furthermore, in that such patients are implicitly reclassified as being Locked-In Syndrome patients, the coherence of the definition of the Locked-In Syndrome is threatened.*

Section 3: The misdiagnosis of PVS

The extent of the misdiagnosis of PVS has, in recent years, been the focus of a number of studies, and articles, published in the learned journals;¹²⁶ four such studies have been summarised

¹²⁵ M. O'C. Drury [*op.cit.* p.3]:

"[T]he chief danger of an unsystematic nomenclature is the danger of regarding its classification as mutually exclusive and completely exhaustive."

¹²⁶ The media have also highlighted a number of cases of misdiagnosis of PVS; one such case - that of Andrew Devine - is discussed later in this section. The misdiagnosis of PVS has also been the subject of an extended television documentary (BBC 2 '*Horizon*' broadcast on 25.11.1996 and entitled 'The Living Death').

It may be suggested that these cases are cases of 'recovery' rather than 'misdiagnosis'; the distinction - and confusion - between 'recovery' and 'misdiagnosis' is discussed later in this section.

in Appendix A.¹²⁷ The aim of this section is to draw some conclusions from these sources; these conclusions are arranged under a number of headings:

- * The extent of the misdiagnosis of PVS as disclosed by these studies.
- * The reasons for the misdiagnosis suggested by these studies.
- * Some terminological issues arising from the studies.

The extent of misdiagnosis.

The aim of this subsection is to find a global estimate of the extent of misdiagnosis of PVS. The rates of misdiagnosis¹²⁸ found in the studies discussed in Appendix A, are shown in the Table 4-1:

<i>Study</i>	<i>Rate of Misdiagnosis</i>
The Tresch Study (1990) ¹²⁹	18%
The Childs Study (1992) ¹³⁰	37%
The Andrews 1993 Study ¹³¹	23% - 26%*
The Andrews 1996 Study ¹³²	43%

* One patient recovered awareness but not the ability to communicate.

Table 4-1: The rates of misdiagnosis as determined by various studies.

It is possible to take the simple arithmetical average of these rates as our estimate; this gives a rate of 31%.¹³³ A more accurate estimate can be found by weighting each percentage in proportion to the number of patients in the respective survey;¹³⁴ thus surveys with a small patient population would not be disproportionately represented in the final result. Such a weighted average is calculated according to the Table 4-2:

<i>Study</i>	<i>The number diagnosed as PVS</i>	<i>The number misdiagnosed</i>
The Tresch Study	62	11
The Childs Study	49	18
The Andrews 1993 Study	43	11
The Andrews 1996 Study	40	17
<i>Totals:</i>	338	110
<i>Weighted average rate of misdiagnosis:</i>	29.38%	

Table 4-2: The weighted average rate of misdiagnosis.

The above methods of obtaining a global estimate of misdiagnosis are open to criticism for two reasons:

- (i) firstly, they are essentially mechanical methods of aggregating results which are based on the assumption that, as global estimates of misdiagnosis, the studies are equally worthy of respect.
- (ii) secondly, a fundamental point concerning the measuring of the misdiagnosis of awareness - and that is, essentially, what these surveys are concerned with - has been ignored. The point

¹²⁷ see Appendix A, Table A-1. A number of articles of a more indirect relevance, are listed in Table A-2.

¹²⁸ *i.e.* false *positive* diagnosis of PVS. It is clear that the risk of false *negative* diagnosis - *i.e.* diagnosing a patient as not PVS when they are PVS - is minimal.

¹²⁹ 'Clinical Characteristics of Patients in the Persistent Vegetative State,' *Archives of Internal Medicine*, (1991).

¹³⁰ 'Accuracy of Diagnosis of Persistent Vegetative State,' *Neurology*, (1993).

¹³¹ 'Recovery of patients after four months in the persistent vegetative state,' *British Medical Journal*, (1993).

¹³² 'Misdiagnosis of the vegetative state: retrospective study in a rehabilitation unit', *British Medical Journal* (1996).

¹³³ $(18+37+26+43)/4 = 124/4 = 31\%$.

is that because of the nature of the test for determining that awareness is present - which is, for example, that the patient sounds a buzzer a number of times in response to a command to do so¹³⁵ - the risk of diagnosing that awareness is absent, when it is not so, is much greater than the risk of diagnosing that awareness is present when it is, in fact, absent. The latter risk is negligible in comparison to the former.¹³⁶ It follows that within a population of patients diagnosed as PVS - as is the case in all the above studies - the risk of a false positive re-diagnosis of PVS is considerably greater than a false negative. Hence the misdiagnose rates should not be interpreted as indicative of the true rate of misdiagnosis (*i.e.* plus, or minus, some percentage error) but rather as indicating absolute *minimum* rates (*i.e.* plus some percentage error).

Conclusion⁴⁻¹¹ *The rates of misdiagnosis determined by various studies should not be interpreted as indicative of the true rate of misdiagnosis but rather as indicating absolute minimum rates.*

This implies that the best indicator for the rate of misdiagnosis is the *maximum* rate of diagnosis found in any of the studies¹³⁷ (*i.e.* 43%) rather than the rate of misdiagnosis found by averaging over the studies (*i.e.* either 29.4% or 31%).

This conclusion can be buttressed by arguments from another direction: that is, by comparing the individual studies and showing that the Andrews (1996) study - and consequently the misdiagnosis rate of 43% - should be accorded a greater authority than the other studies. Let us briefly examine the different studies with a view to comparing the authority that should be accorded them as being global estimates of the misdiagnosis of PVS.

The Tresch Study¹³⁸

The Tresch study was not directly concerned with estimating the misdiagnosis of PVS, but rather with determining the clinical characteristics of patients who were diagnosed as PVS. Thus, the primary aim was not to determine whether, or not, some patients were aware. If, in the course of the study, it was found that some patients were aware then, of course, they could no longer be considered to be PVS. The goal of the study, however, was, given a group of patients diagnosed as PVS, to establish the proximate cause of the condition.¹³⁹ We are told neither the extent, nor the duration, nor the type of tests used to determine awareness; the impression is given that the awareness of these 11 misdiagnosed patients was patent. This contrasts with the much more exhaustive and thorough tests used to determine awareness in the Andrews (1996) study. Furthermore, the test population was derived from patients in nursing homes as distinct from hospitals; many of the patients were old: the mean age of the patients was 64.8 years,¹⁴⁰ 25% suffered from dementia with a mean age of 85.¹⁴¹ The study expressed surprise at the high level of

¹³⁴ a so-called 'weighted average'.

¹³⁵ As in Andrews (1996).

¹³⁶ This is because the buzzer system is in reality a test of ability to communicate rather than a test of awareness; communication without awareness, unlike the converse, is clearly impossible. It is of course possible to be mistaken in the assessment that communication has been established; this question is discussed further in Chapter 10.

¹³⁷ Assuming that the methodology of that particular study is not open to serious question; such issues are outside the ambit of this thesis.

¹³⁸ See Appendix A for a summary of this study.

¹³⁹ The original study population was 62 patients, 11 of whom were found to have some awareness.

"The remaining 51 patients constitute the study population." [op.cit. p.930]

This gives some indication of the focus of the study.

¹⁴⁰ *ibid.* p.930.

¹⁴¹ *ibid.* Table 1 p.931.

dementia¹⁴² amongst the test population and at the use of anti-psychotic drugs and H₂- blockers¹⁴³ which 'was so common'¹⁴⁴ in their treatment. Each of these factors would tend to militate against a finding of awareness and consequently of misdiagnosis.

The Childs Study¹⁴⁵

The Childs study allowed themselves a seven day period to determine the existence of misdiagnosis:

*"This 7-day period was established, a priori, as the cut-off period for a post-admission diagnosis."*¹⁴⁶

This short cut-off period, whilst it may minimise the possibility of 'recovery' being mistaken for 'misdiagnosis', may also clearly result in cases of misdiagnosis not being acknowledged as such. Furthermore, the thoroughness of the tests used to determine awareness is not discussed. As in the Tresch study, the impression is again given of a procedure designed to determine awareness when it is obviously present, rather than a method to uncover awareness when it exists, but without any obvious manifestation. It would be expected that such a study would result in an under reporting of the rate of misdiagnosis.

Andrews (1993)¹⁴⁷

This study was a retrospective review of the case notes of 43 patients admitted to a unit specialising in the rehabilitation of PVS patients:

*"The case notes of 11 of these patients showed that they had been in a persistent vegetative state for at least four months before showing a return to awareness ..."*¹⁴⁸

The study was concerned with 'recovery' rather than 'misdiagnosis'. The insistence by the BMA that cases of recovery are actually cases of misdiagnosis¹⁴⁹ considerably complicates this discussion but does make the Andrews study relevant to a discussion of misdiagnosis. However, in so far as the Andrews (1996) study is directly concerned with misdiagnosis as distinct from recovery,¹⁵⁰ its results are of greater relevance. It is also to be preferred on grounds of reliability as it is a direct study and not a retrospective review of case notes.

¹⁴² *ibid.* p.932:

"This large number of patients in a PVS in our study who were diagnosed as having end-stage dementia is surprising. Patients with dementia rarely develop the profound and complete loss of awareness characteristic of PVS, and it is important to distinguish between PVS and the usual dementia state."

¹⁴³ *ibid.* p.932.

¹⁴⁴ *ibid.*

¹⁴⁵ See Appendix A for a summary of this study.

¹⁴⁶ Childs p.1465. See also p.1466:

"Of the 49 patients referred ... 37% received a change in diagnosis at or shortly after admission. There was little delay in identifying responding patients; 50% ... were identified within the first day of admission and 78% ... by the third day."

¹⁴⁷ See Appendix A for a summary of this study.

¹⁴⁸ Andrews (1993b) p.1598.

¹⁴⁹ as discussed in Section 2 *supra*.

¹⁵⁰ Andrews (1996) p.15:

"It could be argued that the clinical team had introduced a successful treatment programme ... [however] it is our opinion that these patients were not vegetative at the time of admission."

In this study the tests used to determine patient awareness were considerably more thoroughgoing than was the case in either the Tresch, or the Childs, studies:

*"Patients received two half hour occupational therapy sessions a day for six weeks to assess responses to sensory stimulation and to identify the most reliable responses to command."*¹⁵²

Because of this it is to be expected that the misdiagnosis rate would be higher than that found in these other studies. This was indeed the case.

Furthermore, the study noted that:

*"... patient's awareness is nearly always identified first by the occupational therapists and then by the clinical psychologist, and only later is communication achieved by the other members of the team."*¹⁵³

This may help explain why patient awareness might not have been noticed by teams with a less interdisciplinary composition. The team also found more cases of misdiagnosis in 1995 than in previous years; this they attributed to the additional experience and increased sensitivity gained by the team in the previous years. Also the initial assessment period used by the Andrews team to determine misdiagnosis was 6 weeks, this contrasts with the 7 day period in the Childs study. The accumulation of these factors - an interdisciplinary team, considerable experience in detecting awareness and an extended period of assessment - help explain the disparity in levels of misdiagnosis shown in Table 4-1; they also indicate that, of the various studies, the Andrews (1996) rate of 43% is the most reliable estimate of misdiagnosis.

It was mentioned earlier¹⁵⁴ that this rate should, because of the nature of the methods used to determine awareness, be interpreted as a minimum; in relation to the Andrews(1996) study, there are two additional reasons why this should be so:

- (i) The original diagnosis in the Andrews(1996) study was made, in most cases, by a neurologist, neurosurgeon, or rehabilitation specialists - *'all of whom could have been expected to have experience of vegetative state.'*¹⁵⁵ In contrast, in the Tresch study the original diagnosis was by nursing home personnel (both nurses and physicians). It would seem that the original diagnosing personnel in the Andrews(1996) study were exceptionally well qualified; a higher rate of misdiagnosis is to be expected when the original diagnosis is made by physicians of less eminence and experience.
- (ii) The tests used in the Andrews (1996) study required the patients to respond to verbal commands. Thus, the estimate for misdiagnosis is an underestimate to the extent that any patient who had awareness but also had impaired hearing, was excluded.¹⁵⁶ However, the study found evidence of visual impairment in excess of what they had expected;¹⁵⁷

¹⁵¹ See Appendix A for a summary of this study.

¹⁵² *ibid.* p.13.

¹⁵³ *ibid.* p.15.

¹⁵⁴ in discussing Conclusion 4 - 11.

¹⁵⁵ *ibid.* p.15.

¹⁵⁶ *ibid.* p.14:

"Since all patients followed verbal commands it is assumed that none were deaf or had severe hearing impairment."

¹⁵⁷ *ibid.* p.15:

"The very high prevalence of severe visual impairment, to the best of our knowledge, not previously reported, is an additional complicating factor since clinicians making the diagnosis of the vegetative state place great emphasis on the inability of the patient to visually track or blink to threat."

accordingly it seems unreasonable to assume that only hearing unimpaired patients were misdiagnosed.

If these factors are incorporated into the estimate for misdiagnosis then the conclusion that the misdiagnosis rate for PVS is of an order of magnitude of 50% appears to be justified. This is equivalent to the rate of misdiagnosis that would be expected if diagnosis was performed by a purely random process.

Conclusion ⁴⁻¹² *The best estimate for the rate of misdiagnosis of PVS is of the order of 50%. This implies that the diagnosis of PVS is essentially a random process.*

Lest this be considered an extreme conclusion, Andrews statement should be noted:

"... 10 years' experience of training relatives of more than 250 patients in a persistent vegetative state to use a programme of stimulation ... only 4% of patients did not improve; one third became functionally independent." ¹⁵⁸

This statement does not distinguish between 'recovery' and 'misdiagnosis', however - in the context of the BMA's statement that recovery is necessarily misdiagnosis - it suggests a misdiagnosis rate of 33% as an absolute minimum.

The reasons suggested for the misdiagnosis.

The Tresch study noted the extent of misdiagnosis, as it were in passing; its focus lay elsewhere. No reasons were suggested for the occurrence of the misdiagnosis, nor were opinions offered as to what might have been the correct diagnosis. ¹⁵⁹

The Childs study, in contrast, did suggest reasons for the occurrence of misdiagnosis; one such reason was the lack of diligence by staff in observing changes in patient behaviour. ¹⁶⁰ However, the study found that the most important reason for the misdiagnosis lay in the use of inappropriate and confusing terminology:

"We suspect that misdiagnosis in most of these patients was due to the confusion in the terminology used to describe alterations in states of consciousness in the brain injured ... Confusion over terminology may have caused misapplication of the diagnosis of PVS in most of our patients." ¹⁶¹

¹⁵⁸ Andrews (1992) p.486.

¹⁵⁹ Though the authors expressed surprise at the large number of patients (25%) in a PVS who were diagnosed as having end stage dementia. [op.cit. p.932]

¹⁶⁰ As mentioned earlier, the report suggested that medical staff pay particular attention to reports by the families of patients of changes in patient behaviour. In the light of this finding a study which showed that 92% of parents of children diagnosed as being in a PVS, did not accept the doctors determination that awareness was lacking in their children [cf. Borthwick (1996) p.6/15], is particularly disturbing. Earlier, when discussing Wittgenstein's philosophy of pain judgements [see Chapter 3] - and judgements of awareness are no different - it was mentioned that the competence to make such judgements is not within the provenance of any one group but flows to us all of us from our common humanity. Indeed, if a primacy was to be accorded to any one group, then the patient's family would be the obvious first choice - in that they would be knowledgeable of those subtleties of behaviour peculiar to the patient; an obvious second choice would be the nursing staff in that they have most opportunity to observe the patient's behaviour. Accordingly, a finding [in The Irish Report of the Grubb Study p.28] that *one third* of the consultants would accord nurses *no influence* on a decision to withdraw ANH - [which presumably includes the ancillary question of whether the patient shows awareness] - gives particular cause for concern.

Support for the importance of listening to the perspectives of non-specialist medical staff, on the existence of patient awareness, is given by the neurologist Oliver Sachs. Sachs - in a discussion on his patients who suffered from 'sleeping sickness' - was asked:

"What made you dare to think that you could do anything to help them?"

Sachs responded that the nurses were convinced that, though the patients looked on the outside to be 'petrified, there were alive, intact people inside; and that occasionally something - music, or a visit - would draw them out for a few seconds.'

[A radio interview with Barbara Myers, on BBC 4 'Eureka' 1.1.1997].

¹⁶¹ Childs p.1466.

The report found that PVS was 'an area fraught with confusion'.¹⁶² Eloquent testimony to the extent of the confusion lies in the reports observation that the original diagnostic teams used the terms 'coma' and 'PVS' 'inconsistently and interchangeably',¹⁶³ as if they had been unaware that:

*"Coma is an eyes-closed state of unresponsiveness whereas in PVS the eyes are open but there is no awareness."*¹⁶⁴

The report was insistent on the need for appropriate terminology and clarity of definition:

*"There is a need for consensus in description and definition of PVS. If we do not adhere to a strict and precise definition of PVS then confusion and misdiagnosis will follow."*¹⁶⁵

The need for precise and appropriate terminology was also emphasised in the Grubb reports;¹⁶⁶ and in the Andrews(1992) paper.¹⁶⁷

The Andrews (1996) study isolated 'determination of awareness' as the primary stumbling block to a correct diagnosis. They noted:

*"... how difficult it can be, even for experienced clinicians, to diagnose cognitive ability in the presence of profound physical disabilities ..."*¹⁶⁸

The report commented on the fact that even though some of the misdiagnosed patients had a 'nearly normal' cognitive ability:¹⁶⁹

*"... none of the professional carers had recorded any evidence of meaningful responses."*¹⁷⁰

Conclusion 4-13: *The reasons suggested by the studies on misdiagnosis of PVS for its occurrence are inappropriate terminology, imprecise definition of PVS and overly primitive procedures for determining awareness.*

As mentioned earlier, the Andrews(1996) team relied on occupational therapists and psychologists, rather than medical specialists, to first establish the existence of awareness:

*"... patient's awareness is nearly always identified first by the occupational therapists and then by the clinical psychologist, and only later is communication achieved by the other members of the team."*¹⁷¹

Throughout the Andrews 1996 report - as in this last quotation - the terms 'awareness' and 'ability to communicate' are used interchangeably as if they were synonyms; this they clearly are not. However, in this *felix culpa* I suggest that the report unwittingly found the key to help unravel the confusion associated with PVS. One of the proposals of this thesis is that PVS be defined in terms of 'inability to communicate' and not in terms of 'lack of awareness'.¹⁷² The use of a buzzer

¹⁶² *ibid.* p.1465

¹⁶³ *ibid.* p.1466

¹⁶⁴ *ibid.*

¹⁶⁵ *ibid.*

¹⁶⁶ For example, they regretted the developments whereby 'persistent' has come to mean 'permanent' and they noted that 'confusion about the word 'persistent' has extremely important implications.' See: Andrew Grubb *et al* Doctors' views on the management of patients in persistent vegetative state (PVS): report of a small survey in Ireland. p.1.

¹⁶⁷ Andrews(1992) considers the terms 'persistent' and 'vegetative' to be unfortunate:

"... 'vegetative' has the unfortunate connotation of 'vegetable-like'." [op.cit. p.486]

Andrews sees the danger of PVS becoming a "... self-fulfilling prophecy - the prognosis is poor, therefore no treatment is given, therefore the prognosis is poor." [op.cit. p.487]

¹⁶⁸ Andrews (1996) p.15.

¹⁶⁹ *ibid.* .

¹⁷⁰ *ibid.* .

¹⁷¹ *ibid.* . [emphasis added]

¹⁷² this is discussed in the Section 5 of this chapter.

by the Andrews team is clearly,¹⁷³ and primarily, a test of the ability to communicate, as is clearly seen in cases where awareness is present and ability to communicate is absent. Only incidentally is it a test of awareness, notwithstanding that Andrews called it such.

Conclusion 4-14: *The Andrews 1996 study on misdiagnosis used 'ability to communicate' as a surrogate for 'possession of awareness'.*

Cranford criticises the Andrews (1996) study because it does not explain how its conclusion that the misdiagnosed patients were not vegetative at the time of admission, could be justified.¹⁷⁴ Cranford spoke of the need to distinguish between '*late recovery*' and '*late discovery*' of consciousness.¹⁷⁵ Andrews had anticipated¹⁷⁶ this criticism; however his argument is unconvincing.¹⁷⁷ Indeed, Andrews' argument, and Cranford's response, are indicative of a deep underlying confusion between the concepts of 'misdiagnosis' and 'recovery'; a confusion which is exacerbated by the BMA's insistence that cases of recovery are to be classified as cases of misdiagnosis.¹⁷⁸ Ironically, the BMA's position is the very obverse of Cranford's position. This again brings the choice of appropriate terminology to centre stage; it shows that the need for a re-evaluation of the terms used in discussions concerning PVS is pressing and it is to this that we now turn.

Some terminological issues.

PVS is defined by Jennett and Plum not in terms of 'the absence of consciousness' but in terms of 'the absence of consciousness judged behaviourally'. This distinction implies that there are patients who are conscious but who do not manifest 'conscious behaviour'.¹⁷⁹ The Multi-Society Task Force on PVS, for example, recognised such a possibility but countered by asserting that such cases were rare.¹⁸⁰ It is, however, not the rarity of such patients but their theoretical existence that is of importance if clarity of debate is to be achieved.

The distinction between

- (i) '*the absence of consciousness*' and
- (ii) '*the absence of consciousness judged behaviourally*'

may seem trivial, but it goes to the heart of the problem of misdiagnosis, and, in particular, to the dispute between Andrews and Cranford as to whether the cases uncovered by Andrews, were cases of misdiagnosis or cases of recovery. This is so because if PVS is defined as 'the absence of consciousness judged behaviourally', then in considering a patient who at a particular time (T) was conscious, though unable to manifest this behaviourally - and was accordingly judged to be in a PVS; but who at a later time (T+) manifested this consciousness behaviourally - and was

¹⁷³ *ibid.* p.13:

"... the patient was then taught to press the switch once for 'yes' and twice for 'no'."

¹⁷⁴ Ronald Cranford, 'Misdiagnosing the persistent vegetative state' Editorial *British Medical Journal* (1996) at p.5.

¹⁷⁵ *ibid.* p.5:

"Patients who start regaining consciousness several months after the injury (*late recoveries*) should not be confused with patients who may have been conscious for some time before discovery (*late discoveries*)."

¹⁷⁶ Andrews [1996, p.14]:

"To avoid confusing spontaneous recovery with misdiagnosis we did not include those patients admitted within six months of their brain damage, since spontaneous recovery is not uncommon during this period. Patients were considered to have been misdiagnosed if they could follow commands consistently within our initial assessment period of six weeks."

¹⁷⁷ The argument is considered in the next subsection.

¹⁷⁸ See Section 2.

¹⁷⁹ These are the '*frozen aware*' patients discussed in Section 2.

¹⁸⁰ The Multi-Society Task Force on PVS (a) p.1501. No evidence is offered for the supposed rarity of this condition.

accordingly judged not to be in a PVS - it necessarily follows that such a patient was *not* misdiagnosed at time (T).

The relationship between the terms 'recovery' and 'misdiagnosis', and the differing definitions of PVS is shown in the following tables:

At time	Consciousness	Consciousness manifested in behaviour	Diagnosed as PVS	Diagnosis at T:- a misdiagnosis or a recovery?
T	present	absent	yes	a misdiagnosis
T+	present	present	no	

Table 4-3: The scenario if PVS is defined in terms of 'lack of awareness'.

At time	Consciousness	Consciousness manifested in behaviour	Diagnosed as PVS	Diagnosis at T:- a misdiagnosis or a recovery?
T	present	absent	yes	a recovery
T+	present	present	no	

Table 4-4: The scenario if PVS is defined in terms of 'lack of awareness judged behaviourally'.

Andrews, in speaking of a specific patient, said that:

*"... we did not identify his responses until 25 weeks after his admission, though it was obvious from subsequent conversations with him that he had not been vegetative for some time."*¹⁸¹

Andrews subsequently classified this patient as 'misdiagnosed', this was done without showing that the patient had exhibited, at the time of his original diagnosis, behaviour which should have been attributed to awareness; this bespeaks a looseness in the use of language which is unhelpful in a debate which is already confused.

In his 1993 study, Andrews speaks of 'recovery' from PVS and not 'misdiagnosis', whereas in his 1996 study he used the term 'misdiagnosis'. These terms have a radically different connotation. However, it would seem that, depending on the definition of PVS adopted, they may both be applied to precisely the same clinical situation. It is of great importance that the relationship between the definition of PVS and the choice of terminology 'recovery'/'misdiagnosis' is made explicit as the connotations of these terms exert a considerable dominance on the debate on PVS. This is clearly evidenced by, for example, the insistence of the BMA that recovery from PVS is not logically possible and that the term 'misdiagnosis' is the appropriate term.

The confusion between 'misdiagnosis' and 'recovery' is exacerbated by the fact that both of these terms are ambiguous. At least three distinct meaning of the term 'misdiagnosis' can be identified; and at least two meanings of the term 'recovery'. Furthermore, if in particular circumstances, misdiagnosis is regarded as the appropriate term then it is appropriate to ask as to what the correct diagnosis should have been; yet this is a problem which has been consistently ignored and for which, in most cases, no satisfactory answer is forthcoming. The discussion on possible conditions which could/should have been diagnosed in situations where PVS was misdiagnosed, is more usefully conducted in a context of proposals for an alternative definition of PVS; both these discussions are placed in Section 5.

The remainder of this section looks at ambiguities, first in the use of the term 'misdiagnosis', then in the term 'recovery'; it then considers an individual case - that of Andrew Devine - who was a patient of Dr. Andrews; this case is of special interest at this point because of Dr. Andrews' insistence that this was not a case of misdiagnosis but one of recovery.

¹⁸¹ Andrews (1996) p.14.

Ambiguities in the term 'misdiagnosis'

The term 'misdiagnosis' can mean either that

- (i) a patient diagnosed as PVS was, at the time of diagnosis, *in fact* conscious; or
- (ii) a patient diagnosed as PVS manifested, at the time of diagnosis, 'conscious behaviour' which was not interpreted as such, by the physician; or
- (iii) the physician did not interact - *i.e.* stimulate and observe - sufficiently with the patient to elicit possible 'conscious behaviour' before he diagnosed the patient as PVS.

Neither Andrews nor Cranford address these ambiguities. Both appear to accept the first suggested meaning though it may be that Andrews, in using the term 'misdiagnosis', wished to emphasise the third - that is, that he considered the original examination of patient's behaviour to have been unduly cursory; which - in comparison with the programme of patient stimulation, and diligent observation, carried out by the Andrews (1996) team - the original examinations undoubtedly were. Perhaps the problem here, as in so much else connected with PVS, lies with terminology. The phrase 'absence of consciousness judged behaviourally' does not indicate that the role of the observing clinicians should be other than as a passive observer, it does not imply an active process of stimulation as, for example, was carried out by the Andrews (1996) team. Neither does the term suggest that an ongoing process of interaction is what is required.

The phrase 'inability to communicate', in contrast, does imply a judgement made at the end of a long process of attempted interaction. The emphasis on 'communication', which permeates Andrews paper, suggests that a better definition of PVS is to be found using the concept of 'communication' rather than the concept of 'behaviour'.¹⁸² Such a definition would actively encourage the process of sustained interaction with patients which is of such obvious importance.

Andrews has commented that:

*"It is disturbing to think that some patients who were aware had for several years been considered to be, and treated as being, vegetative."*¹⁸³

and Cranford noted that:

*"It would be dreadful indeed to stop treatment in patients who were thought to be unconscious but who could in fact experience thirst and hunger when treatment, including artificial nutrition and hydration, was stopped."*¹⁸⁴

Certainly efforts to reduce the level of misdiagnosis must be welcomed. However, a much more radical approach is needed to ensure that the scenario described by Andrews and Cranford of a conscious patient being treated as being unconscious, does not occur. One of the proposals of this thesis is to treat all PVS patient as *if*¹⁸⁵ they were conscious and could experience pain.¹⁸⁶ Such a proposal would, if adopted, obviously suffice; furthermore, it would lessen the importance of correctly distinguishing between misdiagnosis and recovery.

¹⁸² The definition PVS_{COM} which is advocated in this thesis is such a definition; see also Chapter 9, 10 and Thesis Conclusions.

¹⁸³ *ibid.* p.15.

¹⁸⁴ Cranford *op.cit.* p.6

¹⁸⁵ The term 'as if' is not meant to suggest some pretence, but rather an attitude of acceptance of the fact that some patients undoubtedly are conscious and that we have no way of knowing which.

¹⁸⁶ This proposal is advanced in the conclusions to Part 1 of this thesis.

Ambiguities in the term 'recovery'

In relation to PVS patients, two senses of the term recovery can be identified:

- (i) recovery of consciousness as manifested by behaviour;¹⁸⁷
- (ii) recovery of the capacity to lead a so-called 'meaningful life'.

Many authors use the term 'recovery' in its second sense. Raanan Gillon, for example, was quite scathing in his criticism of Andrews' use of the term 'recovery':

*"These include a patient who, after three years in the persistent vegetative state, recovered sufficient consciousness to smile at cartoons, to show pleasure when his wife was present, and to show distress when she was absent."*¹⁸⁸

Cranford appeared to agree with Gillon, when he suggested that most people would find the position of the 17 misdiagnosed patients, who were found to be conscious and severely disabled, to be:

*"... far more horrifying than the vegetative state itself, and some might think it an even stronger reason for stopping treatment than complete unconsciousness."*¹⁸⁹

This was a view which also found an echo in the judgement of Lynch J., in the Ward Case.¹⁹⁰ The different meanings of the term 'recovery' are also implicit in Grubb's questioning of his respondent, as to whether various predicted outcomes which left the patient severely disabled and dependent on their carers, would justify the withdrawal of treatment.¹⁹¹

It seems clear that many doctors faced with outcomes, such as described by Gillon or Cranford or Grubb, would not describe them as 'recoveries'.¹⁹² This is of importance as it shows that the term 'recovery' is being used not simply as medical concept wholly amenable to, and resolvable by, scientific methods, but that it also embodies ideas of value whereby some types of lives are considered valuable and others less so. Used in such a fashion the term has an essential core which is amenable only to an ethical analysis. Often the different meanings are not distinguished, and the ethical issues are not acknowledged. Problems are portrayed as purely medical or 'scientific' matters amenable to a purely technical solution. It is important that the technical and ethical questions be disentangled and not resolved by some fudging of the terms 'recovery' or

¹⁸⁷ PVS being defined as the lack of such manifested consciousness; if PVS is defined in terms of 'inability to communicate' then recovery would clearly lie in achieving the ability to communicate.

¹⁸⁸ Raanan Gillon, "Patients in the persistent vegetative state: a response to Dr Andrews." British Medical Journal (1993) p.1603:

¹⁸⁹ Cranford *op.cit.* p.6

¹⁹⁰ High Court at p.8:

"... but if such minimal cognition as she has includes an inkling of her catastrophic condition, then I am satisfied that that would be a terrible torment to her and her situation would be worse than if she were fully P.V.S.."

The most eloquent rebuttal of such views is given by Andrews when, in speaking of 11 misdiagnosed patients, he noted:

"Only one patient showed obvious distress at his condition. He had been a professional and fully appreciated his poor physical recovery. ... Among the other patients there was no evidence that limited recovery was associated with depression or a feeling that a condition of severe disability was worse than non-sentience or death. ... the impression gained was that signs of pleasure were far more common than those of distress."

[Andrews (1993b) p.1598-9]

¹⁹¹ Do the predicted outcomes:

A. The patient will be severely disabled, able to speak, but totally dependent on carers but with sufficient insight to be aware of his/her condition.

B. The patient will be severely disabled, able to communicate simple needs without speech

justify the non-treating of acute infections or the withdrawal of ANH?

Andrew Grubb (1996b) *et al* Doctors' views on the management of patients in persistent vegetative state (PVS): report of a small survey in Ireland (1996) p.19 and Appendix p.3.

¹⁹² Socioeconomic considerations, such as scarcity of resources, may also have an influence on the meaning of the term 'recovery'.

'quality of life'. To this end I suggest that the ethical questions and the technical questions be considered separately.

Conclusion 4-15: *It is imperative that the ethical content of the term 'recovery' be recognised and made explicit, and that it not be considered to be a term amenable to a purely technical solution.*

Strictly speaking, the term 'recovery' as applied to a PVS patient can *only*¹⁹³ mean the recovery of the ability to manifest consciousness behaviourally. Used in such a fashion the term 'recovery' is a purely technical term. The value of the life recovered is a separate question; to attempt to include some minimal measure of the value of the life is to muddy the waters. Such questions are certainly of great importance, both clinically and ethically, but clarity of discussion is not served by compounding these questions and treating them as if they were one.

The ethical aspect of the problem relates to the nature of the life recovered - whether it was in the 'best interests' of the individual concerned - and whether the treatment, which such recovery required, was a worthwhile use of scarce resources. The first of these questions is discussed in Chapter 7 where a distinction is made between '*absolute quality of life*' and '*incremental quality of life*' judgements; the former being judgements which attempt to place a value on the totality of a life.¹⁹⁴ The concept of '*a good death*' is introduced in Chapter 9; it is there argued that the achievement of '*a good death*' for a patient can, in certain closely defined circumstances, be a good. Such a principle implies that, in certain circumstances, the non-treatment of a patient may be a '*good*' even though death is the inevitable result of such non-treatment. A necessary criterion for the ascription of personhood is established in Chapter 10; this also has relevance to treatment decisions in circumstances where the ability of the patient to communicate is permanently lost.

These concepts ('absolute quality of life', 'incremental quality of life', 'a good death' and 'personhood') allow ethical issues and the technical question of establishing the likely effects of treatment in an individual case, to be separately addressed.¹⁹⁵

The Case of Andrew Devine¹⁹⁶

Andrew Devine, like Tony Bland, was a victim of the Hillsborough tragedy. He had been in a PVS state for eight years before he recovered sufficiently to be able to use an electronic buzzer to communicate. Commenting on the case Dr. Andrews said:

*"We have considerable experience of diagnosing patients in the vegetative state. We have observed Andrew over a number of years and he certainly did not fit into the criteria for misdiagnosis."*¹⁹⁷

In suggesting that this was a case of recovery rather than misdiagnosis, the reasoning was no doubt that, as a patient of Dr. Andrews, Andrew Devine had benefited from the

¹⁹³ That is, if PVS is defined either in terms of 'lack of consciousness' or 'lack of consciousness judged behaviourally'; if PVS is defined in terms of 'inability to communicate' then recovery would clearly lie in achieving the ability to communicate.

¹⁹⁴ It is argued in Chapter 7 that such judgements are ethically impermissible.

¹⁹⁵ For reasons of space, the issue of 'scarcity of resources' is not discussed in this thesis. However - even leaving the question of resources to one side - the ethical problems posed by the treatment of PVS patients are complex; in a situation of unlimited resources it is by no means obvious that the continued treatment of PVS patients, long after there is any realistic hope of their regaining the ability to communicate, is either ethically required or, indeed, ethically permissible. I suggest that the best way to tackle these problems from a theoretical standpoint, is to attempt to resolve the ethical questions within a framework of imagined unlimited resources and to then to study the effects of introducing the added complication of limited resources on the original analysis. This thesis addresses only the first part of this problem.

¹⁹⁶ Reported in The Times (27-3-1997) '*Joy for parents as Hillsborough victim 'talks' back*'; The Irish Times (27-3-1997) '*Stadium disaster victim was comatose for five years*' and '*Devine case raises questions about PVS, says doctor*'

stimulation/observation regime used by Dr. Andrews.¹⁹⁸ Though this is somewhat at odds with his earlier usage of the term 'misdiagnosis' in connection with Patient B of the 1996 study,¹⁹⁹ it confirms his usage of the term 'misdiagnosis' as being the third of those senses of misdiagnosis identified earlier²⁰⁰ - i.e. *'the doctor did not interact - i.e. stimulate and observe - sufficiently with the patient to elicit possible 'conscious behaviour' before diagnosing the patient as PVS.'*

Dr. Andrews also stated that:

*"PVS is not a concrete diagnosis. It's a continuum from a coma through different levels of vegetative state. We cannot think of being in a vegetative state as a black-and-white situation."*²⁰¹

This statement echoes a statement²⁰² in the original Jennett and Plum article but which has not featured in academic writing on PVS in the intervening years. The acknowledgement that PVS is not a 'black and white condition' surely implies that consciousness - normally interpreted as an all-or-nothing condition²⁰³ - could not logically be the defining criterion of PVS. If PVS lies on a continuum with such as 'locked-in syndrome' - a condition where consciousness is not in doubt - then surely this entails acceptance of the proposition that not all PVS patients lack consciousness?

Section 4: Borthwick's criticism of the definition of PVS

Borthwick's criticism is based on the absence of clear criteria for differentiating between PVS and the Locked-In Syndrome, and on the confusions that flow from this. He argues that, in the absence of such criteria, the assertion that PVS patients lack consciousness and the ability to experience pain, whilst simultaneously accepting that Locked-In Syndrome patients have these abilities, is not defensible. Attempts to bolster these assertions have resulted in the, supposed, lack of consciousness of PVS patients and the permanence of PVS, being incorporated into the *definition* of PVS. Borthwick sees the requirements of medical convenience and the need to husband scarce resources, as the motivating forces for such developments; medical ethicists - in their search for simple solutions to limiting situations - have colluded in this situation.

Distinguishing PVS and the Locked-In Syndrome

The criterion often used to differentiate the Locked-In Syndrome from other similar conditions, is the ability of a Locked-In Syndrome patient to signal by using eye movements. Borthwick considers the case of a patient who, in addition to suffering from the Locked-In Syndrome, also suffers from a medical condition which affects their eye control. He puts the question as to how such a patient would be distinguished from one suffering from PVS. Borthwick argues that the theoretical inability to distinguish between a Locked-In Syndrome patient suffering from loss of eye-muscle control - whose consciousness is not in doubt - and a PVS patient - who, it is asserted, has no consciousness, shows the groundlessness of the assertion that PVS patients have no

¹⁹⁷ The Times 27-3-1997.

¹⁹⁸ This is described in Andrews (1996).

¹⁹⁹ Andrews (1996, p.14):

"Fifteen of the 17 misdiagnosed patients showed the ability to respond to a command ... within 16 days of admission. The exception was patient B; we did not identify his responses until 25 weeks after his admission, though it was obvious from subsequent conversations with him that he had not been vegetative for some time."

²⁰⁰ Subsection entitled 'Ambiguities in the term 'misdiagnosis'' earlier in this Section.

²⁰¹ The Times 27-3-1997.

²⁰² Jennett and Plum [*op.cit.* p.737]:

"Although we would not deny that a continuum must exist between this vegetative state and some others described, it seems wise to make an absolute distinction ..."

consciousness. Borthwick also argues that because, at the margin between 'locked-in syndrome' and PVS, the behavioural characteristics that denote consciousness are minute, and easily overlooked, the danger of patients being diagnosed as PVS - when in fact they are not - is particularly acute. This point is well vindicated by the Andrews (1996) study considered earlier in Section 3.

Borthwick also questions why there has been no medical study to seek to determine whether recovered PVS patients did in fact experience pain.²⁰⁴ As mentioned earlier,²⁰⁵ the BMA Guidelines actually *preclude* this asking of this question.²⁰⁶

The 'permanence' of PVS

Borthwick points out that Jennett and Plum, in their original paper wished to identify an '*irrecoverable state*'. He suggests that the Multi-Society Task Force on PVS, in essence, manipulated the recovery figures to support their contention that, after 12 months in a PVS, recovery was only possible in an insignificant number of cases. He argues that this is a self-validating exercise:

*"... and if, of course, patients with PVS are encouraged to die when ethicists believe that their condition is morally certain then we can at least be sure that the number of disconfirming recoveries will drop to negligible proportions and the statistics will fall into line with the theories."*²⁰⁷

Borthwick's criticism of the use of the term '*permanence*' by the Task Force does not adequately reflect their proposals in that (unlike the 'President's Commission' or indeed to the BMA Guidelines) they clearly distinguished between '*persistent*' - as diagnosis - and '*permanent*' - as prognosis.

However, Borthwick's final conclusion:

*"To say, as the consensus statement²⁰⁸ says: 'By definition, patients in a persistent vegetative state are unaware of themselves or their environment.' is to raise evasion to the level of a diagnosis and denial to the status of a philosophy."*²⁰⁹

This is a serious and sobering criticism of the approach adopted by the Task Force.

The role of the medical ethicists.

Borthwick believes that almost all medical ethicists who discuss post-coma survival, have been guilty of '*pernicious oversimplification of the medical background to their ideas*'²¹⁰ and that this

²⁰³ Though Susan Greenfield, as mentioned earlier in Chapter 1, compares consciousness to a 'dimmer switch'.

²⁰⁴ Borthwick (1995b) p.206.

²⁰⁵ in Section 2.

²⁰⁶ In that the guidelines assert that such patients have not 'recovered' but were originally misdiagnosed.

²⁰⁷ Borthwick (1995b) p.208.

To illustrate the '*self confirming nature of the diagnostic criteria*' Borthwick cites the case of Carrie Coons who after her recovery was deemed never to have been in a PVS.

Borthwick gives an entertaining and instructive example of how the characteristics of the diagnosis are rendered immune to modification through observation.

"If you diagnose a number of people as having tuberculosis and all die, that outcome may for a time be accepted as a characteristic of the condition. If one eventually recovers, however, you will presumably modify your description of the disease to omit the words 'invariably fatal' - will do so, at least, if you follow the usual pattern of medical development. If, contrariwise, you were to work on the rather more specialized PVS model of nosology you would note that while all patients with tuberculosis invariably died there was another rarer, different, but observationally indistinguishable condition called pseudotuberculosis whose patients invariably recovered. It is not clear that this is the most helpful approach to the problem."

[Borthwick (1996) p.170]

²⁰⁸ i.e. The Multi-Society Task Force on PVS (a) p.1501.

²⁰⁹ Borthwick (1996) p.187.

²¹⁰ A quotation from Chris Borthwick's web page.

See also Borthwick (1995b, p.206):

emerges clearly from any close reading of their work on this topic. He suggests that, in ethical discussion of these issues, it is usually taken as axiomatic that PVS patients have no consciousness;²¹¹ Ronald Dworkin, for example, states:

*"Some accidents and diseases leave their victims in comas or in what doctors call a persistent vegetative state. In either case they are unconscious - though many patients in a persistent vegetative state have open moving eyes - and the higher centres of their brains have been permanently damaged in a way that rules out any return to consciousness. They are capable of no sensations and no thoughts."*²¹²

Borthwick suggests that the discipline of medical ethics tends to describe conditions:

*"... in the manner that produces the clearest ethical conclusions, rather than in a manner that takes account of the inevitable ambiguities of uncertain knowledge."*²¹³

He argues that the medical ethicists' inability to cope with the uncertainties inherent in real situations distorts the ethical debate and can result in inappropriate and indeed unethical consequences being advocated in particular cases. The most disquieting example given by Borthwick, of such intervention is in relation to Carrie Coons;²¹⁴ in this case the ethicist Bonnie Steinbock suggested that the (then recovered) Carrie Coons' expressed wish to continue living was not rational and need not be heeded:

*"Her capacity for assessing evidence has been affected by her own bizarre experience ... Courts should resist the temptation to oversimplify this job by treating a patient's utterances during brief periods of consciousness as determinative."*²¹⁵

Conclusions

Borthwick has been one of the very few academics²¹⁶ to challenge the philosophical presumptions underpinning PVS. His criticism of the assertion that PVS patients lack consciousness and cannot experience pain, are trenchant; they appear not to have been acknowledged in the literature, much less answered. His observations - like that of the child who pointed out the king really had no clothes! - are refreshingly direct and much needed in that they bring into the open, questions which have for too long been denied.

His criticism of the role of medical ethics is also apposite. If ethical theory - in distorting the complexities of life so that they fit into convenient ethical categories - validates inappropriate consequences, then surely such an intervention is, in itself, profoundly unethical. In short the *primary* obligation of any ethicist is to be as fully open as is possible to the complexities of an actual

"In simplifying the issue to the point where a clear moral answer emerges, they [i.e. medical ethicists] eliminate the uncertainty that constitutes the source of the primary moral difficulty."

²¹¹ Borthwick (1995b) p.206.

²¹² quoted in Borthwick (1996) p.168.

²¹³ Borthwick (1995b) p.208.

²¹⁴ Carrie Coons had been diagnosed a PVS. A court application had been made, and granted, to withdraw ANH. However, before the tube feeding could be withdrawn, Carrie Coons woke up and started eating and speaking. She said that she did not wish to die. [Borthwick (1996) p.168].

²¹⁵ Borthwick (1996) p.186.

²¹⁶ Although disquiet has been shown by some academics in newspaper articles e.g.

(i) Prof. Binchy, of the TCD Law School, said members of the Supreme Court had used 'primitive philosophical tools' in discussing PVS. [The Irish Times 12.8.96]

(ii) In speaking of the practice of treatment withdrawal for PVS patients, Pat Walsh, acting director for the centre of Medical Law and Ethics was quoted in the London Independent (13.2.1997) as saying "There is a pressing need for further research to unpack the implicit moral reasoning behind what doctors are doing."

situation - to 'let the situation itself speak'.²¹⁷ To approach a situation with a too-ready conceptual structure, guarantees that only those facts that are considered to pertain to the structure will be seen. In stating:

*"If the discipline of medical ethics cannot cope with uncertainty then it is useless in the real world."*²¹⁸

Borthwick has succeeded in putting the management of doubt in the making of ethical judgements centre stage. This issue is addressed in Chapter 6 of this thesis.

Borthwick also offered deeper reasons - other than simply the convenience of medical practitioners and ethicists - for the confused state of the ethical debate on PVS. Firstly, he suggests that 'denial' plays a considerable role in this debate; whether denial of death, or of situations which we find, personally, too traumatic to contemplate. To substantiate this he quotes the response of a medical witness in the Quinlan case to being questioned on whether Karen Quinlan might be conscious:

*"There is such a situation that can occur, and its theoretically possible, in terms of animal experiments. We've seen such patients with such things. There may be, who knows, meditation, but I don't know how you're going to find out. I think it's one of the most horrendous things you can imagine."*²¹⁹

Borthwick concludes:

*"We wish to believe that people in unendurable situations are unaware, and we resist evidence that would indicate otherwise. Some of us avert our eyes. Others elevate our disquiet to the status of a neurological theory and an ethical imperative."*²²⁰

Secondly, he asks the rhetorical question:

*"Why are the qualities of absence of consciousness, clear differentiation²²¹ and established irrecoverability so important that normal canons of reason must be stretched to accommodate them?"*²²²

In answering this question he suggests that ethicists have had a need to isolate limiting cases and in particular a class of subjects who could be separated from the general run of humans. Anencephalic humans have been one such group and PVS patients another.²²³

These two reasons - the denial of death and limiting cases of humanhood - are considered in later chapters of this thesis from a broader perspective than Borthwick's;²²⁴ and a more appropriate solution to the ethical problems associated with PVS arises out of a consideration of these concepts. Part 3 of this thesis sets out this alternative conceptual structure.

(iii) Gerry White, of the TCD Law School, criticised the lack of clarity in relation to the philosophical issues in the Supreme Court judgement in the Ward Case. [The Irish Times 27.3.1996].

²¹⁷ The role of the medical ethicist is best compared to that of a company auditor who gives an 'imprimatur' to the financial reports of the company. His obligation is to go beyond the assurances of the directors of the company that all is as it should be, and to verify, for himself, that this is so; an auditor recognises that his report will be relied on by the general public; he has an obligation to ensure that matters of importance are independently assessed and are not taken on trust. In a similar fashion a medical ethicist should not take the technical aspects of the problems on which they offer comment, as a given, too esoteric for an independent examination; their obligation is, equally, to scrutinise all.

²¹⁸ Borthwick (1995b) p.208.

²¹⁹ *ibid.* p.207.

²²⁰ *ibid.*

²²¹ *i.e.* from Locked-In Syndrome.

²²² Borthwick (1995a) p 24.

²²³ Borthwick (1995b) p.205.

If a point of criticism might be made of Borthwick's analysis it is that it does not offer any way out of the impasse; nor does it seek to transcend the conceptual structure within which the problems are normally placed - it does not utilise the concept of 'personhood' nor attempt to sever the link between 'personhood' and 'consciousness'. It does not address the difficulty of finding less problematic definitions of PVS nor of attempting to incorporate the existence of uncertainties and doubts - and these are an inevitable component of all medical judgements - into a theory of ethical decision making. It is to these issues that we next turn.

Section 5: A proposal for an alternative definition of PVS

Cases of misdiagnosis of PVS are also cases of misdiagnosis - or, rather, non-diagnosis - of some other condition. Two questions arise:

- (i) *What are these other conditions? and*
- (ii) *What diagnostic criterion of PVS was incorrectly perceived by the diagnosing physician as being present, and what diagnostic criterion of the correct condition was missed?*

These questions have been ignored in the rush to insist that cases of patients, who had been diagnosed as being PVS but who had subsequently manifested awareness, were cases of *misdiagnosis* rather than *recovery*. For example, the Grubb studies - which were laudably insistent on the need, in discussing PVS, to use appropriate terminology - made their own contribution to misleading terminology, when²²⁵ they stated that :

*"... a recently published report of cases in one hospital in the United Kingdom suggests that many patients who are regarded as being vegetative have in fact been misdiagnosed. Some patients diagnosed as being vegetative state were in fact in a locked in syndrome."*²²⁶

The phrase 'locked-in syndrome' does not appear in the Andrews article. It may well be that some patients should have been diagnosed as having 'locked-in syndrome' but then the diagnostic criteria for 'locked-in syndrome' should be explicitly stated, and it should be shown that these patients did, at the time of diagnosis, fit these criteria. To attempt to resolve the problem of misdiagnosis of PVS by stating that misdiagnosed PVS patients were in fact suffering from 'locked-in syndrome', *without showing that at the time of the original diagnosis, the criteria for 'locked-in syndrome' were satisfied*, is to replace the problem of misdiagnosis of PVS with the problem of misdiagnosis of 'locked-in syndrome'; in reality there is only an illusion of progress no different than when a problem is 'swept under the carpet'.

The only possibility of restoring clarity to the debate is to return to first principles - to the definition of PVS; for if the definition is uncertain, then all subsequent discussion is based on shifting sands. Only through clarity of definition can subsidiary questions, such as the distinction between misdiagnosis and recovery, be resolved.

The goal of this section is to establish an alternative definition of PVS based on enduring inability to communicate. This definition resolves many of the problems currently associated with the diagnosis (and the misdiagnosis) of PVS. The section is structured into four subsections:

Subsection1: Compares the criteria that have been used, either implicitly or explicitly, to define PVS.

²²⁴ 'Death' - and in particular the concept of 'a' good death' - is considered in Chapter 9. The concept of 'personhood', and a necessary condition for its ascription, is considered in Chapter 10.

²²⁵ in discussing the Andrews Report (1996) on misdiagnosis of PVS.

²²⁶ EC BIOMED 1 'Inquiry Into Law And Regulation - An Overview.' PVS Questionnaire 1996. at p.1.

Subsection2: Examines the medical conditions which are similar to PVS. The main problem in relation to the diagnosis of PVS is not its diagnosis as such, but its differential diagnosis - that is, how it is to be distinguished from a small number of medical conditions with which it may be confused. The 'Locked-In Syndrome' is found to be the condition whose differentiation from PVS presents the greatest difficulties. Thus, the problem is to define both of these conditions in a manner that best facilitates their being distinguished from each other.

Subsection3: Examines the theoretical requirements that the definitions of PVS and Locked-In Syndrome should satisfy in order to best facilitate a differential diagnosis.

Subsection4: Proposes definitions of both PVS and the Locked-In Syndrome. The definition of PVS which is proposed is PVS_{COM} as discussed in Section 1.

Subsection 1. The various criteria used to define PVS

Much of the controversy that has surrounded PVS relates to lack of certainty in its diagnosis; 'misdiagnosis' is nothing but the other face of this particular problem. This lack of certainty can be examined from two interrelated perspectives, firstly from that of theory/practice and secondly from that of 'absolute diagnosis'/'differential diagnosis'.

The perspective of theory/practice

The need for theoretical clarity in drawing the distinction between PVS and other conditions is patent, for unless this is done any attempts at drawing clinical distinctions - and resolving the problem of misdiagnosis - are bound to fail.

The perspective of 'absolute'/'differential' diagnosis

The problem of seeking a definition of PVS can be tackled either by seeking a set of necessary and sufficient criteria for the diagnosis - such could be described as leading to an 'absolute' diagnosis - or by seeking a criterion, or set of criteria which would permit the condition to be differentiated from other conditions - a 'differential' diagnosis.

In its broad outlines PVS does not present any problems in definition - the image of the open eyed, but apparently unresponsive, patient is stark. The difficulties that occur relate to its differential diagnosis - *i.e.* to distinguishing PVS from a small group of other conditions with which it may be confused. It is clear then that what is required is a criterion which will not only theoretically permit a differential diagnosis of PVS, but which is of value in a clinical setting, which is after all where the differential diagnosis must be made.

The various criteria that have been used, either explicitly or implicitly, in the definition of PVS have been described in earlier sections of this chapter. The relationships between these various criteria are represented in the following diagram, from which it can be seen that these criteria are not equivalent, for example, the group of patients who are conscious is not identical to the group which manifest conscious behaviour. Since these criteria are not equivalent it is important that one be clearly chosen as a '*definitional criterion*'; the relationship of the other criteria to this definitional criterion being then a matter of experimental verification and *not* of definition.

Most attempts at definitions have used 'awareness as judged behaviourally' as the main diagnostic criterion. Unfortunately most have sought to subsequently incorporate further criteria - such as lack of consciousness or permanence, which are not *logically* equivalent to the main

definitional criterion - into the definition. Others, such as Andrews and The Multi- Society Task Force, implicitly use 'lack of consciousness' as the primary criterion.

Criterion:	Advocated by:	'LS-PVS'	
<u>never</u> recover 'actual' consciousness		will recover consciousness	Never recover consciousness
<u>never</u> manifest 'conscious' behaviour	BMA (implicitly)	will manifest 'conscious' behaviour	Never manifest 'conscious' behaviour
<u>never</u> recover ability to communicate		will communicate	Never communicate
<u>now</u> - no 'actual' consciousness	Andrews (implicitly)	conscious at present	No present consciousness
<u>now</u> - no 'conscious' behaviour manifested	Jennett and Plum definition	manifesting 'conscious' behaviour at present	No present manifested 'conscious' behaviour
<u>now</u> - no ability to communicate	Proposed usage	able to communicate at present	No present ability to communicate

Table 4-5: The relationship between the differing criteria used in the definition of PVS

*N.B.: - It is convenient to have a term to refer to that group of patients who are - on a preliminary examination but before a differential diagnosis is made - considered to be either 'PVS' or 'Locked-In Syndrome'; the acronym 'LS-PVS' is the term used to refer to this group. These are patients who are open-eyed but apparently unresponsive and who display primitive postural movements. The right hand part of the table indicates how this undifferentiated group are partitioned by the differing criteria such as manifestation of 'conscious' behaviour or ability to communicate etc.; the unshaded portion refers to those who do not possess the criterion, the shaded portion to those who do:

criterion	'LS-PVS'	
	do not possess criterion	possess criterion

The purpose of the table is to show graphically how the partitions occasioned by these different criteria relate and that they are not equivalent.

Subsection 2. The competing medical conditions²²⁷

The Multi-Society Task Force on PVS²²⁸ describe the conditions of severe neurological disability which are similar to PVS. With the exception of the 'Locked-In Syndrome' and 'Akinetic Mutism' - which will be considered separately - these are listed in the Table 4-6 along with the criterion which enables them to be differentiated from PVS or Locked-In Syndrome:

<u>Condition</u>	<u>Differential criterion</u>
Coma	The eyes remain closed.
Brain death	Either 'permanent absence of all brain functions, including those of the brain stem', or 'complete absence of cortical activity'.
Dementia	Progressive loss of cognitive functions in which arousal mechanisms are usually normal. Some awareness is present.
Apallic syndrome	Jennett and Plum had distinguished this term from PVS but the Task Force recommended the discontinuance of its use. The President's Commission considered it to be equivalent to PVS. ²²⁹
Akinetic mutism	<u>Discussed separately below</u>
Locked-In Syndrome	<u>Discussed separately below</u>

Table 4-6: The conditions with which PVS may be confused.

²²⁷ The competing conditions, as described by Jennett and Plum, were considered in Section 1 of this Chapter; the conclusion reached there was:

Conclusion 4.3 : According to Jennett and Plum, the diseases of responsiveness that might be confused with PVS are 'Akinetic Mutism', 'Locked-In Syndrome' and 'Apallic Syndrome'. 'Akinetic Mutism' is better described as a disease of limited responsiveness rather than unresponsiveness; 'inability to communicate' is either not present or, if present, is not believed to be permanent. In 'Locked-In Syndrome' communication is possible though by a primitive means. 'Apallic Syndrome' is a condition which, in so far as it differs from PVS, is characterised by the inability to communicate not being permanent.

²²⁸ The Multi-Society Task Force on PVS (a) p.1502 et seq.

²²⁹ President's Commission [p. 174, footnote 9]:

"The term 'vegetative state' (or, more anatomically, 'apallic syndrome') denotes unconsciousness with persistent brain-stem functions that maintain subsistence functions and often wakefulness."

Despite the surveys by Tresch (who found widespread confusion between the terms 'PVS' and 'coma') and Childs (who found some confusion between the terms 'PVS' and 'dementia') considered earlier,²³⁰ it appears that the 'differential' diagnosis of these conditions from PVS does not present any *theoretical* difficulties.

The condition of 'Akinetic Mutism' - which Schmutzhard²³¹ believes '*needs clear differentiation from vegetative states*'²³² - is more problematic. Both Jennett and Plum and the Multi Society Task Force, suggest some speech is present in this condition; this would obviously provide a criterion sufficient to theoretically differentiate it from PVS. Schmutzhard considers the existence of definite periods of eye fixation (usually lasting several minutes) as the criterion which allows differentiation from the vegetative state.²³³ The various criteria are set out in the Table 4-7:

Akinetic Mutism	Differential criteria
Jennett and Plum	The term 'Akinetic Mutism' presents ' <i>considerable semantic problems</i> ' and ' <i>the akinesia and the mutism do not always go together</i> '. Furthermore it seems that the mutism may only be relative " <i>[his] patient would answer in whispered monosyllables, whilst other reported patients would use sign language to communicate.</i> " ²³⁴
The Multi-Society Task Force on PVS	Pathologically slowed, or nearly absent, bodily movement and loss of speech.
Schmutzhard	Shows periods of definite fixation of eye movements; no mention is made of occasional speech.

Table 4-7: Criteria to enable 'Akinetic Mutism' to be distinguished from PVS.

This leaves Locked-In Syndrome as the remaining condition from which PVS needs to be distinguished. As stated earlier²³⁵ a term is required to enable both these conditions to be discussed together as one *i.e.* in their undifferentiated state; the joint acronyms 'LS-PVS' suffices for this.

Our problem can now be rephrased as to find a criterion which is operative in the 'LS-PVS' field and will enable it to be partitioned into two mutually exclusive categories, one of which is PVS, and the other is the Locked-In Syndrome. The general conditions required for such a criterion will be considered after we have examined various definitions of the '*locked-in syndrome*'; these are summarised in the following table:

²³⁰ in Section 3.

²³¹ Erich Schmutzhard. 'Persistent Vegetative State : Ethical problems arising for the doctor'. European Conference on The moral issues surrounding the treatment and health care of patients in persistent vegetative state. Conference file. Bonn: IWE, (1995).

²³² *ibid.* p.4.

²³³ *ibid.*

²³⁴ Jennett and Plum *op.cit.* p.735.

²³⁵ Table 4-5.

Locked-in syndrome	Differential criteria
Jennett and Plum	"Such patients entirely awake, responsive and sentient, although the repertoire of response is limited to blinking, and jaw and eye movements." ²³⁶
The Multi-Society Task Force on PVS	'consciousness and cognition retained but movement and communication impossible' but 'can usually establish limited communication through eye movement signals'. ²³⁷
Schmutzhard	Complete paralysis of all voluntary muscles except for vertical eye movements. "A patient with locked-in syndrome is able to communicate by blinking code in purposeful and intelligent ways." ²³⁸

Table 4-8: 'Locked-in syndrome' as defined by various authorities

The voluntary use of the eye muscles - leading to the ability to communicate - is noted by both Jennett and Plum and by Schmutzhard. The Task Force, however, does not see these eye movements as being necessary (they speak of 'usually'). The reason for this is, perhaps, that since they conceded that certain patients could in fact be conscious without these patients manifesting any 'conscious' behaviour (the 'frozen-aware' spoken of earlier), and since they wish to assert that *all* PVS patients are unaware, their redefinition of the Locked-In Syndrome becomes *logically* necessary. The practical consequence of this should be that a clinician, faced with a patient in the condition tentatively identified as 'LS-PVS'²³⁹, *who consistently manifested no 'conscious' behaviour*, should not diagnose the patient as PVS but should suspend judgement, leaving open the possibility of either a PVS or a Locked-In Syndrome diagnosis. This conclusion is necessary since the Task Force offers no other definitive criteria to distinguish between PVS and the Locked-In Syndrome patients. However, the whole tenor of their report is to suggest that such a patient should be diagnosed as PVS. It seems that in the interests of stating that all PVS patients are unaware the intellectual clarity of the Jennett and Plum definition was sacrificed - exemplifying the intellectual dishonesty spoken of earlier by Borthwick in his final conclusion.²⁴⁰ Furthermore, the Task Force's 'redefinition' of the Locked-In Syndrome was not done explicitly; nor were any reasons advanced as to why such a redefinition was necessary. For these reasons and because Plum was one of those to first describe the syndrome as such²⁴¹ and, more importantly, for reasons of intellectual clarity, the definitions of the Locked-In Syndrome proposed by Jennett and Plum, and by Schmutzhard, is - with a proviso - being adopted here in contrast to that implicitly suggested by the Multi Society Task Force Report.

A proviso is necessary because there are patients who are open-eyed, apparently unresponsive and who display primitive postural movements, but who it is found subsequently can communicate by some primitive bodily movement other than eye movement. For example, patient B of the Andrews (1996) study was such that:

²³⁶ Jennett and Plum *op.cit.* p.736

²³⁷ Multi-Society Task Force (a) p.1502 [*emphasis added*] The Report continues:

"Diagnosis of the Locked-In Syndrome is established by clinical examination."

and goes on to suggest that PET scans:

"... have shown higher metabolic levels in the brains of patients in the Locked-In Syndrome than in patients in the persistent vegetative state." [*op.cit.* p.1502]

The circularity of this reasoning has been mentioned in Section 2 and has also been pointed out by Borthwick (see Section 4).

²³⁸ Schmutzhard *op.cit.* p.4.

²³⁹ i.e. either PVS or Locked-In Syndrome.

²⁴⁰ "To say, as the consensus statement says, 'By definition, patients in a persistent vegetative state are unaware of themselves or their environment.' is to raise evasion to the level of a diagnosis and denial to the status of a philosophy." [Borthwick (1996) p.14]

²⁴¹ The term 'Locked-In Syndrome' was coined by Plum and Posner in 1965; see: Jennett and Plum p.736

"Only when he was satisfactorily seated was it identified that he had a slight shoulder shrug which could be used for communication purposes."²⁴²

Patient B is not PVS, he is not Locked-In Syndrome (as traditionally defined) and yet he clearly belongs to that same continuum. One possibility is to introduce a new term for such patients who can communicate in a primitive manner by use of other than eye movements, the alternative is to widen the term Locked-In Syndrome. However because no ethical or legal distinction can be drawn between such patients and those traditionally described as Locked-In Syndrome - though there may be valid clinical reasons for a distinction - the term will be used in this wider sense:

Conclusion 4-16: *The Locked-In Syndrome is distinguishable from PVS in that a patient with locked-in syndrome is able to communicate by using the blinking of an eye, or some equally primitive bodily movement.*

Subsection 3. The theoretical requirements on definitions to best enable differential diagnosis

In the context of a patient being diagnosed as 'LS-PVS' - i.e. either PVS or Locked-In Syndrome - it is clear that criteria for differentiating between 'locked-in syndrome' and PVS must themselves satisfy a number of conditions:

- (i) The criteria must be such that PVS and the Locked-In Syndrome are *mutually exclusive* diagnoses. The situation exemplified in Example 1 (Table 4-9) cannot be allowed to occur.
- (ii) The criteria must be such that PVS and the Locked-In Syndrome are *exhaustive* of the field of definition - i.e. 'LS-PVS' - and not as is represented in Example 2 (Table 4-9). Jennett and Plum, in so far as they defined the 'locked-in syndrome' in terms of ability to communicate and PVS in terms of the absence of 'conscious' behaviour, did not obey this condition. A patient who was unable to communicate but who showed some purposive behaviour - such as 'Case 2' in the Andrews (1993b) study - fits neither category.

To ensure the complementarity desired, the criteria must succeed in partitioning the field of definition in a manner such as is represented in Example 3 (Table 4-9). One direct and simple method of achieving this is to forsake attempts at *independent* definitions of PVS and the Locked-In Syndrome and to use, as the defining criterion for PVS, the negative of a criterion used to define the Locked-In Syndrome, - i.e. if the Locked-In Syndrome is (within LS-PVS) defined by criterion 'X', then PVS is defined by the criterion '*not-X*'.

The field of definition: 'LS-PVS'		
<u>Example 1</u> <i>criteria exhaustive but not mutually exclusive</i>	PVS	
		Locked-in syndrome
<u>Example 2</u> <i>criteria not exhaustive but mutually exclusive</i>	PVS	
		Locked-in syndrome
<u>Example 3</u> <i>complementary criteria</i> <i>i.e. both exhaustive and mutually exclusive</i>	PVS	
		Locked-in syndrome

Table 4-9: General conditions to which a definition must conform to enable it to provide a differential diagnosis between two competing diagnoses

²⁴² Andrews (1996) p.15.

Subsection 4. Proposed definition of PVS

The Locked-In Syndrome has been defined in terms of the ability to communicate. Therefore, if - in the context of 'LS-PVS' - PVS is defined as inability to communicate the conditions just specified are satisfied. This is, in fact, the definition PVS_{COM}, considered earlier in Section 1 in discussing the Jennett and Plum 1972 paper.

Conclusion 4-17: *The persistent vegetative state is characterised by seeming wakefulness in the absence of an ability to communicate.*

The meaning of the term 'communicate' requires some clarification so that objections, such as those of Cranford - who had '*viewed the buzzer system with some scepticism*'²⁴³ - can be countered. This is undertaken in Chapter 10 where the *level* of communication required is also discussed. It will be argued in Chapter 10, that a necessary condition for the ascription of personhood is that communication is possible to some minimal level. A level that naturally suggests itself is one which would permit the patient to express their views on the continuance, or withdrawal, of treatment.

The advantages of these definitions over their alternatives are considered in Section 6.

Section 6: Conclusions

Three topics, it is clear, are of pivotal importance to any discussion of PVS:

- (i) The misdiagnosis of PVS.
- (ii) The definition of PVS, and its distinction from Locked-In Syndrome.
- (iii) The possible reasons for, what appears to be, a systematic manipulation of the normal canons of rational discourse in favour of a particular conclusion - *i.e.* that PVS patients have no awareness, can feel no pain and - if in the PVS state for more than 12 months - cannot recover.

This last suggestion may seem extreme, yet the dissimulation - in, for example, the BMA guidelines and the Institute of Medical Ethics Working Party Report²⁴⁴ - is such that some explanation is required.

Misdiagnosis

One of the conclusions²⁴⁵ of Section 3 was that the best estimate for the rate of misdiagnosis of PVS is of the order of 50%; diagnosis of PVS is essentially a random process. Such a rate of misdiagnosis is bizarre and loudly bespeaks the need for a theoretical reevaluation of PVS. Furthermore, that such a high level of misdiagnosis is not considered relevant²⁴⁶ to ethical commentary of PVS is equally bizarre, and it also requires explanation.

²⁴³ Cranford *op.cit.* p.5.

²⁴⁴ as discussed in Section 2.

see also Borthwick's comment that the Multi-Society Task Force report raised - '*denial to the status of a philosophy.*' [Borthwick(1996)p.187] and further:

"Why are the qualities of absence of consciousness, clear differentiation and established irrecoverability so important that normal canons of reason must be stretched to accommodate them?" [Borthwick (1995a) p25]

²⁴⁵ Conclusion 4-12.

²⁴⁶ in that the level of misdiagnosis is not acknowledged by such commentary; see, for example, Ronald Dworkin's discussion mentioned in Section 3.

The first step to a reevaluation of PVS is at the level of its definition. New definitions of PVS and Locked-In Syndrome have already been outlined (they are discussed in the next subsection); these definitions help to establish a rigorous foundation for a discussion of PVS and related issues.

The existence of doubt, or uncertainty, is a fundamental feature of most situations in life, especially in those which give rise to ethical controversy. Ethical commentaries which, driven by a need for theoretical harmony, deny this doubt and oversimplify the existing situation can result in profoundly inappropriate 'solutions' being advocated.²⁴⁷ In Chapter 5, a schema is suggested to permit the existence of doubt to be incorporated into ethical decision making; this permits the level of misdiagnosis to find expression in ethical discussions concerning PVS patients.

Advantages of the proposed definitions of PVS and Locked-In Syndrome

The differential definitions being proposed for the Locked-In Syndrome is:

*'The Locked-In Syndrome is distinguishable from PVS in that a patient with locked-in syndrome is able to communicate by using the blinking of an eye, or some equally primitive bodily movement.'*²⁴⁸

That for PVS is:

*'The persistent vegetative state is characterised by seeming wakefulness in the absence of an ability to communicate.'*²⁴⁹

The advantages of these proposed definitions are that:

- (i) a clear, practical, intellectually rigorous distinction between PVS and the Locked-In Syndrome becomes possible. This distinction is based securely on the 1972 paper by Jennett and Plum which originally described PVS as such.²⁵⁰
- (ii) Because the definition of PVS is based on 'inability to communicate', the problematic concept of '*near-PVS*' is not required.
- (iii) The problem of distinguishing between cases of misdiagnosis and cases of recovery is, to a considerable extent, 'dissolved':-
a PVS patient was 'misdiagnosed' if, at a particular time, he was able to communicate but this was not recognised; the correct diagnosis would have been Locked-In Syndrome.²⁵¹
If, however, at the time he was diagnosed as PVS, he was not able to communicate, but subsequently became able, then his case is one of recovery and not misdiagnosis *even though he may have been conscious at the time of the original diagnosis*.
The adoption of such definitions would bring a terminological clarity to the discussion of misdiagnosis in studies such as Andrews(1996).
- (iv) The chimera of determining patient 'awareness' disappears; the definition makes no assumptions about the consciousness of PVS patients nor their ability to experience pain. It would permit the analgesic treatments of PVS patients without, thereby, resulting in theoretical inconsistency.
- (v) From the studies on misdiagnosis, it is clear that some PVS patients have some level of consciousness and can experience pain, and that there is no method for determining which

²⁴⁷ See Section 4.

²⁴⁸ Conclusion 4 -16.

²⁴⁹ Conclusion 4 -17.

²⁵⁰ when PVS is understood as PVS_{COM} - see Section 1.

PVS patients these are. In Chapter 5 it is argued that the correct ethical decision is to treat *all* PVS patients as *if*²⁵² they are conscious and can experience pain.

- (vi) The definition of PVS, in so far as it coincides with a necessary condition for the ascription of personhood - *i.e.* the ability to communicate to some minimal standard, permits an elegant and intellectually satisfying method of resolving the ethical problems associated with end of life decisions in relation to PVS patients without the danger of introducing a 'slippery slope' - these issues are pursued in Part 3.
- (vii) The definition of PVS in terms of communication, restores an important role to the family and carers of PVS patients, in determining the absence of communication.²⁵³ This permits end-of-life issues concerning PVS patients to be resolved in a much more appropriate fashion than at present. The opportunities for disagreement between family and medical staff would be considerably lessened²⁵⁴ if the criterion being considered was 'communication' rather than 'awareness'. The treatment of the patient as *if* they were conscious might also be therapeutic for the patients' family and permit a less distressing 'leave taking' - these issues are pursued in Chapter 9 where the concept of '*a good death*' is examined.
- (viii) The definition in terms of communication, rather than behaviour, implies an *ongoing obligation* on the medical staff to attempt to establish communication. The requirement is not a passive one - as is observing behaviour - but an active one which would necessitate creative, multidisciplinary endeavours to stimulate and observe the patient; as such it would be in accord with 'current best practice' as exemplified by such as Andrews (1996).
Andrews spoke of the need for developing stimulation programmes to help evince awareness in PVS patients,²⁵⁵ and, in this, he saw a role for the patient's family. Such attempts at stimulation can be interpreted as attempts at communication and the obligation to attempt such stimulation programmes would flow naturally from a definition of PVS framed in terms of communication. In the event of such stimulation programmes not eliciting a response - *i.e.* communication not being established - a diagnosis of PVS_{COM} would follow. A second proposal of this thesis is that 'personhood' is lost if the inability to communicate is judged to be permanent. I suggest that such a definition would usually be in accord with the families' meaning of this term, particularly if they had been closely involved in the attempts to establish communication. A judgement that personhood was lost would permit either treatment withdrawal or other alternatives to be considered; these issues are considered in detail in Part 3.
- (ix) The question of 'permanency' - *i.e.* in 'permanent' inability to communicate - would resolve itself in a natural fashion dependent on the particular patient and their responses.²⁵⁶
Judgements of 'permanence' would flow - not from arbitrary time scales as at present - but naturally from the intensity of the effort used in attempting to establish communication, and the actual patient response, if any.

²⁵¹ used in the wider sense of Subsection 2 of this Section.

²⁵² the term '*as if*' is not meant to suggest some pretence, but rather an attitude of acceptance of the fact that some patients undoubtedly are conscious and that we have no way of knowing which.

²⁵³ This is also in accord with the recommendations of the Childs study; see Appendix A.

²⁵⁴ A study, mentioned by Borthwick, found 92% disagreement between doctors and the parents of children, diagnosed as PVS, regarding the children's awareness. [Borthwick (1996) p.174.]

²⁵⁵ Andrews (1992) p.486.

²⁵⁶ The case of 'Patient B' in the Andrews 1996 study exemplifies what is being suggested; responses were identified only after 25 weeks of admission to the programme and even then the only response was a slight shoulder shrug. [Andrews (1996) p.14]

The patient, known as Case 2²⁵⁷ in the Andrews (1993b study), who recovered awareness, but not the ability to communicate, is of particular interest in that it appears to present an obstacle to the definitions of PVS and 'personhood' which this thesis advocates. Andrews' definition of awareness, however, involved two distinct levels of awareness, firstly, the ability to eye track - that is to follow moving objects with one's eyes²⁵⁸ and secondly, the ability to respond to a command such as to blink, or to squeeze a hand. Case 2 did track moving objects but did not respond to commands but *'he laughed appropriately at cartoons and showed pleasure when his wife visited and distress when she left.'*²⁵⁹ The apparent difficulty is resolved if it is seen that the suggested definition of PVS - PVS_{COM} - is based on an inability to communicate but 'loss of personhood' is defined as occurring only when this inability is judged to be *permanent*. Case 2 would, on these definitions, be considered as in a PVS but as not having lost personhood.²⁶⁰ Case 2 is simply a case in transition about whom no judgement as to permanency can be made either way; this is born out by Andrews' observation that *'at five years after brain damage he [i.e. Case 2] was still developing new responses.'*²⁶¹ and that, generally, the ability to respond to commands occurred some time after the ability to eye-track.²⁶²

I wish to draw a final conclusion from this discussion:

Conclusion 4-18: *Definitions of PVS and Locked-In Syndrome framed in terms of ability to communicate, provide a more fitting resolution of the problems associated with PVS than do alternative definitions.*

Possible reasons for the unsatisfactory nature of current debates on PVS ?

I suggest that the reasons for the unsatisfactory nature of the current debate on PVS are twofold. Firstly, the debate is 'conclusion lead' and secondly, the concept of 'consciousness' is forced to play an inappropriate role in the discussion.

A 'conclusion lead' debate?

By using this phrase 'conclusion lead' I mean to suggest that many commentators - ethical, medical and legal - believe that the correct resolution of problems associated with PVS, and PVS-like, patients is to 'allow' them to die. They may believe this from the most altruistic of motives - such as concern for the patient's and their families welfare, or from less exalted motives - such as a concern over the utilisation of scarce resources, or simply out of personal denial - in that they find the situation of a PVS-like patient too horrendous to contemplate.²⁶³ This resolution may indeed be

²⁵⁷ Andrews (1993b); see Table on p 1598.

²⁵⁸ Though he noted [*op.cit.* p.1599] that:

"Some experts regard this as a reflex pattern, and it is therefore debatable whether this is a true sign of awareness."

²⁵⁹ This is the case referred to by Raanan Gillon in his article 'Patients in the persistent vegetative state: a response to Dr Andrews. *British Medical Journal*, (1993).

²⁶⁰ In that there is a possibility that the ability to communicate may be regained; as such the patient has an 'attenuated personhood'. (The concept of 'attenuated personhood' relates to an individual who though not having a present ability to communicate, may regain this ability at some future stage; the rights of 'attenuated persons' differ from those of 'persons'. The concept of 'attenuated personhood' is discussed Chapter 10.)

²⁶¹ Andrews (1993b) p.1599.

²⁶² *ibid.* p.1598.

²⁶³ The fact that medical professionals may well be interested parties in the debate on the withdrawal of ANH for PVS and other, patients should not be overlooked. Many cases of medical negligence result in brain damage and such patients may well be diagnosed as PVS; such indeed were the circumstances in the Ward case. The damages in a medical negligence action are calculated on the probable cost of providing life-long medical care; thus, if the accepted practise is to withdraw life-sustaining treatment after one year, then the premiums for medical insurance are substantially reduced as are awards

the most fitting resolution for these problems, however, the desired conclusion must not be allowed to dictate the debate. The concepts, definitions and terminology must not be structured, or distorted, to facilitate the reaching of a desired conclusion. The efforts of, for example, the Institute of Medical Ethics, to suggest (in speaking of the hope of the families of PVS patients for the patients recovery) that it is 'unfair and unkind to allow such optimism to be sustained';²⁶⁴ *without mentioning that the diagnosis has a 50% chance of being wrong*, bespeaks a paternalism which is at best outdated. It is, in effect, an abrogation of the rights of both the patient and their family; as such, it is a denial of the 'personhood', not only of the patient, but also of each member of their family.²⁶⁵ The insistence by the BMA Guidelines that cases of recovery from PVS are after 12 months, logically impossible is equally blameworthy. Lest this appear as an overstatement consider the following:

Scenario: The parent of a patient 'John', who had been diagnosed as PVS for over 12 months, is discussing the possibility of recovery with the patients consultant.

<u>Parent</u>	What is John suffering from?
<u>Consultant</u>	He is in a persistent vegetative state.
<u>Parent:</u>	Has John any awareness of his condition?
<u>Consultant</u>	Awareness is completely impossible in a PVS.
<u>Parent:</u>	And he cannot feel pain?
<u>Consultant</u>	Of course not.
<u>Parent:</u>	Is there any chance that he might recover?
<u>Consultant</u>	I can categorically state, with the full backing of the British Medical Association, that recovery from such a condition is completely, that is 100%, impossible.
<u>Parent:</u>	Should I then agree to his treatment being withdrawn? ...

Each answer by the consultant is in accord with the BMA Guidelines; his replies would merit the glowing approval of the Institute of Medical Ethics, but is such dissimulation ethical? Could a 'consent' achieved by such means be considered an *informed* consent? Surely not!

An inappropriate role for 'consciousness'?

The problems associated with the definition, diagnosis and misdiagnosis of PVS can be traced in large measure to the assertion that PVS patient have no consciousness. This assertion and the necessity to defend it have bedevilled the discussions on PVS. However, as is evident from the force with which these assertions are made, it is not consciousness *as such* that is in issue - after all to treat PVS patients 'as if' they are conscious is not demanding of resources, either material or human - it is consciousness *as symbol*.

of damages (to, perhaps, 10% of what would be awarded if normal life expectancy were assumed). The existence of such a scenario was argued in a recent English case:

"A hospital has been accused of turning off the life-support machine of a brain-damaged baby to save itself the cost of the infant's long-term care. ... A dead baby is 'worth' £7,500, according to the compensation tables. This compares with a possible multi-million pound bill for a hospital found liable for the lifelong care of a severely handicapped child. ... The hospital has admitted that its mistakes led to the baby's death ..."

[The Sunday Times 30th July 2000 in article entitled 'Baby's life support cut off 'to save care costs']

²⁶⁴ Institute of Medical Ethics Working Party on the Ethics of Prolonging Life and Assisting Death 'Withdrawal of life-support from patients in a persistent vegetative state.' *The Lancet* 1991 at p. 97.

²⁶⁵ In Part 3 of this thesis it is argued 'personhood' is intimately connected with the possession of rights; conversely a denial of rights implies a denial of personhood.

Consciousness - regarded as symbol - is as an icon for Cartesian 'personhood' and the Christian 'soul'; the supposed lack of consciousness thus becoming the token which justifies treatment withdrawal.²⁶⁶ This suggests that the relevant concept is not 'consciousness' but 'personhood' and that, in relation to PVS patients, the attempts to determine the existence, or otherwise, of consciousness have been a 'cul-de-sac'.

The approach being suggested in this thesis is that, when considering necessary conditions for personhood,²⁶⁷ it is not 'consciousness' but rather 'the ability to communicate to some minimal extent' which is the appropriate necessary criterion. If PVS is defined in terms of 'inability to communicate' then the determination that such is permanent is in fact a determination of loss of personhood. If, at this stage, questions of the scarcity of resources are relevant to such an extent that a choice must be made between two patients one of whom has lost their personhood, then the appropriate choice is naturally dictated by the very meaning of the concept of 'personhood'. These ideas are analysed more fully in Part 3.

The conclusions that were established in this Chapter are:

Conclusion 4.1 : *The definition of PVS and the distinction between it and Locked-In Syndrome given by Jennett and Plum is capable of being formulated either in a 'mentalist' (PVS_{MTL}) or behaviourist (PVS_{BEH}) terminology or in terms of an inability to communicate (PVS_{COM}). The mentalist formulation is peripheral.*

Conclusion 4.2 : *The Jennett and Plum discussion of PVS is unsatisfactory in that in attempting to identify an irrecoverable condition, it ignores the position of those who recover from a condition which at the time of diagnosis was indistinguishable from PVS.*

Conclusion 4.3 : *According to Jennett and Plum, the diseases of responsiveness that might be confused with PVS are 'Akinetic Mutism', 'Locked-In Syndrome' and 'Apallic Syndrome'. 'Akinetic Mutism' is better described as a disease of limited responsiveness rather than unresponsiveness; 'inability to communicate' is either not present or, if present, is not believed to be permanent. In 'Locked-In Syndrome' communication is possible though by a primitive means. 'Apallic Syndrome' is a condition which, in so far as it differs from PVS, is characterised by the inability to communicate not being permanent.*

Conclusion 4.4 : *If, within a context where a patient exhibits only primitive postural movements, PVS is defined in terms of an inability to communicate believed to be permanent (i.e. PVS_{COM}), then it can be readily distinguished from Locked-In Syndrome and the other conditions of unresponsiveness outlined by Jennett and Plum. Furthermore such a definition allows 'near-PVS' and 'PVS' to be assimilated into the one condition.*

Conclusion 4.5 : *A further reason for rejecting the assertion that consciousness is necessarily absent in PVS patients, is to be found in the fact that PVS is a syndrome rather than*

²⁶⁶ Sunday Times 2.11.1997 reported a Professor White, who had given head transplants to monkeys, as stating that: "Researchers believe that there was little disturbance to the monkeys higher brain functions as a result of the procedure." He urged that those in a PVS, in which there was still some brain activity, be used as donors. In the same article Richard Nicholson, Editor of the Bulletin of Medical Ethics, was quoted as stating (of this proposal) that "It is indicative of the disastrous route that Western medicine is taking."

a unitary, theoretically coherent, medical condition; and that it lies on a continuum of conditions at one end of which is the Locked-In Syndrome.

Conclusion ⁴⁻⁶: The President's Commission for the study of ethical problems in Medicine chose a definition of PVS and a terminology for its discussion which effectively precluded the consciousness of PVS patients or their possibility of recovery being questioned.

Conclusion ⁴⁻⁷: The Multi-Society Task Force on PVS acknowledge the possibility that patients who appear to be in a persistent vegetative state might retain awareness but show no behavioural manifestation of this. The Task Force asserts, without giving theoretical ground for such an estimate, that such cases are 'rare'.

Conclusion ⁴⁻⁸: The Multi-Society Task Force acknowledge the existence of patients who are aware but show no behavioural manifestations of awareness [the 'frozen aware']. In categorising these patients as cases of Locked-In Syndrome, rather than PVS, the coherence of the criteria used to diagnose Locked-In Syndrome is damaged.

Conclusion ⁴⁻⁹: The use by the Institute of Medical Ethics of the term 'permanent' in relation to PVS whilst omitting any reference the possibility of recovery, or to the high level of misdiagnosis associated with that condition, is disingenuous.

Conclusion ⁴⁻¹⁰: The suggestion by the BMA Guidelines that patients who recovered, having been previously diagnosed as PVS, were to be classified as cases of misdiagnosis is destructive of honest debate. Furthermore, in that such patients are implicitly reclassified as being Locked-In Syndrome patients, the coherence of the definition of the Locked-In Syndrome is threatened.

Conclusion ⁴⁻¹¹: The rates of misdiagnosis determined by various studies should not be interpreted as indicative of the true rate of misdiagnosis but rather as indicating absolute minimum rates.

Conclusion ⁴⁻¹²: The best estimate for the rate of misdiagnosis of PVS is of the order of 50%. This implies that the diagnosis of PVS is essentially a random process.

Conclusion ⁴⁻¹³: The reasons suggested by the studies on misdiagnosis of PVS for its occurrence are inappropriate terminology, imprecise definition of PVS and overly primitive procedures for determining awareness.

Conclusion ⁴⁻¹⁴: The Andrews 1996 study on misdiagnosis used 'ability to communicate' as a surrogate for 'possession of awareness'.

Conclusion ⁴⁻¹⁵: It is imperative that the ethical content of the term 'recovery' be recognised and made explicit, and that it not be considered to be a term amenable to a purely technical solution.

Conclusion ⁴⁻¹⁶: The Locked-In Syndrome is distinguishable from PVS in that a patient with locked-in syndrome is able to communicate by using the blinking of an eye, or some equally primitive bodily movement.

²⁶⁷ in the context of PVS.

Conclusion₄₋₁₇: *The persistent vegetative state is characterised by seeming wakefulness in the absence of an ability to communicate.*

Conclusion₄₋₁₈: *Definitions of PVS and Locked-In Syndrome framed in terms of ability to communicate, provide a more fitting resolution of the problems associated with PVS than do alternative definitions.*

Chapter 5: Doubt and its incorporation into medical decision making

In medical discussions concerning PVS, a certain cluster of propositions is common:

- P_1 - 'Patient X is in a PVS.'
- P_2 - 'Patient X manifests only reflex actions.'
- P_3 - 'Patient X has no consciousness.'
- P_4 - 'Patient X cannot feel pain.'
- P_5 - 'Patient X is no longer a 'person'.'¹

These propositions are not regarded as being independent propositions, but as being part of a deductive scheme with P_1 implying P_2 ; P_2 implying P_3 and P_5 , and P_3 implying P_4 and P_5 .

It is possible to critically analyse such a proposition cluster on two levels - that of the truth of the individual propositions, or that of the validity of the inferences between the propositions. On the level of the individual propositions; criticism may take the form of an assertion that the individual propositions are not well founded in that they are not capable of verification - *i.e.* there is no clear, unambiguous, procedure for determining, in any particular case, whether or not the propositions are true. On the level of cluster as a whole; criticism may take the form of an assertion that the deductive links between the propositions are not valid - *e.g.* that P_2 does not imply P_3 or that P_3 does not imply either P_4 .²

This analysis has, in essence, been the task undertaken in the last four chapters. The reason for such an undertaking was to show that, in relation to each of the propositions and inferences, a doubt, or uncertainty, existed. The magnitude of the doubt differed as between the propositions, but it was not negligible; for example, in relation to P_1 it was of the order of 50%.³

An attempt at such a rigorous critical analysis seems, at first sight, somehow inappropriate when applied to the propositions of clinical medicine. However, as medicine often clothes itself in the mantle of science, and an analysis, such as is proposed above, would be a commonplace in a discussion of physics or biology, it follows that the sense of inappropriateness does not arise from the propositions in so far as they are *scientific* propositions. The propositions P_1 , P_2 , P_3 and P_4 are somehow more than purely propositions of science and the inappropriateness flows from this 'more'.⁴ What could this 'more' be? This question is explored in Section 1, where it is suggested

¹ It may be countered that the concept of 'personhood' plays no role, and should play no role, in clinical medicine. However, whilst it may not feature *explicitly* in medical discourse, implicitly it plays a pivotal role in discussions of both infant disability, and treatment withdrawal. Its role in, for example, discussions of anencephaly is no less important for being unstated; indeed the fact that its role is unstated implies that it is unexamined and thus is of greater importance - in that its use is unfettered - than if it was made explicit. As an example of its implicit use in discussions concerning PVS patients, I cite a passage from an article by Raanan Gillon:

"... Dr. Andrews cites cases of recovery from the persistent vegetative state. These include a patient who, after three years in the persistent vegetative state, recovered sufficient consciousness to smile at cartoons, to show pleasure when his wife was present, and to show distress when she was absent. If resources were unlimited ... then the treatment should continue. But resources are severely limited ..."

[Raanan Gillon. Patients in the persistent vegetative state: a response to Dr Andrews. *British Medical Journal*, (1993), p.1603]

² As discussed in Chapter 4, PVS is often defined to be such that P_1 implies P_3 , although more circumspect formulations of the definition - *e.g.* Jennett and Plum (1972) - assert only that P_1 implies P_2 . The deductive link between P_1 and P_3 , or P_1 and P_2 as the case may be, is thus not open to question.

³ Conclusion 4.12. *The best estimate for the rate of misdiagnosis of PVS is of the order of 50%. This implies that the diagnosis of PVS is essentially a random process.*

⁴ P_5 - in that it is obviously not a purely scientific proposition - is not included in this discussion.

that the answer to the question lies in the fact that the propositions of clinical medicine - unlike those of pure science - have a normative aspect.

In any clinical situation the basic issues - such as the diagnosis, the appropriate treatment to be adopted, the side-effects of such treatment, the prognosis - are to some extent, open to doubt. The magnitude of the doubt may, of course, vary but it seems intrinsic to the clinical situation. How should such doubt be incorporated into the making of clinical decisions? Should, for example, decisions be based on a simple balance of probabilities basis? Such an approach would dictate that the most probable diagnosis should be chosen and that then the most effective treatment - judged on a probability basis - should be performed. However, consider the following example: a patient presents with a severe leg infection; the diagnosing physician believes that there is a 51% chance that it is gangrene; a 49% chance that it is a rare fungal infection. The best treatment for gangrene is amputation of the leg, that for the fungal infection is application of an ointment. A 'decision procedure' based on choosing that which was most probable would result in the amputation of the leg. This suggests that, whereas to choose the most probable diagnosis is, in many cases, the correct strategy, it should not necessarily be chosen if the unwanted effects of an incorrect choice, are radically disproportionate. An analysis of such decision procedures is developed in Section 2. It is applied to problems concerning the treatment of PVS patients in Section 3. Section 4 draws some conclusions.

Section 1: The normative aspects of medical propositions.

The propositions '*water is composed of atoms of hydrogen and oxygen*' or '*force equals mass times acceleration*' carry of themselves no moral imperative, no urge to action. Contrast these with the proposition '*Mr. Smith is suffering from appendicitis*'. This latter proposition is, in one sense, a scientific proposition - the terms are unambiguous and the assertion is open to verification - but it is not *just* a proposition of chemistry or biology. Such a medical proposition is normative in that it implies an ethical obligation on certain people to act in a particular fashion; to say that a patient is suffering from appendicitis carries the moral obligation on any medical person, who has a duty of care to that patient,⁵ to act in a medically appropriate fashion.

Thus, medical propositions have both a normative and a scientific content.⁶ The canons of criticism which are considered appropriate for scientific propositions are different from those considered appropriate for normative propositions. Herein lies the reason for the seeming inappropriateness of the critique of propositions P_1 , P_2 , P_3 and P_4 discussed earlier - for this was a critique which regarded the propositions as purely scientific and disregarded their normative content.

The following example clearly shows the difference between interpreting a particular proposition in a purely scientific manner, and interpreting it normatively; it also shows that the accepted mode of criticism differs depending on which interpretation is active. Imagine strolling beside the sea and suddenly hearing a shout "*That boy is drowning!*". A purely scientific attitude to this proposition would seek to determine its truthfulness - '*Is the boy really drowning? Perhaps we should wait and*

⁵ such as the 'patient's doctor'.

⁶ The balance between these constituents varies depending on the circumstances: a medical diagnosis based on observations of a patient who appears to be in immanent danger of death has far greater normative content than a medical diagnosis based on the findings of an autopsy.

see!'; and a scientific criticism of the proposition would be that a doubt existed that he was drowning, and that a replication of the event was necessary. Such a response would rightly be regarded as inhuman and monstrously inappropriate because it would be oblivious to the normative content of the proposition - the implication that one should attempt to rescue the boy. An example of criticism from a normative perspective would be that the bystander did not attempt to rescue the boy; a reply from the bystander that he wanted to be absolutely certain that the boy was drowning and that he was attempting to resolve all these doubts before acting, would be considered inappropriate. In such circumstances a commonly accepted ethical perspective would be that, although one might have doubts as to whether the boy was drowning, if, on the balance of probabilities one believed that he was drowning, then one should put these doubts aside and take whatever measures one could to rescue him.

This suggests that the attitude to doubt and its resolution, is an important manifestation of the difference between a set of propositions being interpreted from a purely scientific standpoint and from a normative standpoint. Should doubts be actively sought out? Should a distinction be drawn between 'major' doubts - those likely to influence a judgement made on the balance of probability - and others? or, as in law, between reasonable doubts and others? Is there some proportionality between the magnitude of a doubt and its ethical relevance? Answers to such questions are to a large measure determined by the standpoint adopted.

The role of doubt in scientific, normative and medical discourses contrasted.

In scientific discourse

In a purely scientific discourse the possibility of doubting a particular proposition is the generator for future research and scientific development; doubt is to be cultivated; it is a boon, the seed of growth. If it does not seem an inappropriate use of language, one might say that within a scientific discourse there is a moral obligation to unearth doubts. Moreover, it is the possibility of doubt rather than the magnitude of the doubt that is of importance: if a result can be experimentally verified in all but one case, then what matters is that the result is not universally valid and not that the occurrence is once in a hundred cases rather than once in a billion. The situation is otherwise in a normative discourse.

In normative discourse

A normative proposition has the form '*If condition X occurs, then Y must be done.*' There are two obligations implicit in this, the obligation to determine whether, in fact, condition X has actually occurred and, if it has, the obligation to do Y. The first obligation is similar to the obligation of the scientist to determine the truth of the proposition '*X has occurred*' but this similarity is superficial. There may indeed be some circumstances where the obligation to determine whether X has occurred is an absolute one - *i.e.* such that under no circumstances must Y be done unless X has occurred; an example from clinical medicine would be the determination of death before the signing of the death certificate; but generally not only is the obligation to determine the condition X not only not absolute, but there is a time constraint, so that an undue time spent on the determination of X is at the cost of time that should be spent on Y. To spend time achieving certainty in determining X, resulting in time not remaining to do Y, would indeed be considered to be an abject failure. A corollary of this is that under conditions of urgency there may well be a moral obligation *not* to raise

minor doubts as to the truth of X, because to do so would mitigate against the possibility of Y being accomplished; this is particularly so if Y - as in the case of health interventions - is regarded as being generally salutary.

In medical discourse

The situation is similar in clinical medicine. There the normative aspect of the situation - the obligation to ease the patient's suffering - is ever present and 'doubt' has a much more limited role than in a scientific investigation. A tension exists between the normative and the scientific aspects of the medical discourse; and a concentration on the scientific aspects of a problem - *i.e.* a concern with resolving uncertainties, or doubts - may be seen as being incompatible with, or destructive of, the normative aspects. The diagnosis, and the decisions that flow from it, must often be made under conditions of urgency and though major doubts cannot be ignored, fanciful or 'academic' doubts must be set aside because, if they are entertained, they not only create indecision - which can cripple effective action - but they require time to resolve and such time may well be of the essence: the belief being that the patient may well be dead before all the doubts as to their illness can be resolved.⁷ This tendency to dismiss doubts may be reinforced by the generally accepted perception that it is better to err on the side of a health intervention than not - the belief that a health intervention, when not actually required, is less damaging than an absence of intervention when it is required, gives added momentum to the tendency to disregard minor doubts. Thus, in clinical medicine, in contrast to pure science, *the moral obligation is understood to imply that doubts should be minimised rather than nurtured.*

Hence the reason for the seeming inappropriateness of the analysis discussed earlier⁸ lies in the fact that - in seeking to establish lacunae where doubt could gain a foothold - it was embarking on a project whose value is not necessarily accepted in clinical medicine.

The compartmentalising of medical problems and its effect on ethical judgements

The exigencies of the clinical situation may demand not only that doubts, other than major doubts, be disregarded but also that different aspects of a presenting situation be separated. A medical professional, in order not to be overwhelmed by the problem with which he is faced, must compartmentalise it. He must split the problem into simpler problems and solve these separately. First, he must diagnose: he must ask '*What is the most probable medical condition obtaining at present?*'; then he must put aside any uncertainty as to the diagnosis - as otherwise his ability to act effectively is hampered - and he must ask '*Given the condition as diagnosed, what is the prognosis of this condition and what is the most effective treatment?*'

⁷ A perception echoed by the following Buddhist parable:

"It's just as if a man were wounded with an arrow thickly smeared with poison. His friends and companions, kinsmen and relatives would provide him with a surgeon, and the man would say, 'I won't have this arrow removed until I know whether the man who wounded me was a noble warrior, a priest, a merchant, or a worker.' He would say, 'I won't have this arrow removed until I know the given name and clan name of the man who wounded me ... until I know whether he was tall, medium, or short ... until I know whether he was dark, ruddy-brown, or golden-coloured ... until I know his home village, town, or city ... until I know whether the bow with which I was wounded was a long bow or a crossbow ... until I know whether the bowstring with which I was wounded was fibre, bamboo threads, sinew, hemp, or bark ... until I know whether the shaft with which I was wounded was wild or cultivated ... until I know whether the feathers of the shaft with which I was wounded were those of a vulture, a stork, a hawk, a peacock, or another bird ... until I know whether the shaft with which I was wounded was bound with the sinew of an ox, a water buffalo, a langur, or a monkey'. He would say, 'I won't have this arrow removed until I know whether the shaft with which I was wounded was that of a common arrow, a curved arrow, a barbed, a calf-toothed, or an oleander arrow.' The man would die and those things would still remain unknown to him."

[From '*The Cula-Malunkya Sutta*' (MN 63, The Shorter Instructions to Malunkya), included in the Middle-length Discourses of the Buddha; Internet source: <http://www.accesstosight.org/canon/majjhima/mn63.html>]

⁸ *i.e.* of P₁, P₂, P₃, P₄, and their interrelationships.

These two aspects of clinical medicine - the propensity to disregard 'non-major' doubts and the compartmentalisation of a problem into sub-problems - whilst often necessary within the confines within which clinical medicine must operate, can, if carried over into settings other than those requiring emergency medical intervention, have profoundly unethical and inappropriate consequences; this is particularly so in relation ethical discussions of medical issues. Simplifications which may well be justified in a clinical situation have no justification in the more relaxed conditions within which medical ethicists debate.⁹

Conclusion 5-1: *'Doubt' plays an unequivocally positive role in a scientific discourse in that it is the very seed for future development. In contrast, its role in a medical discourse is ambivalent: from a scientific perspective, 'doubt' is valued; however, from a clinical perspective, the cultivation of doubt may be seen as destructive of appropriate, and timely, intervention. Medical ethics appears to assign a role to 'doubt' similar to that accorded to it by clinical medicine without, however, having the justifications for doing so which are available to clinical medicine.*

Section 2: A schema to permit the incorporation of uncertainty into the making of medical decisions.

In the face of uncertainty as to which of two particular states of affairs persists, it may be thought that the correct course is to assume to be true, that which is most probably true [*'Principle of choosing the most probable'*]. A moment's reflection will show that this principle, when used as a decision procedure for making ethical choices, is not appropriate because it does not seek to minimise the evils or maximise the goods that would flow from a choice between two possibilities; an example - which I have called the *'rescue problem'* - shows this to be so.

The rescue problem

Let us assume that after an earthquake some people have been trapped in the ruins of a building and, because of extreme weather conditions, it is most improbable that any have survived; rescue operations are difficult and costly. Should the rescuers act on the most probable hypothesis? Or should they choose some alternative principle? The various options and eventualities are set out in Table 5-1:

<u>line</u>	<u>Rescuer's option</u>	<u>Actual situation (unknown)</u>	<u>Ethically relevant consequences</u>
1.	A: Act <u>as if</u> survivors	There are survivors	In hindsight this was the appropriate action
2.	(ditto)	There are no survivors	Economic cost but no loss of human life
3.	B: Act <u>as if</u> no survivors	There are survivors	Saving of economic cost, loss of human life
4.	(ditto)	There are no survivors	In hindsight this was the appropriate action

Table 5-1: The Rescue Problem

⁹ I refer to, for example, Ronald Dworkin's description of PVS patients as "... permanently damaged in a way that rules out any return to consciousness. They are capable of no sensations and no thoughts." (quoted earlier - see Chapter 4, Section 4).

Borthwick [Borthwick (1995b) p.208] concisely states the position being advocated:

"If the discipline of medical ethics cannot cope with uncertainty then it is useless in the real world."

I suggest, however, that he understates the position: not only is it useless, but it is positively harmful.

Using the 'principle of choosing the most probable' would suggest that option B should be chosen. This is so *irrespective* of the economic costs of attempting a rescue. If the situation resolves according to line 4 then the most appropriate action will, fortuitously, have been chosen. If, however, it resolves according to line 3 then the consequences are tragic; this is particularly so if the economic cost of rescuing the survivors was minimal. It is clear that a more sophisticated decision procedure is required, one which incorporates the consequences of the choices, rather than simply taking note of the probabilities of the various choices being true. The ethical difficulty is caused - not by lines 1 or 4 - but by lines 2 and 3. So the focus must be placed on the unwanted consequences of choices which are, in hindsight, incorrect. But the choice cannot be made by simply comparing the respective unwanted outcomes for this takes no account of the likelihood of the initial probabilities. What is needed is a method of bringing together both the probability of a state of affairs, and the consequences of an incorrect judgement, into one index so that a more rational choice can be made. This involves estimating, or quantifying, the unwanted consequences¹⁰ and then multiplying each of these estimates by their respective probabilities - in effect this is a method of estimating the likelihood of the unwanted outcomes corresponding to the differing choices - and then choosing the option corresponding to the minimum likelihood. An example (set out in Table 5-2) may help clarify. In order that the underlying method be clearly explained it has been assumed that the probability of survivors being present is 1 in 10. It is also assumed that the unwanted consequences of a wrong decision can be quantified and are in the ratio 1:1000, i.e.:

$$\frac{\text{Consequences of assuming that there were no survivors whilst there were, in fact, survivors}}{\text{Consequences of assuming that there were survivors whilst there were, in fact, no survivors}} = \frac{1000}{1}$$

<u>line</u>	<u>Rescuers have option</u>	<u>Actual situation (unknown)</u>	<u>P (Probabilities)</u>	<u>Ethically relevant consequences of an incorrect decision.</u>	<u>C*</u>	<u>Product of P and C</u>
2.	A: act <u>as if</u> survivors	There are no survivors	9/10 (Probability of no survivors)	Considerable economic cost but no loss of human life	1	(9/10)x1 = 0.9
3.	B: act <u>as if</u> no survivors	There are survivors	1/10 (Probability of survivors)	Saving of economic cost, loss of human life	1000	(1/10)x1000 = 100

*relevant consequences of an incorrect decision, quantified and expressed as a ratio.

Table 5-2: The rescue Problem - analysis of unwanted consequences

¹⁰ At least in the form of a ratio so that, for example, consequence A is 1000 times worse than consequence B. The following betting example shows the point at issue more clearly because the consequences are already quantified: a man is betting on whether a card taken from a deck is an ace or a spade. The probabilities are as follows:

choose ace	4/52 = 0.077
choose spade	13/52 = 0.25

He is then told that if he chooses an ace and is correct he wins £1000, but that if he is incorrect he must pay £1000; if he chooses a spade and is correct he wins £300, but if he is incorrect he must pay £300. What should he do to minimise his likely losses? What should he do to maximise his likely gains?

By multiplying each consequence by its associated probability he estimates the likely consequence of each course of action; these are shown by the last column in the following table:

	<u>option</u>	<u>actual eventuality</u>	<u>probability of event</u>	<u>Consequences of event</u>	<u>Likely consequence</u>
1.	choose ace	Ace	0.077	+ £1000	+ £77
2.		not an Ace	0.923	- £1000	- £923
3.	choose spade	Spade	0.25	+ £300	+ £75
4.		not a Spade	0.75	- £300	- £225

If he wishes to minimise his possible losses he chooses a spade (line 4). If, however, he wishes to maximise his gains he chooses an ace (line 1).

The last column in Table 5-2 attempts to quantify the likelihood of the unwanted consequences of each course of action if, in hindsight, a factually incorrect choice was made. If the ethical principle adopted is that one should minimise the evils (the unwanted consequences) of one's actions, then one should minimise the index (P multiplied by C). In the example given, since 100 is far in excess of 0.9 one should act as if there are survivors; this is so even though it is not the most probable situation.

Conclusion ₅₋₂: *Acting on the basis that those circumstances which are most probably true, are true, does not ensure that the unwished for consequences that flow from a (then unknowably) incorrect choice are minimised. In such cases an index should be compiled of the probabilities of various eventualities, weighted in proportion to the magnitude of their respective unwanted consequences, and the eventuality be chosen which corresponds to the minimum index. In short, the decision procedure to be adopted in such cases of incomplete knowledge, is that one should act so that the unwished-for consequences that flow from a (then unknowably) incorrect choice are minimised.*

Section 3: Application of the decision schema to the PVS situation.

Let us first consider the traditional ethical approach to PVS/pain/consciousness judgements. A patient presents with the symptoms of PVS and, after a thorough examination, is diagnosed as such. Once this diagnosis is made then the judgement that the patient has no consciousness or cannot experience pain, is said to follow either as a matter of strictly logical necessity or else to be of such high probability that to suggest otherwise is to raise purely fanciful doubts. The suggestion that the patient be treated as if they are conscious and can experience pain elicits the immediate reply that to do so would be to act contrary to what is known to be true and that to follow such a course of action could hardly be ethical; and, furthermore, that an acceptance of the ability of the patient to experience pain would be seen as destructive of the diagnosis of PVS. I suggest that this bifurcation of the problem into diagnosis and treatment, with the doubts being separately resolved on the basis of accepting that which is most probable, distorts PVS/pain/consciousness judgements. Let us apply the analysis undertaken in the rescue problem to these judgements.

The rescue problem applied to the PVS situation.

To apply the analysis of the rescue problem to the situation of PVS patients and the possibility of their experiencing pain, it is first necessary to estimate the probability of a PVS-like patient being diagnosed, wrongly, as being 'unable to experience pain'. At first sight it may appear fanciful to attempt to ascribe probabilities to such a proposition. It is not: if, as is usual, the proposition that 'a PVS patient cannot experience pain' is held to follow as a matter of strict deduction from the diagnosis of PVS then an estimate of the rate of misdiagnosis of PVS would, subject to certain reservations, appear to give a minimum estimate of probability. However, the problem is more complicated than being simply one of misdiagnosis. Three, intertwined, issues are involved:

- (i) the possibility that a PVS-like patient be misdiagnosed as being PVS.
- (ii) the possibility that a misdiagnosed PVS patient has experienced pain whilst diagnosed as PVS.

- (iii) The possibility that a correctly diagnosed PVS patient has experienced pain whilst diagnosed as PVS.

We have seen¹¹ that the best estimate for the rate of misdiagnosis of PVS is of the order of 50%. This suggests that *even if* the 'principle of choosing the most probable' is adopted, PVS patients should be treated as being able to experience pain. This, however, presumes that in each case of misdiagnosis the patient was - whilst diagnosed as PVS - at some stage able to experience pain. As this inference may not be fully justified let us assume, for the sake of illustration, that 30% of patients diagnosed as PVS are both wrongly diagnosed and can at some stage (whilst diagnosed as PVS) experience pain. The possibility that a correctly diagnosed PVS patient has experienced pain¹² is more problematic because it directly raises the problem of the definition of PVS. This has been discussed exhaustively in Chapter 4 and, for the purposes of this discussion, it is clear that if PVS is defined by the absence of behavioural manifestations of consciousness then there is a clear possibility that a correctly diagnosed PVS patient could experience pain. The inclusion of such patients would obviously increase the estimate derived from misdiagnosis studies; nonetheless let us assume that the conservative estimate of 30% still applies.

We have next to make an estimate of the detrimental consequences of treating an aware patient as not aware, in comparison to the detrimental consequences of treating an unaware patient as aware. The various consequences are set out in Table 5-3:

line	Option: Patient treated as if aware and able to feel pain	Patient in fact aware and able to feel pain	Ethical consequences	
1.	A: Yes	Yes	Considerable positive consequences to all concerned	
2.	A: Yes	No	Professional carers:	slight economical cost
			Patient's family:	possible benefits
			Patient:	no detrimental effect
3.	B: No	Yes	Professional carers:	slight economical benefits
			Patient's family:	possible negative consequences
			Patient:	very severe negative consequences
4.	B: No	No	Slight ethical consequences; possible detriment to the family	

Table 5-3: Analysis of doubt applied to the PVS Problem.

As in the rescue problem, the analysis must concentrate on comparing the unwanted consequences of, in hindsight, incorrect choices *i.e.* lines 2 and 3. We must compare the consequences of treating a patient as unable to experience pain (when they are able), with the consequence of treating one as able to experience pain (when they are unable). In essence, this reduces to comparing the suffering of a patient who is untreated for pain, with the cost of providing analgesic procedures when they are, in fact, unnecessary. It is invidious to make such comparisons but they are required for the analysis and I have chosen a ratio of 1000:1 for illustrative purposes.

¹¹ see Conclusion 4-12. *The best estimate for the rate of misdiagnosis of PVS is of the order of 50%. This implies that the diagnosis of PVS is essentially a random process.*

¹² whilst diagnosed as PVS.

	(i)	(ii)	(iii)	(iv)	(v)
	<i>Treat as able to experience pain</i>	<i>In fact able to experience pain</i>	<i>Probability (P) that patient able to experience pain - 30%</i>	<i>The unwanted results expressed as a ratio (R) 1000:1</i>	<i>Product of P and R</i>
2.	A: Yes	No	0.7	1	0.7
3.	B: No	Yes	0.3	1000	300

Table 5-4: The PVS Problem: a tentative attempt at quantification for the purposes of illustration

Because 300 is greater than 0.7 the analysis as developed in the rescue problem, implies that such patients should be treated as if they can experience pain. By asking what figures are required in either Columns (iii) or (iv) to make the indices in column (v) equal, the conclusion can be restated in alternative ways:

Conclusion ₅₋₃: *If it is accepted that the probability of a patient diagnosed as PVS being able to experience pain is 30%; then, in order to justify analgesic treatment being withheld from PVS patients, it must be accepted that the non-treatment of PVS patients for pain, when they can, in fact, experience pain, is no more than just over twice as abhorrent as the treatment of PVS patients as being able to experience pain, when, in fact, they cannot.*

Conclusion ₅₋₄: *If it is accepted that the non-treatment of PVS patients for pain, when they can, in fact, experience pain, is of the order of 1000 times as abhorrent as the treatment of PVS patients as being able to experience pain when, in fact, they cannot; then, in order to justify analgesic treatment being withheld from PVS patients, it must be accepted that the possibility of a PVS patients being able to experience pain is of the order of 1 case in every 1000.*

A note on the phrase 'as if'

The phrase 'as if' has been used in the context of suggesting that PVS patients should be treated as *if* they are conscious. The use of this phrase is not meant to suggest that some pretence be enacted but rather that an attitude towards PVS patients be cultivated which acknowledges that *some* patients who are diagnosed as PVS undoubtedly are conscious and able to experience pain but that we have no way of identifying *which* patients are, in fact, in pain.

A not dissimilar problem relating to the attitude to be adopted by medical staff in situations where there is incomplete knowledge occurs in relation to the disposal of used syringes, particularly in so far as they present a danger of contracting aids or hepatitis. The attitude of medical staff in such cases - in that they presume some are contaminated but they do not know which - exemplify the sense of 'as if' that is being proposed: the medical staff treat *all* syringes as *if* they were contaminated.

Section 4: Conclusions

The conclusion to be drawn from this chapter is that - especially in view of the extent of misdiagnosis of PVS:

Conclusion ₅₋₅: *All patients diagnosed as PVS, should be treated as if they are conscious and can experience pain.*

It could be argued that erroneously treating a patient as being able to feel pain might cause distress to the patient's family; however, this would be a misunderstanding of what is being suggested which is *not* that the patient *can* feel pain, but rather that there is uncertainty, and in the face of this uncertainty the ethical practice should be to treat the patient as if they can feel such pain. It does *not* mean that the withdrawal of life-sustaining treatment or the withdrawal of ANH should not occur;¹³ other than to ensure that pain relief is given, it is simply not relevant to these decisions.¹⁴

The conclusions that were established in this Chapter are:

Conclusion 5-1: *'Doubt' plays an unequivocally positive role in a scientific discourse in that it is the very seed for future development. In contrast, its role in a medical discourse is ambivalent: from a scientific perspective, 'doubt' is valued; however, from a clinical perspective, the cultivation of doubt may be seen as destructive of appropriate, and timely, intervention. Medical ethics appears to assign a role to 'doubt' similar to that accorded to it by clinical medicine without, however, having the justifications for doing so which are available to clinical medicine.*

Conclusion 5-2: *Acting on the basis that those circumstances which are most probably true, are true, does not ensure that the unwished for consequences that flow from a (then unknowably) incorrect choice are minimised. In such cases an index should be compiled of the probabilities of various eventualities, weighted in proportion to the magnitude of their respective unwanted consequences, and the eventuality be chosen which corresponds to the minimum index. In short, the decision procedure to be adopted in such cases of incomplete knowledge, is that one should act so that the unwished-for consequences that flow from a (then unknowably) incorrect choice are minimised.*

Conclusion 5-3: *If it is accepted that the probability of a patient diagnosed as PVS being able to experience pain is 30%; then, in order to justify analgesic treatment being withheld from PVS patients, it must be accepted that the non-treatment of PVS patients for pain, when they can, in fact, experience pain, is no more than just over twice as abhorrent as the treatment of PVS patients as being able to experience pain, when, in fact, they cannot.*

Conclusion 5-4: *If it is accepted that the non-treatment of PVS patients for pain, when they can, in fact, experience pain, is of the order of 1000 times as abhorrent as the treatment of PVS patients as being able to experience pain when, in fact, they cannot; then, in order to justify analgesic treatment being withheld from PVS patients, it must be accepted that the possibility of a PVS patients being able to experience pain is of the order of 1 case in every 1000.*

Conclusion 5-5: *All patients diagnosed as PVS, should be treated as if they are conscious and can experience pain.*

¹³ i.e. as in situations where lack of consciousness is accepted as the criterion for withdrawal of ANH; it is argued in Part 3 that 'lack of consciousness' is not an appropriate criterion for such decisions.

¹⁴ The concepts of 'a good death' and 'personhood' provide a conceptual structure to enable these decisions to be made (to be discussed in Part 3).

Conclusions to Part 1

The assertion that '*A specific patient, who has been diagnosed as PVS, cannot feel pain*' can be defended on the grounds that:

- * consciousness is lacking and that this is so either:
 - (i) as a theoretical consequence of being diagnosed as PVS; or
 - (ii) as has been experimentally verified in the instant case.
- * the ability to experience pain is lacking and that this is so either:
 - (iii) as a theoretical consequence of being diagnosed as PVS; or
 - (iv) as has been experimentally verified in the instant case.

Each of these grounds has been examined in the preceding chapters and found wanting: Chapter 1 considered the experimental grounds for judging that consciousness was absent and found that the only conclusion (assuming the complete identification of 'brain processes' and 'mental processes') that was justified was that consciousness was absent if all brain activity had ceased.¹ Because of its importance, a particular form of this argument was considered separately in Chapter 2: *i.e.* the argument that the manifestation of only reflex actions justifies the conclusion that consciousness is absent. The theoretical underpinnings of the distinction between 'reflex' and 'non-reflex' actions, were found on examination, to be dependent on the adoption of a Cartesian perspective. Both the distinction itself, and the implication to be drawn from the absence of 'non-reflex' behaviour, were found to be open to challenge and it was concluded that even if a patient manifested only reflex behaviour, it was still possible that consciousness might persist. Hence ground (ii) was undermined.

Chapter 3 examined whether it is possible to demonstrate conclusively that an individual is not experiencing pain. It was found that no definitive test exists for establishing the presence, or absence, of pain and that there are grounds for suggesting that such tests cannot - even theoretically - exist. Furthermore, it was found that the concept of 'pain' is not a purely scientific concept but is intimately bound up with questions of value and attitude. These conclusions undermined ground (iv).

Chapter 4 considered the definition of PVS and found that different academic studies had used definitions of PVS which were not equivalent; the confusion caused by this was exacerbated by the use of inappropriate terminology which - in certain instances - could even be described as being inimical to honest debate. This chapter also considered studies on the misdiagnosis of PVS and found that the level of misdiagnosis of PVS was so great as to be comparable to that to be expected in a purely random process such as the toss of a coin. Chapter 4 also considered the justification for the inferences that a patient, diagnosed as PVS, was not conscious or could not experience pain; it concluded that such inferences were open to doubt; a doubt which, in view of the studies on misdiagnosis, is substantial. These conclusions undermined grounds (i) and (iii).

Thus, none of the four arguments listed above (i) - (iv) is conclusive; in each case the conclusion that the patient cannot experience pain is accompanied by a penumbra of doubt.

Chapter 5 considered how, in the making of medical judgements, the existence of such doubt could best be incorporated. It concluded that decision procedures based on choosing that which was most likely, were deeply flawed; it proposed that, in cases of doubt, one should -

“... act so that the unwished-for consequences that flow from a (then unknowably) incorrect choice are minimised.”²

This decision procedure was then applied to the problem of whether PVS patients should be treated as being conscious and able to experience pain; the conclusion was drawn that:

Conclusion 5-5: *All patients diagnosed as PVS, should be treated as if³ they are conscious and can experience pain.*

This conclusion was based simply on the extent of misdiagnosis of PVS which had been uncovered and was without reference to doubts that have been found to exist in relation to the other grounds (i) - (iv); these doubts are cumulative and add further weight to this conclusion, which is the main proposal of Part 1 of this thesis.

The use of ambiguous terminology appears to be a constant and discomforting feature of the debate on PVS.⁴ The terms ‘consciousness’, ‘reflex’, ‘pain’, ‘recovery’, ‘misdiagnosis’ have all been used in the academic literature with two or more meanings. In the presence of such ambiguity it is no wonder that PVS has been described as ‘an area fraught with confusion’.⁵ Perhaps, the single greatest cause of such confusion is the role played by the concept of ‘consciousness’. I have argued that ‘consciousness’ plays a symbolic role and acts as a surrogate for the concept of personhood, and that, in the interests of clarity, it is imperative that questions of personhood be explicitly addressed. However, a matter of even greater importance in bringing order to the debate on PVS, is the need for the definition of PVS - and that of the locked-in syndrome - to be clarified. I have argued that ‘the ability to communicate’ and not ‘consciousness’ is the key to unravelling both the concept of personhood,⁶ and the definitions of PVS and locked-in syndrome. The following definitions were proposed:

Conclusion 4-16: *The Locked-In Syndrome is distinguishable from PVS in that a patient with locked-in syndrome is able to communicate by using the blinking of an eye, or some equally primitive bodily movement.⁷*

Conclusion 4-17: *The persistent vegetative state is characterised by seeming wakefulness in the absence of an ability to communicate.*

Treating a PVS patient as being conscious and able to experience pain, has no implications for their ‘personhood’. In Chapter 10 it will be argued that ability to communicate is a necessary

¹ In cases of PVS some brain activity persists.

² Conclusion 5-2: *Acting on the basis that those circumstances which are most probably true, are true, does not ensure that the unwished for consequences that flow from a (then unknowably) incorrect choice are minimised. In such cases an index should be compiled of the probabilities of various eventualities, weighted in proportion to the magnitude of their respective unwanted consequences, and the eventuality be chosen which corresponds to the minimum index. In short, the decision procedure to be adopted in such cases of incomplete knowledge, is that one should act so that the unwished-for consequences that flow from a (then unknowably) incorrect choice are minimised.*

³ The phrase ‘as if’ is used not in the sense of suggesting a pretence, but rather in the sense of suggesting that in the face of incomplete knowledge as to which PVS patients are conscious - and some undoubtedly are - all should be treated as if they were conscious.

⁴ See: Conclusion 4-13: *The reasons suggested by the studies on misdiagnosis of PVS for its occurrence are inappropriate terminology, imprecise definition of PVS and overly primitive procedures for determining awareness.*

⁵ Childs *op.cit.* p.1465.

⁶ This question is considered in Chapter 10.

⁷ It was necessary to introduce the proviso ‘... or some equally primitive bodily movement’ because there are patients who are open-eyed, apparently unresponsive and who display primitive postural movements but who it is subsequently found can communicate by some primitive bodily movement other than eye movement; for example, patient B of the Andrews (1996) study was such that:

condition for the ascription of personhood and the adoption of such a criterion, in conjunction with the definition of PVS proposed, would imply an obligation on medical staff to work diligently to establish patient communication. This is precisely what is found at present in the best medical practice in relation to the treatment of PVS patients; however, the proposals being made here enable such practice to be put on a more secure theoretical footing.⁸ Furthermore, treating PVS patients as being conscious and able to experience pain removes the urgency and much of the ethical necessity for distinguishing between the 'PVS', 'near-PVS' and the 'locked-in syndrome'.⁹ All such patients are to be treated as conscious and as having the ability to experience pain. The ethical obligation on carers is identical for all three conditions - it is to attempt to devise methods of communication with the patient to a level where their views as to their treatment, can be ascertained.

If such attempts are successful, then, as a corollary, the 'personhood' of the patient is also established.

If they are not successful and the ability to communicate is considered to be permanently lost, then the 'personhood' of the patient has ceased. The patient has died 'as a person'. The implications that follow from such judgements are considered in Part 3.

"Only when he was satisfactorily seated was it identified that he had a slight shoulder shrug which could be used for communication purposes." [Andrews (1996) p.15]

⁸ The proposal is, in essence, to bring the definition of PVS into harmony with best clinical practice which, I suggest, implicitly uses just such a definition; see, for example:

a) Conclusion 4.14: *The Andrews 1996 study on misdiagnosis used 'ability to communicate' as a surrogate for 'possession of awareness'*

b) A new test devised by the Royal Hospital for Neurodisability in London for examining PVS patients - though described in media reports as a testing for 'returning awareness' - appears to be essentially concerned with developing communication:

"The technique, known as Smart (Sensory Modality Assessment and Rehabilitation Tool) involves systematically stimulating each of seven modalities - sight, hearing, touch, smell, taste, movement and communication - whilst looking for signs of returning awareness." [The Independent 17.12.1997.]

⁹ indeed, the term 'near-PVS' becomes redundant.

Part 2: Introduction¹

" 'There is a strident cry in America to terminate the lives of other people - deemed physically or mentally defective ... Assuredly one test of civilization is its concern with the survival of the 'unfittest', a reversal of Darwin's formulation ... In this case the court must decide what its ward would choose, if he were in a position to make a sound judgement.'² This last sentence puts it right. It is not appropriate for an external decision maker to apply his standards of what constitutes a liveable life and exercise the right to impose death if that standard is not met in his estimation. The decision can only be made in the context of the disabled person viewing the worthwhileness or otherwise of his life in its own context as a disabled person - and in that context he would not compare his life with that of a person enjoying normal advantages. He would know nothing of a normal person's life never having experienced it.'³

In the Ward case⁴ the Irish courts were presented with an application by the family of a woman who had been in a 'near-PVS' state for over twenty years, seeking that she be 'allowed'⁵ to die. There was no statutory provision, nor no judicial precedent, in Irish law to help resolve such a problem; however the Irish courts were able to draw on the experience of the US courts (in the Cruzan case⁶) and the English courts (in the Bland case⁷) both of which had considered similar problems involving PVS patients. The US and the English courts considered these cases as being essentially concerned with the withdrawal of life-sustaining medical treatment; they had resolved these cases by first delineating the conditions under which medical treatment might be given to, or withdrawn from, patients who lacked the capacity to consent to such treatment and by then applying this analysis to the particular situation of the PVS patient. The Irish courts adopted a similar method of analysis.

¹ Summaries of the more important legal cases discussed in Part 2, are given in Appendix C.

² Ashe J. in *Re Weberlist* (1974) 360 NYS 2d 783 at 787.

³ McKenzie J. in *Re Superintendent of family and Dawson* (Appendix C - number 15). This passage was cited (at p.936) by Lord Donaldson in *Re J* (Appendix C - number 10) who commented:

"This gives effect, as it should, to the fact that even very severely handicapped people find a quality of life rewarding which to the unhandicapped may seem manifestly intolerable." (at p.938)

⁴ The judgement of the High Court is an unreported judgement of Lynch J. delivered on 15th May 1995. The judgements of the Supreme Court is reported as *In the Matter of a Ward of Court* [1995] 2 ILRM 401.

⁵ The term 'allow' appears to have become traditional in this situation suggesting as it does a causal link to, but an absence of moral responsibility for, the inevitable consequences of the withdrawal of sustenance; the language mirrors the distinction between acts which are 'directly intended' in contrast to those 'indirectly intended' which are regarded as carrying a lesser, or indeed no, burden of moral responsibility. Some dispute the existence of a causal link:

"The true cause of the ward's death will not be the withdrawal of such nourishment but the injuries which she sustained ..." [The Ward case, Hamilton CJ., at p.429]

However, others regard such reasoning as pure sophistry amounting to evasion of the central issue. Lord Mustill, for example, in his judgement in the Bland case - having noted the suggestion that the death will not be caused by the implementation of the proposed course of action - continued:

"I am bound to say that the argument seems to me to require not manipulation of the law so much as its application in an entirely new and illogical way. In one from the argument presented ... asserts that the cause of Anthony Bland's death ... will be the Hillsborough disaster ... it is in my judgement perfectly obvious that the conduct will be, as it is intended to be, the cause of death ..." [Airedale N.H.S. Trust v Bland [1993] A.C. 789 per Lord Mustill p.895].

Thomas J., in *Auckland Area Health Board v AG* (Appendix C - number 17) proposed a novel solution arguing that although the doctors in withdrawing life-sustaining treatment might be said to cause the death of the patient they did not 'legally cause' his death.

⁶ *Cruzan v Director, Missouri Department of Health* (1990) 110 S Ct 2841.

⁷ *Airedale N.H.S. Trust v Bland* [1993] A.C. 789; see Appendix C - number 2.

The aim of Part 2 of this thesis is to show that the method of analysis chosen by the Ward court⁸ to justify the decision to permit the withdrawal of life-saving treatment from a patient who was not terminally ill,⁹ entails that that decision can be applied to the situation of individuals who are not in a persistent vegetative state¹⁰ but who are seriously disabled. The English courts, by using a line of argument essentially the same as that adopted in the Ward case, have in a series of decisions, sanctioned just such a development. These cases - some of which pre-dated the Bland decision and were used in its support - concerned the withholding of life-sustaining treatment from disabled individuals (mainly children) who were not terminally ill. The nature and extent of the disabilities differed and ranged from very severe disability (*In re J*¹¹) to the case of a Down Syndrome infant with an easily curable intestinal blockage (*Re B*¹²). In many of these cases the courts have sanctioned the withdrawal of treatment, though in *Re B* the situation was more complex.¹³ I wish to use these two cases - *In re J* and *Re B* - as paradigms of the extremes of the disability spectrum and keep them as points of reference for the development of the argument in this thesis.

Against the suggestion that the Ward decision can be applied to cases of disability is the explicit statement by Hamilton C.J., that:

*"... my ruling in this matter will be based on and relate only to the circumstances and rights of this particular ward."*¹⁴

Furthermore, there are many statements in the Ward judgements to the effect that the decision has no application to cases of disability; O'Flaherty J., for example, states:

*"Thus, the circumstances of the current case are clearly distinguishable from the position as regards, for example, a seriously mentally handicapped person. A mentally handicapped person is conscious of his or her situation and is capable of obtaining pleasure and enjoyment from life."*¹⁵

⁸ I use the phrase 'the Ward court' to cover the judgements of all of the courts that dealt with the Ward case, similarly with the phrase 'the Bland court'.

⁹ *pace* Hamilton C.J., who was the only member of the court to hold that the Ward was 'terminally ill'; his reasoning is unconvincing:

"It is quite clear from the evidence that, without the benefit of the nourishment provided by the treatment being afforded to her she would die within a short period of time and in this regard, she must be regarded as 'terminally ill'."

(The Ward case, at p.428)

¹⁰ or who are not - as in the Ward case - in a 'near PVS'.

¹¹ Appendix C - number 10.

¹² 'J' was an 18 week-old baby who had been born prematurely with very severe, and irreparable, brain damage. He was epileptic and was likely to develop serious spastic quadriplegia and to be blind and deaf. Though he may have become able to make sounds to reflect his mood and to smile and cry, he was unlikely ever to speak or develop even limited intellectual abilities. It was likely that he would feel pain similar to a normal baby. He was not terminally ill. His life expectancy was uncertain but he was expected to die before late adolescence. He had been ventilated twice for long periods, and the prognosis was that, in the absence of ventilation, any further collapse would be fatal.

¹³ Appendix C - number 7.

The case concerned a week old baby girl who had been born with Down Syndrome. The child had an intestinal blockage which could be cured, without difficulty, by a simple operation; her life expectancy would then be 20 to 30 years. The child would die in a matter of days without the operation. The child's parents refused consent for the operation believing it not to be in the child's best interests that she should survive because she would be handicapped both mentally and physically.

¹⁴ At first instance the court agreed to treatment being withheld; this decision was subsequently reversed by the same court and the reversal upheld by the Court of Appeal on the grounds that the issue to be considered was not whether the parent's wishes should be respected, but whether the withdrawal was in the 'best interests' of the child. However, this distinction seems to have been blurred by the subsequent case of *T (a minor)* [Appendix C - number 12] where the Court of Appeal held that the judge at first instance should not have restricted himself solely to medical factors when judging the child's 'best interests'; he "... should have considered whether it was in the child's 'best interests' that the mother should be forced to take on the commitment of caring for a child after surgery with which she did not agree." The decision should be taken by the child's parents as the child had been 'entrusted by nature' to their care.

In the Ward case counsel for the Attorney General (referring to *Re B*) submitted that "... the case uniquely illustrates why the quality of life should not be adopted as a test." (The Ward case at p. 401) None of the judgements in the Ward Case give any detailed consideration to the decision in *Re B*.

¹⁵ *op.cit.* p.423.

¹⁶ *ibid.*

Yet it was accepted that the Ward had some awareness: “ ... *this is not a case of no cognitive function.*”¹⁶ Indeed, the existence of such awareness *itself* became a reason for the withdrawal of treatment in the judgement of Lynch J. :

“ ... *but if such minimal cognition as she has includes an inkling of her catastrophic condition, then I am satisfied that that would be a terrible torment to her and her situation would be worse than if she were fully P.V.S..*”¹⁷

How then is the Ward case to be distinguished from cases of severe disability?

This question has both a philosophical aspect and a legal aspect.

Philosophically, the problem is to isolate the principles used by the court to justify its decision in the Ward case and then to see whether there is some feature present in cases of disability - but not in cases of PVS (or 'near PVS') - which would preclude the application of these same principles to cases of disability. Such a feature must, of course, be considered 'relevant' to the application of the principles; however, the very use of the term 'relevant' shows that our analysis cannot be restricted to a simple search for some explanatory principle but must dig deeper. This is because a proposition - or principle - cannot be understood in isolation from the context or background into which it is embedded and from which it draws its meaning: an objection only has 'relevance' in a particular context. The term 'conceptual structure' was used in the introduction to this thesis to describe just such a system of concepts and their interlinking propositions within which a problem is placed. Thus, viewed from a philosophical perspective, the problem is to make explicit the conceptual structure used in the Ward case; to show what parts of this conceptual structure were used to justify the decision and to see whether this conceptual structure permits cases of PVS, or 'near PVS', to be distinguished from cases of disability.

The legal aspect of the problem relates to the question of whether there are peculiarly *legal* grounds for asserting that the Ward decision has no application to cases of disability. Under the doctrine of precedent¹⁸ not everything said in a court decision is binding on subsequent cases but only those aspects of the decision which were necessary in the making of the decision; these propositions and the decision itself are called the '*ratio decidendi*'¹⁹ of the case; statements in a judgement which are not part of the *ratio* are not binding in subsequent cases; such statements are called '*obiter dicta*'.²⁰ Returning to the statements by Hamilton C.J., and O'Flaherty J. quoted at the beginning of this introduction, it is clear that they were not logically necessary to the decision in the Ward case. Though they may have persuasive value, they are not binding in subsequent cases. Hence, they cannot be taken as definitively excluding the application of the *ratio* in the Ward case to cases of disability. However, were a case concerning the withdrawal of life-saving treatment from a disabled individual to come before the Irish courts, then clearly, constitutional arguments might be

¹⁶ *op.cit.* per Egan J., p.437.

¹⁷ The Ward case p.8; per Lynch J..

¹⁸ P. G. Osborn. *A Concise Law Dictionary* London: Sweet and Maxwell, (1964), p.248:

“Precedent: A judgement or decision of a court of law cited as an authority for deciding a similar set of facts; a case which serves as an authority for the legal principle embodied in its decision. The common law has developed by broadening down from precedent to precedent. A case is only an authority for what it actually decides.”

¹⁹ *ibid.* p.267:

“Ratio Decidendi: [The reason (or ground) of a judicial decision.] It is the ratio decidendi of a case which makes the decision a binding precedent for the future. However, the ground of a decision is the material facts of the case, so that if a similar or comparable set of facts come before the court again, so that a new case is on 'all fours' with an earlier case, the court will follow and apply the decision in the earlier case.”

²⁰ *ibid.* p. 227:

“Obiter dictum: [A saying by the way.] An observation by a judge on a legal question suggested by the case before him, but not arising in such a manner as to require decision. It is therefore not binding as a precedent. But there is

advanced against such a withdrawal different to or more persuasive than those that were advanced in the Ward case; the existence and cogency of such possible arguments require a legal analysis and are not the concern of this thesis whose focus in Part 2 is on an examination of the philosophical argument used in the Ward decision to see whether it permits cases of disability to be distinguished from cases of PVS.

Part 2 is divided into three chapters. Chapter 6 examines the conceptual structures which were used by the courts in the Ward and Bland cases and in some subsequent English cases dealing with PVS. It is argued that the conceptual structure adopted by the courts - defining tube feeding as a medical treatment, thus reducing the problem to one of delineating the conditions necessary for the withdrawal of medical treatment - necessitated the acceptance of *'best interests'* as being the appropriate standard for decisions to withdraw ANH.

Chapter 7 argues that the concept of 'best interests' depends on that of 'quality of life'; it distinguishes between two uses of the concept of 'quality of life' - which it calls *'incremental quality of life'* and *'absolute quality of life'* - and argues that 'incremental quality of life' judgements do not depend on there being a possibility of making of 'absolute quality of life' judgements. It suggests that 'absolute quality of life' judgements are crucial to the conceptual structure adopted in the Ward case,²¹ and moreover that the danger of a *'slippery slope'*²² is occasioned primarily by its reliance on such judgements; it concludes that such judgements should, for ethical reasons, be avoided. This conclusion does not affect the use of 'incremental quality of life' judgements.

Chapter 8 considers the 'slippery slope' argument itself, and the question of whether the Ward decision engendered a 'slippery slope'.

The arguments set out in Part 2 are not an attack on the Ward decision as such but on the conceptual structure upon which it was based. There are other conceptual structures which could have been used to justify the Ward decision without incurring the danger of a 'slippery slope' such as might lead to the withdrawal of life-saving treatment in cases such as *Re B*. One such alternative conceptual structure is set out in Part 3, it enables a clear distinction to be made between on the one hand, cases of PVS or very severe disability such as found in anencephaly or in *In re J*, and on the other hand cases of Down Syndrome such as is found in *Re B*. The conceptual structure used in the Ward decision was such that cases of PVS, 'near-PVS', anencephaly, severe disability and mild disability are all placed on the same continuum, differing only in degree.

no justification for regarding as obiter dictum a reason given by a judge for his decision because he has given another reason also."

²¹ in the sense that, without this concept, the conceptual structure of treatment withdrawal would not have been sufficiently powerful to resolve the Ward case.

²² To argue against a proposal on the grounds of the undesirable consequences which are said to necessarily flow from it rather than on the merits of the proposal *per se* is known in philosophy, as the *sorites* or *'slippery slope'* argument; in short, it asserts that a proposal is *'the thin end of the wedge'* inevitably leading to unacceptable consequences. See: David Lamb, *Down the Slippery Slope: Arguing in Applied Ethics*, (1988).

Chapter 6: The theoretical approach adopted by the courts to 'end-of-life' decisions for PVS patients

This chapter analyses the conceptual structures used by the Irish and English courts in their consideration of 'end-of-life' decisions for PVS patients. It is divided into 5 sections.

Section 1 discusses some of the legal and constitutional constraints under which the courts operate when making judicial decisions. Section 2 outlines some possible conceptual structures within which the Ward and similar decisions might have been resolved. Three such structures are identified; the first centres on the rules relating to medical treatment and its withdrawal; the second centres on the rules relating to liability for the causing of death, the third centres on rules relating to the allocating of scarce resources. Section 3 considers the method of analysis used in the Ward and Bland cases; Section 4 the analysis used in subsequent PVS cases. Section 5 draws some conclusion from the discussion.

Section 1: Legal constraints on the power of the courts.

The courts, in tackling 'end-of-life' decisions, do not have an unrestricted discretion as to the solutions they adopt. They are constrained by legal and constitutional theory. They may, as in the Bland case, acknowledge that there are other, better, ways of resolving these problems than by means of 'treatment withdrawal', but decide that it is not within their legal competence to impose such solutions.

In constitutional theory the roles of the legislature and of the courts, are strictly separated; the function of the legislature is to make law and that of the courts is to apply the law so made. Theoretically, the courts have no role in the creation of law, their role is simply one of interpretation. In practice however, the situation is not so clear cut; the courts are often faced with the problem of applying existing law to situations¹ which have not been foreseen by the legislators and, rather than refusing to deal with such situations until legislation has been enacted - a path which would rapidly bring the judicial system to a halt - the courts have developed various mechanisms² to facilitate the closing of the inevitable lacunae that occur in legislation, but always conscious of the fine line that divides 'creative interpretation' of existing law from a declaration of new law - a role which is the sole prerogative of the legislature. The cumulative effect of such a process of creative interpretation is a substantial body of judge-made law; indeed, much of what is termed 'the common law' is just such a body of law.

In constitutional law - *i.e.*, the Constitution and its judicial interpretation - the same theoretical prohibition on judicial law-making applies. However, in practice - because a constitution is normally formulated in a more abstract fashion than is ordinary legislation - there is considerably more scope for judicial law-making than in non-constitutional matters, though again this is under the guise of interpretation.

¹ An amusing example is given by a recent Court of Appeal case which was concerned with whether a 'floating house' could be considered a 'houseboat'. It decided that as a matter of law a houseboat need not be boat-shaped, but that "... it was a question of fact and degree whether a craft consisting of a low rectangular platform with a two-storey prefabricated building erected on it diverged so far from the typical as no longer to merit the description 'houseboat'."

(Sussex Investments Ltd v Secretary of State for the Environment and Another. The Times 29.11.1997)

² The '*mischief rule*' is one such, whereby the problem which the original legislation was seeking to resolve (the '*mischief*') is examined in an effort to determine the correct judicial approach to a problem unforeseen in the original legislation.

These remarks are made to indicate the nature of the response of the courts when presented with a problem which has not previously been the subject of legislation or of judicial consideration. In such a situation, the judicial approach is *not* one of radical innovation, nor of abstract speculation in an effort to determine the most fitting solution - such would be the approach of a legislature - but is rather one of attempting, by analogy or by reinterpretation or by some such similar device, to situate the problem within the corpus of existing law.

There may be a number of ways that such a novel problem may be so situated, but whichever method of analysis is chosen it is incumbent on the courts to portray their decision as somehow flowing naturally from - '*logically implied by*' is too strong a phrase - an existing body of law.

Such differing ways of analysing the problem may be more accurately described in terms of the differing 'conceptual structures' within which the particular problem may be described, analysed and resolved. The discussion above could then be summarised in saying that the courts must, in analysing a problem, utilise not any conceptual structure, but only those which already have an accepted jurisprudential legitimacy.

Section 2: Possible conceptual structures for the resolution of the Ward case³

To date the US, the English and Irish courts have exhibited a uniformity of approach in considering 'end-of-life' decisions for PVS patients. The Irish courts (in the Ward case) the English courts (in the Bland and subsequent cases) and the US courts have all sought to use the withdrawal of medical treatment as the conceptual framework to resolve these questions. The unanimity is such that even to speak of *choosing* the withdrawal of medical treatment as the conceptual framework to be used seems somehow inappropriate; it is as if treatment withdrawal was the 'natural' and inevitable way of tackling these problems. It is important to see that this is not so and that alternative conceptual structures are available which would also have permitted a resolution of the problem.⁴ Unless it is acknowledged that such other conceptual structures exist, then the difficulties which occur in relation to the treatment withdrawal structure will, if they are unresolved within that structure, be regarded as intrinsic to the problem itself.

There are at least three ways in which the problems relating to 'end-of-life' decisions for PVS patients can be made amenable to a legal analysis.

- (i) The problem can be viewed as one essentially concerned with *medical treatment* and its withdrawal. A resolution to the problem can be found by clarifying the rules under which treatment may be withdrawn from an incompetent⁵ patient in situations where the result of such withdrawal is the death of the patient.
- (ii) The problem can be viewed as one essentially concerned with the rules assigning *legal responsibility for the causing of death*. A resolution of the problem can be found by restating these rules so that certain closely defined acts resulting in the death of a PVS patient could be distinguished from other acts resulting in death. In circumstances to be

³ N.B.: This thesis is concerned with formulating a conceptual scheme which will permit a more fitting resolution of the problem concerned with 'end-of-life' decisions for PVS patients. A secondary question is whether the courts could, in fact, have applied this proposed structure on the basis of existing law or whether enabling legislation would have been required, this latter question is a purely legal one and will not be examined. Equally, in considering alternative conceptual structures, the emphasis will be on their potency for resolving the problem within a recognised legal framework and not on whether their utilisation would require legislation.

⁴ In Part 3, one such alternative structure is proposed which, it is there argued, not only resolves the problems associated with 'end-of-life' decisions for PVS patients but does so without occasioning the 'slippery slope' engendered by the withdrawal of medical treatment conceptual structure.

closely defined, either such acts would not be illegal, or a defence to a charge of wrongful killing would be available. Such a method would have the effect of separating ideas of causality from legal responsibility and blameworthiness.⁶ Assistance in the making of such a restatement can be found from the concept of 'a good death' and the argument - developed in Part 3 - that the achievement of such a death is a positive good. Lord Hoffman's suggestion⁷ that amongst the interests of a patient needing protection was that of a peaceful and dignified death gives some support to this perspective. Alternatively - and this argument is also developed in Part 3 - by utilising the philosophical concept of 'personhood' a distinction can be drawn between being 'human' and being a 'person'. The conditions under which a PVS patient might be said to have lost their personhood can be examined; as can the consequences that might flow from such a loss. In particular, the rules relating to the causing of death of patients who have lost their personhood can be prescribed. Differences in status such as that between citizens and non-citizens, or between the mentally competent and the incompetent are an accepted part of the law and thus it is not an impossibility that the concept of personhood might find an acceptable place in juridical thinking.

- (iii) Lastly, the problem can be viewed as one essentially concerned with distributive justice and the *allocation of scarce resources*. Such a perspective would recognise that the resources required to sustain a PVS patient over many years are considerable, and that the allocation of such resources to a PVS patient entails a *de facto* limitation on the medical care available to others. The rights of these other patients must be balanced against the rights of the PVS patient.

In the Ward case, the Irish courts in seeking a judicially acceptable framework within which to situate the problem before them, chose to use the corpus of existing law concerned with medical treatment and its withdrawal; in this they followed the example of other jurisdictions, most notably that of the US and England. The Irish court did not use the 'WMT' framework⁸ reluctantly; they did not find that it was in any way inappropriate to the problem before them, nor did they foresee that the adoption of such a framework might have unwanted 'side-effects' in relation to future cases.

In the Bland case the English courts - in contrast to their Irish counterparts - explicitly acknowledged that alternative analytic structures existed for the consideration and resolution of 'end-of-life' decisions for PVS patients. They acknowledged - courageously - that the problem could be resolved by a re-examination of the rules relating to the legal responsibility for the causing of death or by allowing the law to take cognisance of the fact that health resources are strictly limited; but they considered that the implementation of such alternatives would have occasioned a departure from existing law of too radical a nature to be imposed by the courts and such that it necessitated legislation.

Lord Browne-Wilkinson, for example, stated:

"Where a case raises wholly new moral and social issues, in my judgement it is not for the judges to seek to develop new, all embracing, principles of law ... Moreover, it is not

⁵ *i.e.* a patient unable to consent to treatment.

⁶ As occurred, for example in *Auckland Area Health Board v AG* (Appendix C - number 17) where Thomas J. proposed that although the doctors in withdrawing life-sustaining treatment might be said to *cause* the death of the patient they did not '*legally cause*' his death.

⁷ The Bland case at p.833.

⁸ The acronym 'WMT' is used as shorthand for 'withdrawal of medical treatment'.

legitimate for a judge ... to take into account the wider practical issues as to allocation of limited financial resources ... For these reasons, it seems to me imperative that the moral, social and legal issues raised by this case should be considered by Parliament ... The function of the court ... is to determine this particular case in accordance with the existing law, and not seek to develop new law laying down a new regimen.”⁹

The House of Lords recognised that the only framework available to them to deal with the problem was that of ‘treatment withdrawal’ and that this was a less than ideal structure within which to consider it. Lord Mustill, for example, stated:

“My Lords, I must recognise at once that this chain of reasoning makes an unpromising start by transferring the morally and intellectually dubious distinction between acts and omissions into a context where the ethical foundations are already open to question. The opportunity for anomaly and excessively fine distinctions, often depending more on the way in which the problem happens to be stated than on any real distinguishing features, has been exposed by many commentators”¹⁰

Lord Browne-Wilkinson concluded his judgement by saying:

“I am very conscious that I have reached my conclusions on narrow, legalistic, grounds which provide no satisfactory basis for the decision of cases which will arise in the future where the facts are not identical ... the conclusion I have reached will appear to some to be almost irrational. How can it be lawful to allow a patient to die slowly, though painlessly, over a period of weeks from lack of food but unlawful to produce his immediate death by lethal injection? ... I find it difficult to find a moral answer to that question. But it is undoubtedly the law ...”¹¹

Conclusion₆₋₁: *The court in the Bland case, in contrast to that in the Ward case, acknowledged that the methods of analysis (i.e. withdrawal of medical treatment) available to them for the resolution of the problem were not ideal; that other more appropriate methods existed but were not available to the courts until appropriate legislation was enacted.*

Let us now consider the attitude of the courts - in the Ward and Bland cases - to each of the suggested frameworks.

Section 3: The method of analysis used in the Ward and Bland cases.

This section is divided into three subsections. Subsection 1 considers the difficulties encountered by the courts in using ‘medical treatment’ as the conceptual framework for analysing the problem underlying both the Ward and Bland cases; Subsection 2 considers the attitude of the Ward and Bland courts to the possibility of reformulating the rules relating to the causing of death, in the search for a solution; Subsection 3 considers the attitude of the Ward and Bland courts to using the concept of ‘scarce resources’ as a mechanism to resolve the problem.

⁹ *ibid.* p.880.

¹⁰ *ibid.* p.898.

¹¹ *ibid.* p.885.

Subsection 1: The Ward and Bland decisions: the medical framework.

The discussion in this subsection is structured as follows:

- (i) Some possible reasons for the Ward court preferring the 'WMT' framework.
- (ii) The legal minefield to be navigated in order that 'WMT' not be legally deemed to be murder: the distinctions between 'motive' and 'intention', between 'direct' and 'indirect' intention, between 'act' and 'omission'.
- (iii) The legal conditions necessary to justify the withdrawal of ANH;¹² the questions: '*Who should exercise the right to refuse treatment on behalf of an incompetent?*' and '*What criteria should be used?*'
- (iv) An example is given to help 'de-medicalise' the problem underlying the Ward and Bland cases. This example shows that the medical setting within which the problem is usually viewed is contingent with no necessary connection to the underlying problem. It is argued that, because of this dependence on contingent facts, the choice of the 'WMT' framework is inherently flawed.

(i) Why was 'withdrawal of medical treatment' the preferred framework?

Let us examine some of the reasons why the choice of the 'medical treatment' framework seemed so compelling to the Ward court. As presented to the courts the Ward case was redolent of medicine. A botched medical operation was the cause of the original problem; the Ward had been hospitalised and cared for by medical personnel for over twenty years and she was under continuing medical care; the intervention sought from the courts - and the suggested resolution to the problem, the withdrawal of ANH - was expressed in a terminology¹³ which was purely medical. Furthermore, the courts regarded these cases as something of a poisoned chalice; by interpreting the problem as a purely medical one of treatment withdrawal, and seeking comfort from the distinction between direct and indirect intention, they were able to put to one side consideration of the fact that the goal¹⁴ of the withdrawal of ANH was the inevitable death of the patient.¹⁵ The issue for the courts then became the withdrawal of treatment from the patient rather than the occasioning of the death of the patient or, more euphemistically, the 'allowing' of the patient to die, thus permitting the courts to achieve some psychological distance from that which is doubtlessly the central issue of the problem - the death of the PVS patient. This need to psychologically avoid the actuality of the problem was considerably more evident in the Ward case than in the Bland case. In the Bland case, for example, Lord Browne-Wilkinson acknowledged that:

¹² The acronym 'ANH' is the standard abbreviation for 'Artificial Nutrition and Hydration'.

¹³ e.g. "An Order that all artificial nutrition and hydration cease." High Court unreported judgement at p.10.

¹⁴ R. A. Duff, in *Intention, Agency and Criminal Liability*, (1990) suggested that to determine what the 'goal' of a procedure is we need only ask as to what must happen before the procedure would be adjudged to be successful.

What is the goal in the withdrawal of artificial ventilation in cases such as the Carrie Coons or Karen Quinlan cases (discussed in Part 1)? Is it the (peaceful) death of the patient, or simply that the patient may breathe unaided? A consideration of the Carrie Coons case - who started to breathe unaided - or the case of David Glass (Appendix C - number 14) shows that, in such cases, the goal of the withdrawal is clearly the (peaceful) death of the patient. This would imply that the death is the intended result of the procedure.

¹⁵ Auckland Area Health Board v AG (Appendix C - number 17) offers an interesting perspective on the question of causation. Counsel had urged that the withdrawal of medical treatment could not be considered to be *causing* the death of Mr. L; Thomas J., however, found such an analysis to be unhelpful. He considered the example of a polio victim who, unable to breathe, was being ventilated but who was desirous of remaining alive. He suggested that it is not acceptable to say of a doctor who in such a case did in fact remove ventilation, that he did not cause the death of the patient. He held that the question must be resolved not by an analysis of cause, but by an analysis of the lawfulness of the proposed course of action.

*"... the whole purpose of stopping artificial feeding is to bring about the death of Anthony Bland"*¹⁶

Lord Mustill fully acknowledged that the treatment withdrawal would cause the death of Tony Bland:

*"I am bound to say that the argument¹⁷ seems to me to require not manipulation of the law so much as its application in an entirely new and illogical way. In one form the argument presented ... asserts that the cause of Anthony Bland's death ... will be the Hillsborough disaster ... it is in my judgement perfectly obvious that the conduct will be, as it is intended to be, the cause of death ..."*¹⁸

To both Lords Browne-Wilkinson and Mustill, the issue before the court was not whether the withdrawal of ANH caused the death but whether the withdrawal was lawful; both concluded that it was, though for differing reasons.

In contrast, in the Ward case Hamilton CJ. stated:

*"The true cause of the Ward's death will not be the withdrawal of such nourishment but the injuries which she sustained ... in 1972."*¹⁹ and *"It is important to emphasise that the court can never sanction steps to terminate life."*²⁰

Denham J. stated:

*"If this court determines that the order of the High Court be upheld then ... the ward would die shortly as a result of the medical catastrophe which occurred 23 years ago."*²¹

Conclusion^{6.2}: *Part of the attractiveness of the 'WMT' to the Ward court was that it offered to the court the possibility of evading responsibility for occasioning the death of the Ward. This evasion was accentuated by the decision of the court that an application to the court is not required in future cases where the withdrawal of ANH is contemplated; this was in contrast to the Bland court which did lay down such a requirement.*²²

(ii) The legal minefield: Is the withdrawal of ANH legally murder?

There are a number of legal rules and distinctions which are of central importance to any discussion of treatment withdrawal resulting in the death of the patient; the most important of these are the distinction between 'motive' and 'intention', between 'direct intention' and 'indirect intention', between 'act' and 'omission'; and the legal rules relating to omissions which cause death.

Motive

The law is concerned with the prohibition of certain acts; it is not concerned with a determination of the supposed moral justification, if any, for the commission of such acts; thus it is not concerned with motive; in Smith and Hogan's Criminal Law - which is a leading authority on criminal law - it is stated that:

¹⁶ The Bland case p.881.

¹⁷ i.e. on causation.

¹⁸ *ibid.* p.895.

¹⁹ The Ward case p.429.

²⁰ *ibid.* p.423.

²¹ *ibid.* p.462.

²² The respective requirements are set out in Appendix C, numbers 1 and 2.

“... it is entirely irrelevant to his guilt that he had a good motive. The mother who kills her imbecile and suffering child out of motives of compassion is just as guilty of murder as is the man who kills for gain.”²³

Equally, the doctor who kills his patient out of compassion is as guilty of murder as the doctor who kills his patient out of the desire to receive a promised inheritance; the case of *R v Cox* (1992) exemplified just such circumstances and was discussed in the judgements in the *Bland* case.²⁴

The distinction between direct and indirect intention

The importance of preserving the distinction between directly intended acts and those indirectly intended was reiterated by the Ward and Bland courts on many occasions; it is a distinction which has been of great importance in both moral and legal theory:

In moral theory

Particularly in Roman Catholic moral theory - where it is sometimes known as the ‘*doctrine of double effect*’ - the distinction has been used both in discussing abortion and the withdrawal of medical care resulting in death.

In relation to abortion, it has been used to justify medical procedures where the direct intent is to preserve the life of the woman, but which have the (indirect) effect of terminating her pregnancy.

In relation to the care of the terminally ill, it has been used to justify the administering of pain relieving medicine if the primary (or direct) intent is to relieve pain even though there is a recognition that death will result.

In legal theory

The legal responsibility for acts which are directly intended is not in doubt; the situation for indirectly intended acts is more problematic. Smith and Hogan defines ‘*direct intention*’ in terms of those acts which are ‘*foreseen and desired*’:

“It is clear that a man [directly] intends a consequence of his act when he foresees that it may result and desires that it should do so.”²⁵

In relation to ‘*indirect intention*’ Smith and Hogan comment that:

“When the consequence is not desired for its own sake difficulties arise. The problem occurs where D, in deciding to act, contemplates two consequences, (A) and (B). (A), considered in isolation, is a consequence which D does not desire, indeed its occurrence may be abhorrent to him. (B) however he wants badly.”²⁶

The authors then distinguish between cases where (A) and (B) are *necessarily connected* and cases where the connection is *contingent*. They suggest that if (B) is intended, and (A) is necessarily connected with (B), then liability should automatically follow for (A); whereas if the connection is contingent then liability for (A) should depend on the degree of probability of (A) ensuing. The reported cases, which hinge on liability for indirectly intended acts, are few and do not readily fit the suggested framework; however, the authors considered an hypothetical case which is instructive: a nephew who, on the death of his uncle, is due to inherit the uncle’s estate; the nephew

²³ Smith and Hogan. *Criminal Law*. (1969 - 2nd ed.) p.47.

²⁴ See Appendix C - number 2.

²⁵ Smith and Hogan *op.cit.* at p.37.

²⁶ *ibid.* p.37 (speaking of some imaginary individual D).

desires to enjoy his inheritance immediately though he does not desire his uncle's death as he loves him; the nephew gives his uncle a fatal dose of poison: *Does he intend his uncle's death?*

*"Of course ... the courts would say that he intended to cause death. His intention to inherit [the] property would be regarded as a mere motive, irrelevant except for the purposes of proof."*²⁷

Two points emerge from this legal analysis:²⁸

- (i) criminal responsibility attaches to an *act* if it is foreseen and desired.
- (ii) criminal responsibility attaches to an *act* which has death as a foreseen and necessary, but not desired, consequence.

The distinction between act and omission

Applying the above analysis to the withdrawal of ANH from a PVS patient, the conclusions follow that because the withdrawal of ANH is either an *act* or an *omission*:

(A) If it is considered as an *act* then certainly the death of the patient is a foreseen consequence;

- (i) If the death is a desired consequence then the act is murder.
- (ii) If the death is not a desired consequence but is a necessary consequence then again the act is murder

It is extremely difficult to avoid the conclusion that, in the withdrawal of ANH from a PVS patient, death is the desired result; for example, in the Ward case Lynch J. stated:

*"I take the view that the proper and most satisfactory test to be applied by the Court in this case is the best interests test, i.e. whether it is in the best interests of the Ward that her life, such as it is at present, should be prolonged by the continuation of the abnormal artificial means of nourishment or whether she should be allowed to slip away naturally by the withdrawal of such abnormal artificial means ..."*²⁹

The '*allowing to slip away naturally*' is clearly a desired consequence; however even if this were disputed, the death is clearly a necessary consequence of the withdrawal of ANH. Thus, if the withdrawal of ANH were considered an *act* - as distinct from an omission - it would amount to murder. Hence:

(B) In order to be considered lawful, it is necessary that the withdrawal of ANH be categorised as an *omission*.³⁰ This, of course, is not a sufficient condition.

Conclusion⁶⁻³: *In order that the withdrawal of ANH be not legally categorised as murder, it is necessary that it be deemed to be an omission as distinct from an act.*

The importance of categorising the withdrawal of ANH as an omission was clearly recognised in the Bland judgement; though Lord Browne-Wilkinson had a certain difficulty in categorising it as such:

²⁷ *ibid.* p.38.

²⁸ See also the footnote reference to Duff, *Intention, Agency and Criminal Liability*, at the beginning of Subsection 1.

²⁹ The Ward case; unreported judgement of the High Court at p.23.

³⁰ There are many judicial pronouncements to this effect; for example:

"It is important to emphasise that the court can never sanction steps to terminate life." [Hamilton C.J., the Ward case p.423]

"... the court would never sanction positive steps to terminate the life of a person" [Re J. (A Minor) (wardship: medical treatment) [1990] 3 All ER 930 at p.931].

*"The positive act of removing the nasogastric tube presents more difficulty. It is undoubtedly a positive act, similar to switching off a ventilator in the case of a patient whose life is being sustained by artificial ventilation. But in my judgement in neither case should the act be classified as positive, since to do so would introduce intolerably fine distinctions. If, instead of removing the nasogastric tube, it was left in place but no further nutrients were provided for the tube to convey to the patient's stomach, that would not be an act of commission. Again ... if the switching off of a ventilator were to be classified as a positive act, exactly the same result can be achieved by installing a time-clock which requires to be reset every 12 hours; the failure to reset the machine could not be classified as a positive act ... In my judgement, there is a further reason why the removal of the nasogastric tube in the present case could not be regarded as a positive act causing death. The tube itself, without the food being supplied through it, does nothing. The removal of the tube itself does not cause the death since by itself it did not sustain life."*³¹

Lord Mustill found the distinction between an act and an omission to be crucial to his judgement, though he expressed an acute sense of unease at relying on it and suggested that the distinction was *'both morally and intellectually dubious'*.³² Lady Butler-Sloss found the distinction unhelpful,³³ as did Lord Hoffman, who described it as *'barren'*.³⁴

The legal liability for omissions which cause death³⁵

In considering criminal liability for omissions, Smith and Hogan noted that the criminal law very rarely punished omissions; it considered its task as being that of preventing men from doing positive harm leaving the encouragement of doing good to other social institutions such as religion. An illustration of this attitude which is commonly given is the example of a group of people watching a child, whom they could easily save, drown in a shallow pool. In the absence of any special relationship with the child, they commit no crime. However, if a special relationship which implies a duty to intervene exists, then liability for omissions may be imposed. Smith and Hogan cite the case of *Gibbins and Proctor* where a woman living with a man withheld food from the man's child intending it death or serious harm; she was convicted of murder.³⁶ The case *R v Stone [1977]* was mentioned in the Bland case;³⁷ this case concerned a doctor who was convicted of manslaughter for failing to supply food and to procure medical attention for an elderly and infirm, but conscious, woman who was capable of feeding herself if food had been supplied. These authorities suggest

³¹ The Bland case p.881.

³² *ibid.* p.898.

³³ *ibid.* p.823.

³⁴ *ibid.* p.831.

It is argued in Chapter 10 that of the rights that flow from the ascription of personhood to an individual the most fundamental is the *'right to be let alone'*: this implies that no intervention be made to an individual without his consent even if - perhaps, especially if - it was being done for his supposed 'best interests'. If such a wrongful intervention is made then the removal of the intervention is justified and this is so whether the removal of the intervention involves an act or an omission. In short, the important concept is *'intervention'*; *'act'* and *'omission'* have had an historical importance because they function as a rough classificatory guide in that *'interventions'* are usually *'acts'* whereas *'omissions'* are usually not interventions. Lord Hoffman - in speaking of the *'principle of inviolability'* and in suggesting that the prohibition is not against *'acts'* as such but against introducing an *'external agency of death'* (The Bland case at p.831) - suggests a similar analysis.

³⁵ A recent BMA report is of interest:

"Where ventilatory support is to be withdrawn, for example, any medication which has the effect of suppressing the patient's ability to breathe unaided should also be withdrawn. Failure to do so could be interpreted, in law, as action taken with the purpose or objective of ending the patient's life."

[BMA (1999a) Withholding and Withdrawing Life-prolonging Medical Treatment : Guidance for decision making. 3C.17.4]

³⁶ Smith and Hogan *op.cit.* at p.36

³⁷ The Bland case p.815.

that the withdrawal of food by medical carers would appear to be murder.³⁸ Unlike the duty to provide medical treatment, the duty of (medical) carers to provide food would appear to be absolute. However, Lord Hoffman in the Bland case suggests that such a duty is not absolute and ceases when it can achieve no humane purpose.

In summary: The withdrawal of ANH from a patient by medical personnel who are charged with his care is legally murder unless the following conditions, are satisfied:

- (i) The withdrawal of ANH must be considered as an omission, as distinct from an act (*pace* Butler-Sloss, LJ).
- (ii) The ANH must not be considered as being 'food'. (*pace* Hoffman LJ.)

Conclusion 6.4: *In order that the withdrawal of ANH from a patient by medical personnel who are charged with his care not be legally held to be murder, it is necessary that ANH be deemed not to be 'food'.*

The above conclusions are essentially negative in that they are of the form '*if such and such is the case then the withdrawal of ANH is not murder*'; they do not specify when such a withdrawal is justified; a further analysis is required to clarify this latter question.

A framework within which the withdrawal of ANH could be justified could have been found either from a re-examination of the rules relating to the causing of death or the rules concerning the allocation of scarce resources; the courts however, chose to reconsider the rules relating to medical treatment and its withdrawal. However, before the existing law on medical treatment could be used to justify the withdrawal of ANH; certain prerequisites had first to be established.

(iii) The legal preconditions required to justify the withdrawal of ANH.

The previous section considered the conditions which were necessary in order that the withdrawal of ANH not be legally deemed to be murder; these were that ANH must not be considered to be 'food', and that the withdrawal must be considered to be an omission. We now seek sufficient conditions; *i.e.* criteria that would *justify* the withdrawal of ANH even though death was the foreseeable result of such a withdrawal.

If the problem is to be resolved by 'WMT' framework then it is first necessary that ANH be considered a medical treatment - for in the absence of this initial step the 'WMT' framework would simply be irrelevant and could find no point of purchase on the problem. Once ANH is deemed to be a 'medical treatment' then the next step is to establish that consent of the patient is required for all medical procedures including those which are life-saving. It is a corollary of this proposition that a competent person has the right to refuse medical treatment even though such refusal may result in their death. The next step in the analysis is to establish that the right of a patient to refuse life-sustaining treatment is not lost by virtue of their incompetency. The following step is to clarify who may exercise that right on behalf of the incompetent patient and the final step is to determine the criteria that should be used by the one who is exercising the right on behalf of an incompetent.

To summarise:

Conclusion 6.5 : *In order that the 'WMT' may be used to justify the withdrawal of ANH the following propositions must be established:*

- (a) that ANH is a medical treatment.*

³⁸ Remembering that their motive is of no legal relevance.

- (b) that a patient's consent is required for all, including life-sustaining, medical treatment.
(A corollary of this is that a patient can refuse life-sustaining medical treatment.)
(c) that a patient does not lose the right to refuse life-sustaining treatment by virtue of their incompetency.

Once this right is established, then those who may exercise the right on behalf of an incompetent patient must be identified, and the criteria that must be used by them in making the decision to withdraw life-sustaining treatment must be specified.

(a) ANH is a medical treatment

In the Ward and Bland cases 'food' and 'medical treatment' are conceived of as being mutually exclusive categories; for example, in the Ward case Blayney J., stated:

*"Normal food and drink could never be categorised as medical treatment."*³⁹

Hence, the categorising of ANH as a 'medical treatment' precludes it being categorised as a 'food' thus avoiding the first hurdle specified in the previous subsection: *i.e.* that if ANH is categorised as a 'food' its withdrawal by medical carers is, legally, murder. However, is ANH a 'medical treatment'?

Although the feed itself may be a medical preparation, and the means by which it is administered - the nasogastric or gastrointestinal tube - may require medical expertise, the classifying of ANH as a 'medical treatment' is by no means clear cut. The issue was not fully argued in any of the judgements in either the Ward or Bland cases.⁴⁰

In the Bland case, the general view was that the existence of a medical consensus which considered ANH to be a medical treatment, was decisive; though some of the judges sought to resolve the problem in a more indirect way. Butler-Sloss LJ. for example, considered '*medical care*' rather than '*medical treatment*' as being the important concept thus avoiding the need for 'over-fine distinctions'; Lord Keith suggested that the focus should be on the whole medical regime which kept Anthony Bland alive and that this was undoubtedly '*medical treatment*'.⁴¹

In the Ward case, the argument on whether ANH is a 'medical treatment' was resolved in a peremptory manner best exemplified in the statement of Denham J.:

*"I am satisfied that feeding the ward a formula through a gastrostomy or nasogastric tube is a form of medical treatment."*⁴²

Once it is conceded that ANH is a medical treatment then a further question arises: does the treatment consist of the '*food*' or the '*nasogastric tube*' or, perhaps, both? Dr. Andrews argued that the '*tube*' - but not the '*food*' - was the treatment:

"At the trial I suggested that treatment, by its very nature, was given to treat an abnormality and said that I could not understand what abnormality the food was supposed to be treating"

³⁹ *ibid.* p.444.

⁴⁰ A recent BMA report is of interest in that it gives added reasons for regarding the giving of ANH as a medical treatment:
"The provision of nutrition and hydration by artificial means requires the use of medical or nursing skills to overcome a pathology in the swallowing mechanism, in the same way that the artificial provision of insulin is given to diabetic patients to overcome the body's own inability to produce that substance."

[BMA (1999a) Withholding and Withdrawing Life-prolonging Medical Treatment : Guidance for decision making. 1.3 .4]

⁴¹ See Appendix C - number 2

⁴² The Ward case p.456.

*... there is no reason, apart from the time needed for its preparation, why liquidised 'normal' food should not be used. The tube is therefore the treatment the food is not."*⁴³

However, Lord Browne-Wilkinson found a difficulty in regarding the tube as the treatment; he noted, as quoted earlier, that the removal of the tube was a positive act not an omission; and he held that *"The tube itself, without the food being supplied through it, does nothing."*⁴⁴ and that the withdrawal of treatment sanctioned by the court related to the withdrawal of food - an omission not a positive act; this approach however clouds any possibility of distinction between 'food' and 'treatment'. In point of fact the judgements in the Bland case refer explicitly at many points to 'food' rather than 'treatment' being withdrawn; it is, perhaps, best to interpret this as an informal use of the term 'food' to cover the mixture that was used in the tube-feeding, and not 'food' in the technical sense whose withdrawal would constitute murder. However, doubt is cast on this interpretation by a statement of Dr. Andrews, quoted above, that there was *"... no reason ... why liquidised 'normal' food should not be used."* Andrews, speaking of the Bland case, continued:

*"The tube is therefore the treatment, the food is not."*⁴⁵

It is ironic that in the Bland case, the tube was not, in fact, removed; it was left in place in case it might be useful in the giving of medication.⁴⁶ To hold that the tube was the treatment would imply that the treatment had not been withdrawn!

In conclusion:

Conclusion⁶⁻⁶: *The arguments for classifying ANH as a 'medical treatment', though less than compelling, were accepted by both the Ward and Bland courts.*

(b) The patient's consent is a prerequisite for all medical treatment.

Once it has been accepted that ANH is a medical treatment, then the existing law concerning the legal requirements for medical intervention come into play. In describing these legal requirements it is easier to first consider the law relating to the medical treatment of competent patients, and to then consider the situation where competency is absent.

Competent patients: the necessity for consent

The current law is to the effect that no medical treatment can be given to a competent patient without their consent and that any attempt to do so constitutes a legal assault.⁴⁷ Although this has generally been accepted in Ireland as being the law, it was not until the Ward case that it was authoritatively and unambiguously stated to be so.

Conclusion⁶⁻⁷: *The Ward case established that a competent individual has the right to refuse medical treatment even if their death is the result of such a refusal.*

Until the Ward case there had been some doubt as to whether a refusal of life-sustaining treatment was legally binding in Irish law. Indeed, in the Ward case Hamilton CJ. sought to restrict the right to refuse life-sustaining treatment to those cases where the patient was terminally ill:

⁴³ Andrews (1993a) p.1600.

⁴⁴ The Bland Case at p.882.

⁴⁵ Andrews (1993a) p.1600.

⁴⁶ This came to light in a radio interview given by Dr. Howe (the neurologist in charge of Tony Bland) to RTE Radio on 26.5.1999.

⁴⁷ The legal defence of 'necessity' gives a gloss on this rule to the effect that, in cases of urgency and when a patient is unable to communicate, medical intervention may be justified; see the judgement of Denham J. in the Ward case at p.454.

*"A competent adult if terminally ill has the right to forego or discontinue life-saving treatment."*⁴⁸

Hamilton CJ. found that the Ward was in fact terminally ill thus allowing him to avoid conceding a general right to refuse life-sustaining treatment. The attempt to categorise PVS as a terminal illness is unsustainable and was not supported by other members of the court.

Denham J, in contrast, was unequivocal in declaring the general right to refuse life-sustaining treatment:

*"Medical treatment may not be given to an adult person of full capacity without his or her consent. There are a few rare exceptions to this e.g. in regard to contagious diseases; in a medical emergency where the patient is unable to communicate ... The consent ... is not necessarily a decision based on medical considerations ... Such reasons may not be viewed as good medical reasons, or reasons most citizens would regard as rational."*⁴⁹

O'Flaherty J. was equally forthright:

*"... there is an absolute right in a competent person to refuse medical treatment even if it leads to death."*⁵⁰

As was Blayney J.:

*"Where a person who is compos mentis has a condition which, in the absence of medical intervention, will lead to death, such a person has a right in law to refuse such intervention."*⁵¹

There had been some legal opinion to the effect that a refusal of life-sustaining medical treatment, without sufficient medical reason, was *necessarily* evidence of irrationality thus implying mental incompetence and thus obviating the need for patient consent, the treatment being given under the legal doctrine of necessity.⁵² Such non-consensual interventions had also been justified by theories of the 'sanctity of life'; these held that an individual's life was the very precondition for the possession of rights and as such implied that an individual could have no right to take his own life. A similar philosophy underlies the (still accepted) legal prohibition on a person selling themselves into bondage or slavery - one has total contractual freedom but such freedom does not extend to the giving away of one's freedom! In the Ward case, the statement of the Chief Justice exemplifies such an approach:

*"No person has the right to terminate or have terminated his or her life or to accelerate or have accelerated his or her death."*⁵³

As does the comment in Smith and Hogan - a leading textbook on criminal law - that:

*"Prison officials may - indeed, must - forcibly feed prisoners if that is necessary to preserve their health and, a fortiori, their lives."*⁵⁴

⁴⁸ The Ward case p.427.

⁴⁹ *ibid.* p.454.

⁵⁰ *ibid.* p.431.

⁵¹ *ibid.* p.442.

⁵² Such opinions were not uncommon in both the medical and legal professions up to recent times as is evidenced in attitudes towards Jehovah Witnesses who refused life-sustaining blood transfusions and towards the force feeding of anorexics and those on hunger strike. A very recent example of such opinions is found in an English case which concerned the decision of Ian Brady, the so-called 'Moors murderer', to starve himself to death. Brady embarked on his hunger strike because his application for remission of his life sentence had been refused and he did not wish to live the remainder of his life in prison without any hope of release. He had been on hunger strike for 164 days and he was being fed, against his wishes, by means of a nasogastric tube. Brady applied to the court for an order that his refusal to consent to the tube-feeding be respected, and the tube-feeding be discontinued. The court, holding that the hunger strike was a symptom of his mental illness, refused the order sought on the grounds that the refusal was in Brady's 'best interests'.

Ironically, these very prisoners were tube fed!⁵⁵

(c) Incompetent patients do not lose the right to refuse life-sustaining treatment.

Once it is conceded that competent patients have the right to refuse life-sustaining treatment then the following questions arise:

Should this right to refuse treatment have any applicability to incompetent patients?

If so: *Who should exercise this right?* and

What criteria should they use?

There was no dissent in either the Ward or Bland case from the proposition that the right to refuse treatment applied to incompetent patients; the argument in favour is well expressed in Denham J.'s pithy comment that:

*"To continue the treatment is as much a decision as not to do so."*⁵⁶

This implies that a treatment decision is unavoidable; either a consent or a refusal to consent is required, there is no third way.

The other two questions were much discussed by the courts; in examining the judgements it is easiest to consider the Ward and the Bland cases separately.

Who should exercise this right? What criteria should they use? - The Bland case

The *parens patriae* jurisdiction⁵⁷ of the court gives the court the power to make decisions for those who are incompetent. This jurisdiction was, in part, removed by statute from the English courts, with the result that the English courts lost the power to consent to the medical treatment of incompetent adults other than those who were wards of court. However, the English courts⁵⁸ laid down the principle, based on the law of necessity, that a doctor can lawfully treat an incompetent adult if it is in the patient's 'best interests' that he do so. The result is that although the court could not make a decision to permit treatment withdrawal for Anthony Bland, they did assert the right of his doctor to make that decision and they laid down the criterion to be used by the doctor in making the decision: the decision should be made in the patient's 'best interests'.

A more detailed consideration of the criterion to be adopted

At first instance,⁵⁹ the withdrawal of ANH was held to be '*in the best interests of Tony Bland.*'⁶⁰ In the Court of Appeal, Sir Thomas Bingham MR held that the question of whether ANH be withdrawn:

*"... is to be resolved by the doctors in charge of his case ... conscientiously exercising a careful and informed judgement as to what the best interests of their patient require."*⁶¹

Butler-Sloss LJ. held that the 'substituted judgement' test had no application in such cases and that the appropriate test was the 'best interests' test. Hoffman LJ. based his judgement on the

[The Times and The Irish Times 11th March 2000].

⁵³ *ibid.* p.426.

⁵⁴ Smith and Hogan *op.cit.* p.137.

⁵⁵ A recent case (Sec of State v Robb [1995] 1 F.L.R.), relying on the Bland judgement, has decided that a prisoner has the right to refuse nutrition. However, the case of Ian Brady, mentioned above, seems to restore the *status quo ante*.

⁵⁶ The Ward case p.456; the observation was originally made by Lord Hoffman in the Bland Case.

⁵⁷ This is discussed more fully in Appendix C - number 2.

⁵⁸ In the case *In re F* see Appendix C - number 6.

⁵⁹ *i.e.* at the first hearing of the case.

⁶⁰ The Ward case p.805.

⁶¹ The Bland case p.812.

wrongfulness of introducing 'an external agency of death';⁶² this permitted him to conclude that, in the instant case, the withdrawal of ANH was not wrongful in that it was not an external agency of death. The concept of 'best interests' played only a limited role in his analysis:

*"The best interests of the patient in my judgement embrace not only recovery or the avoidance of pain (neither of which apply to this case) but also a dignified death."*⁶³

In the House of Lords, Goff LJ. decided that the appropriate criterion was the 'best interests' test; however, he distinguished between cases where some consciousness remained and those - as in the Bland case - where the patient was totally unconscious. In cases of the former type the rule was laid down in *In re J*⁶⁴ i.e. that it -

*"... is for the court to judge the quality of life the child would have to endure if given the treatment and decide whether in all circumstance such a life would be so afflicted as to be intolerable to that child."*⁶⁵

Goff LJ. held that in the Bland case "... there is in reality no weighting operation to be performed ... it is the futility of the treatment which justifies its termination."⁶⁶ He held that the 'substituted judgement' test formed no part of English law.⁶⁷

Lord Browne-Wilkinson held that the 'best interests' test was the appropriate test:

*"... the critical decision ... is whether it is in the best interests of Anthony Bland to continue the invasive medical care ..."*⁶⁸

Lord Mustill found the 'substituted judgement test to be 'meaningless'.⁶⁹ His analysis of the application of the 'best interests' test was novel in that he found that Tony Bland had no interests of any kind and as such the requirement for the continuance of treatment - i.e. that it be in his 'best interests' - was not satisfied and accordingly the treatment must cease. Lord Mustill argued that the suggestion that the duty of the state to preserve life may be overridden in situations where the 'quality' of life is diminished by disease or incapacity should be firmly rejected:

*"This is the first step on a very dangerous road indeed, and one which I am not willing to take."*⁷⁰

Who should exercise this right? - The Ward case

It had been submitted in argument that the exercise of the right to withdraw treatment from the Ward lay with either the patient's family, or with his medical team, or with the courts or, indeed, with the patient herself in so far as she had made her views known before the onset of the near-vegetative state. The court held that the decision ultimately rested with the courts. The court explicitly used their *parens patriae* jurisdiction and thus the decision is not restricted to cases of wardship. However, the court did not stipulate that its permission be sought in future cases where the withdrawal of ANH was contemplated; it seems that in such cases, if the patient's family and

⁶² *ibid.* p.831.

⁶³ *ibid.* p.833

⁶⁴ see Appendix C - number 10.

⁶⁵ The Bland case p.868.

⁶⁶ *ibid.* p.869.

⁶⁷ *ibid.* p.872.

⁶⁸ *ibid.* p.884.

⁶⁹ *ibid.* p.895.

⁷⁰ *ibid.* p.894

medical carers are in agreement, that such a course is in the patient's 'best interests', the ANH can be withdrawn without court approval.⁷¹

What criteria should be used? - The Ward case.

Various tests were suggested to the Ward court as to the criteria that should be applied in making a decision of treatment withdrawal for an incompetent patient. For example, it was suggested⁷² that the criterion should be either a '*benefits and burdens test*', a '*substituted judgement test*', or an '*objective medical standards test*'. It was also suggested that a '*best interests*' test was the most appropriate.

In the High Court, Lynch J. stated:

*"I take the view that the proper and most satisfactory test to be applied by the Court in this case is the best interests test ... Whilst the best interests of the Ward is the acid test, I think that I can take into account what would be her own wishes if she could be granted a momentary lucid and articulate period."*⁷³

In the Supreme Court, O'Flaherty J. found that it was:

*"... impossible to adapt the 'substituted judgement' to the circumstance of the case ... For now, I prefer to rest my judgement by deciding what is in the best interests of the ward."*⁷⁴

Blayney J. approved the test laid down by Lord Goff in the Bland case, that the appropriate criterion is:

*"... whether it is in the best interests of the patient that his life should be prolonged by this form of medical treatment."*⁷⁵

Denham J. held that:

*"The test is: whether it is in the best interests of the ward ... for the court to consent to the medical treatment."*⁷⁶

Conclusion⁶⁻⁸ : *The Ward and Bland cases held that treatment decisions for incompetent patients should be made on the basis of the patient's 'best interests'.*

The injunction to a patient's physician that treatment decisions should be based solely on the 'best interests' of the patient clarifies the ethical duties of the physician; it implies, for example, that interests of parties other than the patient - such as interests of the patient's family or of the medical authorities if these do not coincide with the patient's interests - should be disregarded. However, it does not help to distinguish between two possible courses of action both of which, it is claimed, are in a patient's 'best interests'; for such a task, the concept of 'quality of life' is required. The concept of 'quality of life' is examined in Chapter 7.

⁷¹ For further discussion see Appendix C - number 1.

⁷² The Ward case p.449-450.

⁷³ *ibid.* unreported judgement of the High Court p.23-5.

⁷⁴ *ibid.* p.434.

⁷⁵ *ibid.* p.444.

⁷⁶ *ibid.* p.463.

(iv) *An example*

Let us attempt to separate the medical description of the problem underlying the Ward and Bland cases from the problem itself; this is a difficult task since even the word 'patient' connotes a medical setting and 'PVS', a medical condition.

Consider the example of a PVS patient who is normally cared for at home by their immediate family but who, in emergencies, is hospitalised. Let us further assume that when at home, the patient is given his normal food, which is fed by spoon by a family member.⁷⁷ Such circumstances are not unknown: the last days of the Ward, for example, were spent at home though under nursing care.⁷⁸

Compare these two situations: the hospitalised tube-fed PVS patient 'X', and the home based spoon-fed PVS patient 'Y'. The families of both patients wish that the patients be 'allowed' to die. Certainly, as we have seen, a *legal* distinction can be drawn between the family ceasing to feed patient 'X' and the medical carers ceasing to give ANH to patient 'Y',⁷⁹ but can an *ethical* distinction be drawn between the two cases?

It is clear that the intent is the same in both cases. A distinction might be attempted between the withdrawal of treatment and the withdrawal of food by suggesting that, unlike the withdrawal of food, the withdrawal of life-saving treatment need not *necessarily* lead to death. Though this distinction may have some slight validity in cases where the life-saving medical treatment being discussed is withdrawal of ventilation⁸⁰ it is difficult to justify with regard to withdrawal of ANH.⁸¹

A distinction between the withdrawal of treatment and the withdrawal of food based on the possibly greater suffering caused to the patient by the withdrawal of food can be dismissed in the recognition that sedation is possible in both cases.

A distinction based on the difference of role between family and medical staff in that the motives of the family might be mixed, whereas the motives of the carers are altruistic is lessened by the realisation that the medical carers may also act from mixed motives: the best utilisation of scarce resources rather than the best interests of the individual patient may predominate. At any rate questions as to the determination of motive are essentially legal questions and for the purpose of an ethical inquiry it can be assumed that the motives of both the medical carers and of the family are beyond reproach.

Must the family of patient 'Y' in seeking a resolution of the problem place him into hospital care knowing that as a consequence spoon-feeding will cease and tube-feeding can commence only to be quickly discontinued?⁸²

⁷⁷ As to the possibility of spoon feeding a PVS patient with normal food, Jennett and Plum have stated:

"Chewing and teeth grinding are common and may go on for long periods; liquid and food placed in the mouth may be swallowed." [(1972) at p.734]

Andrews has noted that:

"... there is no reason, apart from the time needed for its preparation, why liquidised 'normal' food should not be used." [(1993 a) p.1600]

⁷⁸ A recent English case (*Swindon and Marlborough N H S Trust v S*) has considered the situation of a patient being cared for at home and permitted the withdrawal of life-sustaining treatment. [The Guardian 10.12.1994.]

⁷⁹ For example, in the Ward case the statement (at p.444) of Blayney J. that: *"Normal food and drink could never be categorised as medical treatment."*; though the judgement of Hoffman LJ. in the Bland case offers a different view.

⁸⁰ The case of Karen Quinlan, for example, who survived for a number of years after her artificial ventilation had been removed pursuant to a court order gives some support to this distinction.

⁸¹ Though the highly unusual case of Carrie Coons who awoke and started feeding after her feeding tube was removed by court order [see Andrews (1993a) p.1601] might argue to the contrary.

⁸² The circumstance giving rise to *Re R* (Appendix C - number 11) bear an uncanny resemblance to this example: R had been fed by food syringed to the back of his mouth; the hospital authorities originally applied for orders permitting them to withhold *'nutrition and hydration by artificial means'* and to withhold CPR (cardio-pulmonary resuscitation). The application for the order concerning withdrawal of ANH was withdrawn from the court and replaced by an application for leave to begin tube-feeding; this was granted as was the original application for permission to withhold CPR. The reason for the adoption

Such intrigues seems a travesty of ethical behaviour and suggest that medical treatment and its withdrawal is being used as a subterfuge,⁸³ and that a fortuitous circumstance with no inherent connection to the underlying problem is being used to find a resolution. Wittgenstein's memorable phrase that the primary task of philosophy is to '*convert concealed nonsense into overt nonsense*'⁸⁴ so that it may dissipate, seems apt. If, indeed, the withdrawal of medical treatment is being used as a convenient camouflage to mask the goal of the procedure - the death of the patient - then this is most unlikely to produce an ethical response appropriate to the actual problem. In such circumstances the primary task of any ethical investigation - of more importance than any attempts at solution - is surely to begin to peel away such masks so that the true problem can at least emerge from the fog of obfuscation and be fully perceived for what it is; for only then can an appropriate solution emerge.

The conclusion is that the ethical problems faced by the carers of patients 'X' and 'Y' are identical. Certainly it may be the case that the legal resolution of the problem posed by patient 'Y' may be considerably more difficult than that posed by patient 'X', in that the possibility of abuse is greater; but surely the *formulation* of the underlying ethical problem must not be distorted to suit legal convenience. The law would, as in the Ward and Bland cases, consider the behaviour of the medical carers of patient 'Y' in withdrawing ANH as beyond reproach⁸⁵ yet would deem the behaviour of the family who withheld food as being legally guilty of the murder of 'X'.⁸⁶

The conclusion that I wish to draw from this discussion is that:

Conclusion 6-9 : As a mechanism for resolving 'end-of-life' issues for PVS patients, the 'WMT' framework is intrinsically flawed in that its utility depends on the existence of a set of circumstances which are contingent and which, though of considerable legal importance, have no inherent ethical relevance.

Subsection 2: The Ward and Bland cases: reformulating liability for death

In the previous subsection we examined one method of resolving the ethical and legal problems relating to 'end-of-life' decisions for PVS patients *i.e.* by formulating the problem as one of medical treatment and its withdrawal. We now examine a second possible way which is by reformulating the rules relating to liability for the causing of death. We are not here concerned with how this might be formulated theoretically - that will be considered in Part 3 where one such proposal is made - but with the attitude displayed by the Ward and Bland courts to a solution along such lines.

In the Bland case, the House of Lords showed considerably more willingness than did the Irish Supreme Court in the Ward case to directly confront the issue of death and to acknowledge that the goal of the withdrawal of ANH was the death of the patient.

of such convoluted procedures appears to have been that the cessation of syringe feeding is not on all fours with withdrawal of tube-feeding in that the arguments for classifying it as a 'medical treatment' rather than as a 'food' are considerably weakened.

⁸³ Jeff McMahan, writing of the distinction between '*killing*' and '*letting die*', states:

"... it is difficult to believe that the way in which an agent is instrumental in the occurrence of an outcome could be more important than the nature of the outcome itself."

A remark which seems apposite in the present context.

[McMahan. J. 'Killing, Letting Die and Withdrawing Aid' in Steinbock, Bonnie and Norcross, Alastair. (eds.) *Killing and Letting Die*. (1994) pp. 383-420 at p.413]

⁸⁴ Quoted in John Passmore, *A Hundred Years of Philosophy*, p.428.

⁸⁵ The contrast is not so great under English law because of the requirement to seek the approval of the courts before ANH can be withdrawn.

⁸⁶ The legal and the ethical analyses of the examples differ to such a great extent because (as discussed in Subsection (ii)) the law regards motive as irrelevant and it makes certain technical distinctions between directly and indirectly intended acts and between the legal responsibility for acts and for omissions.

The original court application in the Bland Case - which was in fact granted - sought a declaration that the carers were entitled to discontinue medical treatment and:

*"... thereafter need not furnish medical treatment to Anthony Bland except for the sole purpose of enabling Anthony Bland to end his life and die peacefully with the greatest dignity and the least amount of pain, suffering and distress."*⁸⁷

This placed the achievement of a peaceful death centre-stage. In contrast, the application to the Irish courts was considerably more circumspect; it sought a order simply for *'the discontinuance of all further artificial nutrition and hydration.'*⁸⁸

The refreshing directness with which the judgements in the Bland case addressed the issue of death - which ranged from Sir Stephen Browne statement that *'The process would be one of starvation'*,⁸⁹ to Lord Lowry's acceptance that the intention was to bring about the patient's death,⁹⁰ to Lord Mustill's refusal to countenance the *'manipulation'* of the doctrine of causation⁹¹ involved in suggesting that the cause of death would not be the withdrawal of ANH - is in stark contrast to the judgements in the Ward Case. It was made clear at many points in the judgements in the Bland Case that - as a mechanism to enable a solution to emerge - the withdrawal of ANH was less than ideal but that a more appropriate solution would require the intervention of Parliament because it would involve a radical revision of the law. Lord Mustill, for example, noted that one possibility would be for the courts:

*"... to create, through a binding precedent, a new common law exception to the offence of murder ... arising from the termination of life for medical reasons ... This approach would have the great attraction of recognising that the law has been left behind by the rapid advances of medical technology. By starting with a clean slate the law would be freed from the piecemeal expedients to which courts ... have been driven when trying to fill the gap between old law and new medicine ... This can only be achieved by democratic process through the medium of Parliament."*⁹²

and again:

*"The whole matter cries out for exploration in depth by Parliament and then for the establishment by legislation not only of a new set of ethically and intellectually consistent rules, distinct from the criminal law, but also for a sound procedural framework ..."*⁹³

In the Ward case, in contrast, though the desirability of the Ward being allowed to die peacefully and with dignity was expressed on many occasions, the achievement of this goal was not directly addressed; it was as if the death of the Ward was a slightly unexpected, but nonetheless satisfactory, side effect of the withdrawal of ANH. The issue of 'death' was addressed in many of the judgements; Lynch J, for example, stated:

⁸⁷ The Bland case p.796.

The *Practice Direction* of March 1994 which laid down the procedure for a court applications in England in relation to treatment withdrawal for a PVS patient, suggested the wording:

"... may lawfully disconnect all life-sustaining treatment and medical support measures designed to keep (X) alive ..." [emphasis added]; see *Current Law Year Book* (1994) at p.1028.

⁸⁸ The Ward case p.9.

⁸⁹ The Bland case p.796.

⁹⁰ *ibid.* p.876. His analysis then considered whether circumstances existed where this could be lawful; he held that that such circumstances did exist.

⁹¹ *ibid.* p.895.

⁹² *ibid.* p.889.

⁹³ *ibid.* p.891.

*"Death is a natural part of life. All humanity is mortal and death comes in the ordinary course of nature and this aspect of nature must be respected as well as its life-giving aspect. Not infrequently, death is welcomed and desired by the patient and there is nothing legally or morally wrong in such an attitude. A person has a right to be allowed to die in accordance with nature and with all such palliative care as is necessary to ensure a peaceful and dignified death."*⁹⁴.

Hamilton CJ. stated:

*"As the process of dying is part, and an ultimate inevitable consequence, of life, the right to life necessarily implies the right to have nature take its course and to die a natural death ..."*⁹⁵

and O'Flaherty commented eloquently:

*"In the submissions ... death was said to be part of life - indeed the only certainty in life. Although, as Bryan MacMahon has written 'each person attempts to mute or cancel the terror of impending death' ... nonetheless, in everyone's sub-conscious there is a hope of a peaceful and dignified death."*⁹⁶

But at no stage were these insights incorporated into the intellectual structure of the judgements.⁹⁷ It is as if the acknowledgement of the intention to achieve a 'peaceful and dignified death' for a patient was treading on dangerous ground; this reticence was doubtlessly caused by the fear that to acknowledge an intention to occasion a 'peaceful and dignified death' for another is, as matter of pure logic, an intention to occasion the death of that other, and thus falling foul of, if not the distinction between 'killing' and 'letting die', then certainly that between direct and indirect intention.⁹⁸

Conclusion 6-10 : *It was acknowledged at many points in the various judgements in the Bland case, that a fitting resolution of the problem of 'end-of-life' decisions for PVS patients required a reformulation of the rules relating to liability for causing death; in contrast, the judgements in the Ward case made no such acknowledgements.*

In summary: the traditional distinction between 'killing' and 'letting die' is predicated on the assumption that

- (i) 'Death is an evil' and that
- (ii) since both 'killing' and 'letting die' cause death, both are evil.

The discussion then proceeds to consider whether they are of a comparable evil or whether 'killing' is a greater evil than is 'letting die'.

The argument to be advanced in this thesis is that:

- (i) The proposition 'Death is an evil'(simpliciter) is unsustainable.⁹⁹
- (ii) The achievement of 'a good death' is a good.

⁹⁴ The Ward case p.17.

⁹⁵ *ibid.* p.426.

⁹⁶ *ibid.* p.432.

⁹⁷ It was suggested earlier in this chapter that this was for reasons of 'denial'.

See Conclusion 6-2 : *Part of the attractiveness of the 'WMT' to the Ward court was that it offered to the court the possibility of evading responsibility for occasioning the death of the Ward. This evasion was accentuated by the decision of the Ward court not to require that in all future cases where the withdrawal of ANH was contemplated, an application be made to the court; this was in contrast to the Bland court which did make such a requirement.*

⁹⁸ A possible solution to the problem of incorporating death into the theoretical framework for making 'end-of-life' decisions for PVS patients is developed in Part 3, and is based on the concepts of 'a good death' and 'personhood'.

- (iii) Assisting another to achieve what is for them 'a good death' may, depending on the circumstances, involve active participation or direct assistance (killing) or may require a more passive participation (letting die).
- (iv) From an ethical perspective, the important distinction is not that between 'act' and 'omission' nor between 'killing' and 'letting die' but between non-consensual interventions (including omissions¹⁰⁰) and those made with consent. It will be argued that interventions of a type which usually result in the death of another should not be made without the consent of this other unless they have permanently lost the ability to communicate (thus implying the loss of their personhood) and then only if such an intervention is in their 'best interests'.

Subsection 3: The Ward and Bland cases: the role of 'scarcity of resources'¹⁰¹

In the previous subsections we examined the attitude of the Ward and Bland courts to two possible methods of resolving the ethical and legal problems relating to 'end-of-life' decisions for PVS patients: the interpretation of the problem as one of medical treatment and its withdrawal; the reformulation of the rules relating to liability for the causing of death. We now consider the attitude of the Ward and Bland courts to a third possibility for resolving the problem: because health care resources are limited the continued medical treatment of PVS patients entails the use of considerable resources resulting in many other patients being denied, if not life-sustaining then life-enhancing, treatment.

Many of the medico-legal problems in our society appear, on a superficial examination, to concern only those individuals on whom the problem is centred; however, on a deeper analysis these problems can be seen to have a wider social dimension. Problems such as abortion, euthanasia, the sterilisation of the mentally retarded, the preventive detention of the untreatably violent, concern both particular individuals and the wider society; by 'wider society' is meant the interests of non-identifiable individuals. For example, in considering the release of a particularly violent individual, there may be no *identifiable* individual whose rights are infringed by such a release and who accordingly should be considered, but there may be many non-identifiable individuals whose rights may well be affected. The term '*the common good*' - as used in the Irish Constitution - refers to these wider non-specific interests.

The political philosophy of individualism current in Western society and reflected in its jurisprudence has usually ensured that any analysis of such problems is framed only in terms of the rights of particular determinable individuals. Powerful historical reasons exist for this tendency to favour the rights of the individual over those of the common good not the least of which is that the 'common good' has been used in the past as a convenient cloak to mask severe and unjustifiable repression of individual rights. Very few examples exist of medico-legal problems where the rights

⁹⁹ This removes the usual justification for the propositions 'killing is evil' and 'letting die is evil' considered as absolute, or unqualified, propositions.

¹⁰⁰ Consider the example given in *Auckland Area Health Board v AG* (Appendix C - number 17) of a polio victim unable to breathe and being ventilated, but desirous of remaining alive. Thomas J. held that it is not acceptable to say of a doctor, who in such a case did in fact remove ventilation, that he did not cause the death of the patient.

¹⁰¹ The BMA have recently addressed the issue of scarce resources:

"It is obvious, however, that money spent caring for irreversibly and severely brain-damaged patients is money which cannot be used to treat other patients. This is an issue which needs to be acknowledged and addressed on a national scale as part of the debate on rationing and prioritising of resources. The BMA is concerned that, in reality, cost factors probably have a disproportionate influence on decision making for this very vulnerable patient group and is also concerned that the lack of a clear societal consensus on this most vexed area may unfairly leave doctors open to criticism."

[BMA (1999a) *Withholding and Withdrawing Life-prolonging Medical Treatment : Guidance for decision making*. 3C.18.5]

of the wider society are explicitly acknowledged to an extent comparable to the recognition of the individual rights; one such example is where an individual with a contagious disease is confined against his will and where this is justified by an appeal to the common good; the reliance on the common good is especially clear when the contagious disease is non-treatable thus precluding any attempt to justify the intervention in terms of the 'best interests' of the incarcerated individual. Usually such interventions would, if at all possible, be justified in terms of the rights of the individual, the right of the wider society being not explicitly acknowledged. This hesitation to appeal to wider social interests can lead to a misuse of language, as when interventions which have in fact a wider social interest, are justified *solely* in terms of individual rights; for example the sterilisation of mentally retarded girls is justified solely in terms of their '*best interests*,' without any acknowledgement of the social reasons for such intervention - social reasons may in fact be the decisive consideration.

The perceived need to justify interventions solely in term of individual rights can militate against open and honest debate; in the Ward case for example, the issue of the scarcity of resources was not addressed; there was no acknowledgement that the resources required to sustain a PVS patient over many years are considerable and that the allocation of such resources to a PVS patient necessarily entails, as a matter of strict economic fact, that other patients will be deprived of some entitlement to health care. In the Bland Case the issue of scarcity of resources was explicitly withdrawn from the court's consideration, nonetheless it was referred to in some of the judgements.

Medical academics have not been so reserved and the relationship between the scarcity of resources and the treatment PVS patients has been discussed in the medical literature; Raanan Gillon, for example, in commenting on Dr Andrew's work with misdiagnosed PVS patients, stated:

*"But resources are severely limited ... We withdraw ventilation in certain hopeless cases of respirator dependency; we withdraw dialysis in certain hopeless cases of renal failure ... In many such cases the patients, were they to be given treatment, would manifest at least as much conscious life as the example of 'recovery' after three years of being in a vegetative state cited by Dr. Andrews."*¹⁰²

An explicit consideration of such issues could clearly provide, if not a full framework for the making of decisions for treatment withdrawal for PVS patients, then certainly a valuable adjunct to other frameworks. Such possible developments will not be considered in this thesis; suffice to examine how the issue of scarce resources was considered in the Ward and Bland cases.

The Ward Case and 'scarcity of resources'

This topic can be disposed of quickly in that the case was resolved *solely* on a consideration of the Ward's 'best interests'; the question of the scarcity of resources played no role whatever in the judgements. Denham J., however, did discuss the concept of 'the common good' but she judged its relevance to the Ward case solely in relation to the interests of the community in the protection of life and, as such, the concept argued *against* a decision to withdraw treatment:

¹⁰² Gillon (1993) p.1603.

*"Also, the common good, the interest of the community, in the protection of life, must be considered ... The primary constitutional concept is to protect life within the community. The state has an interest in the moral aspect of society - for the common good."*¹⁰³

That the interests of the common good might be also served by the husbanding of scarce resources was not considered.

The Bland Case and 'scarcity of resources'

The hospital authorities who made the original application in relation to Tony Bland, explicitly requested that the issue should be considered as if their resources were unlimited. However, Lord Browne-Wilkinson urged 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."*¹⁰⁴

In his view, such questions were for Parliament to resolve.¹⁰⁵

Lord Mustill agreed, stating:

*"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 conditions of other patients, who if treated may have useful, healthy and enjoyable lives for years to come. This argument was never squarely put, thought 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 ... must be for Parliament alone ... Until the nettle is grasped, we must struggle on with the existing law, imperfect as it is."*¹⁰⁶

Alone amongst the judges, Lord Hoffman provided a conceptual structure whereby 'scarcity of resources' could be included in a decision making process. His analysis of the Bland Case hinged on the point that the important distinction is not, as he called it, the 'barren' one between act and omission, nor that between medical treatment and medical care, but between introducing an external agency to cause death and not doing so. He suggested that if someone starves to death a child or invalid in his care we treat him as *if* he had introduced an external agency; that generally there is no moral difference between the prohibition on violating the person and the positive obligation to act with humanity towards the helpless but that there are two exceptions: unlike the prohibition on violating the person which is absolute, the duty to provide care ceases when such care can provide no humane purpose; furthermore the duty to provide care is also restricted to what one can *reasonably* provide; health resources are not limitless and choices must be made. Lord Hoffman continued:

"No one is under a moral duty to do more than he can, or to assist one patient at the cost of neglecting another. The resources of the National Health Service are not limitless and choices have to be made ... But one is bound to observe that the cost of keeping a patient

¹⁰³ The Ward case p.459.

¹⁰⁴ The Bland case p.880.

¹⁰⁵ *ibid.* p.880:

"For these reasons, it seems to me imperative that the ... issues raised by this case should be considered by Parliament."

¹⁰⁶ *ibid.* p.896.

like Tony Bland alive is very considerable and that in another case the health authority might conclude that its resources were better devoted to other patients.”¹⁰⁷

Conclusion⁶⁻¹¹ : The relevance of ‘scarcity of resources’ to the issue before the court was acknowledged in the Bland case; however, the court considered that questions of ‘scarcity of resources’ could not be considered by the court in the absence of legislative intervention. In contrast, the Ward case did not acknowledge the relevance of the concept of ‘scarcity of resources’ to the problem.

Section 4: Subsequent Irish and English cases concerning PVS.

Irish cases

The Ward case has been the only case concerning PVS to come before the Irish courts.

English cases

Grubb writing in 1996,¹⁰⁸ found it was surprising that only seven cases had come before the English courts since the Bland decision; and that only two of these had been formally reported. He believed that a possible reason for such a low level of court applications was because doctors chose to manage PVS patients by not treating acute infections or other life threatening conditions - such decisions do not require prior court approval - rather than by the withdrawal of ANH which, in England, does require an application to the High Court. The two reported cases alluded to by Grubb were *Frenchay Healthcare NHS Trust v S*¹⁰⁹ and *Re G (Persistent Vegetative State)*;¹¹⁰ these are discussed below as is a third case *Re D (Medical Treatment)*¹¹¹ which dates from 1997.

These cases, which have been summarised in Appendix C, are of interest for two reasons:

- (i) They show how the courts applied the principles laid down in the Bland judgement in regard to the obligation to seek the approval¹¹² of the High Court and to ensure that the Official Solicitor was enabled to commission a full independent medical assessment before ANH was withdrawn.
- (ii) They show how the requirement set out in the Bland case that its judgement be applied *only* to cases of ‘true’ PVS evolved under continuing judicial interpretation.

Frenchay Healthcare NHS Trust v S (1994)

A young man had taken a drug overdose which resulted in extreme brain damage. He was being fed by means of a nasogastric tube which had become disconnected and an operation was required to reinsert the tube. The hospital had applied, as a matter of urgency, to the court for authorisation not to replace the tube and as a result of this procedure being adopted the Official Solicitor had been unable to conduct as full an examination of the patient as he had wished. The Official Solicitor also contended that the patient was not fully PVS.

¹⁰⁷ *ibid.* p.833.

¹⁰⁸ Grubb *et al* (1996a) at p.39.

¹⁰⁹ *Frenchay Healthcare NHS Trust v S* [1994] 2 All ER 403; Appendix C - number 3.

¹¹⁰ *Re G (Persistent Vegetative State)* [1995] 2 F.C.R. 47; Appendix C - number 4.

¹¹¹ The Times 21st and 22nd March 1997; subsequently reported as *Re D (Medical Treatment)* [1998] 1 F.L.R. 411; [Appendix C - number 5].

¹¹² A practice note of March 1994 stipulated that virtually all cases of termination of ANH required the prior sanction of a High Court judge.

[Practice Note (Official Solicitor)(Persistent Vegetative State), March 1994; Current Law Year Book 1994 at p.1028.]

Medical evidence had been given to the court by one consultant who “... *did not unequivocally diagnose PVS ...*”¹¹³ that:

*“There is still no verbalisation although he often grunts and can be noisy. He appears to suffer pain but it is not obvious where this is originating.”*¹¹⁴

A consultant neuropsychiatrist had concluded that:

*“His current quality of life is nil and I see no prospect of this improving.”*¹¹⁵

However, a consultant in rehabilitation medicine believed that a reduction in sedation was advisable to better enable her to judge the patient’s ability to communicate; though the judgements commented that: “... *[she] expresses her views on his ability to communicate in a somewhat equivocal way.*”¹¹⁶

In relation to the procedural point Sir Thomas Bingham MR. held that to uphold the right of the Official Solicitor to conduct a full examination of the patient before a court application to discontinue ANH would, in this case, necessitate the tube being first reconnected and then a subsequent application for its disconnection; this he was not willing to do. He did, however, affirm the general rule.

In relation to the applicability of the Bland judgement to patients who were not fully PVS, Sir Thomas Bingham MR. summarised the strictness of the Bland decision in the words:

*“... the [Bland] courts made plain that their decisions were to be understood as strictly applying to the Bland situation and no other ... A number of the judges were at pains to emphasise that they should not be taken as approving anything falling outside the factual situation which was then before the court.”*¹¹⁷

Waite LJ. noted that the Bland judgements had laid stress on the absence of any ‘*glimmering of awareness*’.¹¹⁸

In the event, the court decided to permit the treatment withdrawal; Sir Thomas Bingham MR. stated:

*“I think it is plain that the evidence in this case is not as emphatic and not as unanimous as that in Bland’s case.”*¹¹⁹

He continued:

*“It is not suggested that one is dealing here with a brain damaged patient who has some significant cognitive function.”*¹²⁰

The Bland criterion of ‘*absence of any glimmering of awareness*’ seems to have been transformed imperceptibly into ‘*absence of significant cognitive function*’!

¹¹³ Frenchay Healthcare NHS Trust v S [1994] 2 All ER 403 at p.410.

¹¹⁴ *ibid.* p.407.

¹¹⁵ *ibid.* p.408.

¹¹⁶ *ibid.* p.411.

¹¹⁷ *ibid.* p.409.

¹¹⁸ *ibid.* p.412.

¹¹⁹ *ibid.* p.411.

¹²⁰ *ibid.*

Re G (Persistent Vegetative State) (1994)

In 1991 G, a married man then aged 24, had a serious motorcycle accident; he never regained consciousness and was diagnosed as being in a PVS. This diagnosis had been confirmed by four leading consultant neurologists including Professor Jennett and Dr. Andrews. Dr Andrews' report, which had been commissioned by the Official Solicitor, concluded that G was in a more profound PVS than was Tony Bland. Although the patient's wife reluctantly agreed to a withdrawal of ANH, his mother - believing that her son had some awareness - did not. The patient's mother had based her belief that her son had some awareness on the fact that he became distressed by discomforts such as chest infections, and that he could be calmed by the presence and care of his family. The court accepted the unanimous medical evidence that G had no awareness and decreed that ANH should be withdrawn.¹²¹

Re D (Medical Treatment) (1997)

In the case of 'Miss D' there was a dispute as to whether the patient was fully PVS because she appeared to track moving objects with her eyes, she flinched in response to gestures and she reacted to the feeling of ice on her body. The Official Solicitor argued that Miss D's responses showed that she was not in a PVS whilst there was expert medical opinion to the effect that these movements were simply 'primitive reflexes' showing no evidence of consciousness.

Sir Stephen Browne held that - as all the medical consultants and family agreed - Miss D had no awareness and as there was '*no possibility for a meaningful life whatever*',¹²² that Miss D was in reality in a PVS and it was in the patient's best interests not to operate. Sir Stephen stressed that he was not extending the list of cases where a declaration for the withdrawal of ANH could be considered:

*"The court recognises that no declaration to permit or sanction so extreme a step could be granted where there is any real possibility of a meaningful life continuing to exist."*¹²³

Conclusion 6-12 : *The criterion which the Bland case deemed necessary for the withdrawal of ANH namely that no 'glimmerings of awareness' be present, has in subsequent cases effectively been widened to include 'no possibility for a meaningful life whatever' or 'absence of significant cognitive function'.*

Section 5: Conclusions.

In conclusion, the Ward case was resolved by interpreting the problem before the court as being essentially concerned with the conditions under which medical treatment may be given to and

¹²¹ This case is of interest in that it reinforces the arguments for proposals which were made in Chapters 4 and 5. In Chapter 4 it was argued that a definition of PVS based on absence of ability to communicate rather than one based on a supposed absence of consciousness, would restore an important role to the family and carers of PVS patients; would permit end-of-life issues concerning PVS patients to be resolved in a much more appropriate fashion than at present; and would ensure that the opportunities for disagreement between family and medical staff would be considerably lessened (Conclusion 4-17: *The persistent vegetative state is characterised by seeming wakefulness in the absence of an ability to communicate*). In Chapter 5 it was argued that PVS patients should be treated as if they were in pain; and that doing so is not compatible with a diagnosis of PVS (Conclusion 5-5: *All patients diagnosed as PVS, should be treated as if they are conscious and can experience pain*).

¹²² The Times 22nd March 1997.

¹²³ *ibid.*

In so far as this was a judgement of the High Court it could not affect the authority of the earlier decisions. (Frenchay and Re G had been considered by the Court of Appeal and Bland by the House of Lords.)

withdrawn from an incompetent patient; it held that an incompetent patient may have life-sustaining medical treatment withdrawn if it is deemed to be in their 'best interests' that this should occur. The judgements did not stipulate that application be made to the court in future cases where withdrawal of ANH was contemplated.

The Bland judgements, in contrast, did stipulate that application be made to the court for permission to withdraw ANH. Furthermore, the judgements recognised - again in contrast to the Ward case - that the death of the patient was central to the resolution of the problem. Many of the judgements in the Bland case considered that the optimal method of tackling the problem lay in a reformulation of the rules relating to liability for the causing of death; such, however, required the intervention of Parliament and in the absence of legislation the rules relating to the withdrawal of treatment were reluctantly pressed into service.

In England, subsequent cases on the withdrawal of ANH have - although paying lip service to the strict criteria laid down in the Bland case - effectively widened these criteria.

In Ireland, the subsequent development of medical practice in relation to the withdrawal of ANH is not open to public scrutiny in that application to the court is not obligatory in such cases.

The conclusions established in this chapter are:

Conclusion ₆₋₁: *The court in the Bland case, in contrast to that in the Ward case, acknowledged that the methods of analysis (i.e. withdrawal of medical treatment) available to them for the resolution of the problem were not ideal; that other more appropriate methods existed but were not available to the courts until appropriate legislation was enacted.*

Conclusion ₆₋₂: *Part of the attractiveness of the 'WMT' to the Ward court was that it offered to the court the possibility of evading responsibility for occasioning the death of the Ward. This evasion was accentuated by the decision of the court that an application to the court is not required in future cases where the withdrawal of ANH is contemplated; this was in contrast to the Bland court which did lay down such a requirement.*¹²⁴

Conclusion ₆₋₃: *In order that the withdrawal of ANH be not legally categorised as murder, it is necessary that it be deemed to be an omission as distinct from an act.*

Conclusion ₆₋₄: *In order that the withdrawal of ANH from a patient by medical personnel who are charged with his care not be legally held to be murder, it is necessary that ANH be deemed not to be 'food'.*

Conclusion ₆₋₅: *In order that the 'WMT' may be used to justify the withdrawal of ANH the following propositions must be established:*
(a) that ANH is a medical treatment.
(b) that a patient's consent is required for all, including life-sustaining, medical treatment.
(A corollary of this is that a patient can refuse life-sustaining medical treatment.)

¹²⁴ The respective requirements are set out in Appendix C, numbers 1 and 2.

(c) that a patient does not lose the right to refuse life-sustaining treatment by virtue of their incompetency.

Once this right is established, then those who may exercise the right on behalf of an incompetent patient must be identified, and the criteria that must be used by them in making the decision to withdraw life-sustaining treatment must be specified.

Conclusion ₆₋₆ : *The arguments for classifying ANH as a 'medical treatment', though less than compelling, were accepted by both the Ward and Bland courts.*

Conclusion ₆₋₇ : *The Ward case established that a competent individual has the right to refuse medical treatment even if their death is the result of such a refusal.*

Conclusion ₆₋₈ : *The Ward and Bland cases held that treatment decisions for incompetent patients should be made on the basis of the patient's 'best interests'.*

Conclusion ₆₋₉ : *As a mechanism for resolving 'end-of-life' issues for PVS patients, the 'WMT' framework is intrinsically flawed in that its utility depends on the existence of a set of circumstances which are contingent and which, though of considerable legal importance, have no inherent ethical relevance.*

Conclusion ₆₋₁₀ : *It was acknowledged at many points in the various judgements in the Bland case, that a fitting resolution of the problem of 'end-of-life' decisions for PVS patients required a reformulation of the rules relating to liability for causing death; in contrast, the judgements in the Ward case made no such acknowledgements.*

Conclusion ₆₋₁₁ : *The relevance of 'scarcity of resources' to the issue before the court was acknowledged in the Bland case; however, the court considered that questions of 'scarcity of resources' could not be considered by the court in the absence of legislative intervention. In contrast, the Ward case did not acknowledge the relevance of the concept of 'scarcity of resources' to the problem.*

Conclusion ₆₋₁₂ : *The criterion which the Bland case deemed necessary for the withdrawal of ANH namely that no 'glimmerings of awareness' be present, has in subsequent cases effectively been widened to include 'no possibility for a meaningful life whatever' or 'absence of significant cognitive function'.*

Chapter 7: The concept of 'quality of life'

The concept of 'quality of life' is widely used in medical decision-making to facilitate comparison between different medical treatment options; it has also been used by the courts in the legal analysis of decisions concerning the giving, or withholding, of medical treatment from incompetent patients (that is, patients who lack the capacity to consent). This chapter analyses the concept with particular reference to situations where medical treatment is withdrawn from patients whose death is the foreseeable result of such a withdrawal. Two types of quality of life judgements are distinguished: *'incremental quality of life'* judgements - which seek to estimate the difference, or increment, that a medical intervention will make to the quality of life of a patient - and *'absolute quality of life'* judgements - which seek to give a global, or absolute, measure of the quality of life of a patient at a particular moment in time. It is proposed that, on ethical grounds, 'absolute quality of life' judgements should be avoided; this however, does not affect the use of 'incremental quality of life' judgements because - as is shown - 'incremental quality of life' judgements do not logically depend on the ability to make prior 'absolute quality of life' judgements. Thus, the suggested prohibition does not affect the use of quality of life judgements as normally encountered in clinical medicine, as these are 'incremental' rather than 'absolute quality of life' judgements. It is also argued that the concept of *'best interests'* as used in the Ward and Bland cases,¹ necessitates the making of 'absolute quality of life' judgements and that the danger of a 'slippery slope' being occasioned by the Ward and Bland decisions, is due primarily to their reliance on 'absolute quality of life' judgements.

This chapter is divided into four Sections. Section 1 considers the concept of 'quality of life'. Section 2 introduces the distinction between 'absolute' and 'incremental quality of life judgements' and discusses the relationship between them. Section 3 analyses the relationship between the concepts of 'best interests' and 'quality of life'; it also considers the meaning of the term 'best interests' as used in the Ward and Bland cases. Section 4 draws some conclusions from the discussion.

Section 1: The concept of 'quality of life'.

James F. Drane in his Clinical Bioethics suggests² that the concept of 'quality of life' evolved in medicine to help bridge the gap between scientific medicine - with its preoccupation with objective diseases and their cure - and the lives of individual patients with their own particular experiences and value systems. The need for such a concept arose from a recognition that the same medical intervention performed on individuals with different life styles and values could have radically different effects on the lives of these individuals; it might be beneficial in some cases but harmful in others. The Hippocratic admonition that a physician *'Do no harm'* does not mean 'harm' in some abstract sense but in relation to the individual patient; it requires an assessment of whether a proposed intervention - even though usually beneficial - will *in fact* benefit the particular individual patient. In an attempt to formulate this problem more clearly, medical interventions have been

¹ see Appendix C - numbers 1 and 2

² James F. Drane, Clinical Bioethics (1994), at p.172.

considered to affect a patient in two ways, they can affect his actual life span (the *quantity* of his life or, as usually described, his *life expectancy*) or his capacity to enjoy his life (the *quality* of his life).

In scientific medicine, as in all scientific investigations, the primary goal is to quantify in order that decisions and comparisons can be more readily made. The 'quantity of life' is by its very nature quantified: a proposed intervention will increase or lessen the individual patient's life by 'x' years. However, the 'quality of life' is a more elusive concept. Before any attempt at quantification can be made it is necessary to clarify the meaning of the term 'quality of life' though some commentators³ believe that this problem has usually been resolved in the reverse order, that is by prioritising the quantification - this being easier to resolve - over attempts to clarify that which is supposedly being quantified.

To attempt to discuss the various definitions of quality of life would lead us too far afield. Suffice to say that not only is there no consensus amongst academic commentators in the medical journals, as to the *definition* of 'quality of life' - indeed, the possible measures of 'quality of life' are numbered in the hundreds, each, presumably, with its own definition; but there is considerable dispute as to its *usefulness*, i.e. as to whether it helps to add clarity to discussions of a difficult topic or whether its actual function is to add a veneer of objectivity to what is in fact a subjective judgement, thus functioning as a mask and obfuscating discussion. For example, a BMA report states:

*"Terms such as 'quality of life' are problematic because of the pejorative implication they may convey that some lives are less valued. Assessments of 'quality' are inevitably value laden and subjective. Even if we resist the terms, however, the concept underlies much of the discussion and decision-making at the end of life."*⁴

Edlund and Tancredi in an article entitled 'Quality of Life: an Ideological Critique' also suggest that the term is ill defined:

*"The very nebulous nature of the phrase 'quality of life', the lack of serious attention to what it means, and the extraordinary variety of definitions it may include make it susceptible to that characterisation most beneficial to the individual decision maker ... Decision makers will shift their ideology of quality of life to suit their interests."*⁵

Lest it be thought that this criticism might be dated, a recent article published in the Journal of the American Medical Association is considerably more hard hitting:

*"... a clear conceptual basis for quality-of-life measures is lacking, and the few attempts to develop models or operational definitions of quality of life have been woefully inadequate. ... We thus infer quality of life from a variety of indicators, many of which tell us something about life but nothing about quality. The consequence of this confusion is that it is often impossible to know exactly what is being measured ..."*⁶

These quotations show that even within medical circles, there is considerable dispute as to the usefulness - and indeed the meaning - of the concept 'quality of life'. Nonetheless it is a widely

³ Leplege A. and Hunt S., 'The Problem of Quality of Life in Medicine', Journal of the American Medical Association (1997), at p.47.

⁴ BMA 'Withdrawal and Withholding Treatment: A consultation paper from the BMA's Medical Ethics Committee' (1998), p.11.

⁵ Matthew Edlund and Laurence R. Tancredi 'Quality of Life: an Ideological Critique' Perspectives in Biology and Medicine (1985), at p.604.

⁶ Leplege and Hunt *op.cit.* p.47.

used concept in medicine and it plays a crucial, albeit implicit, role in the judgements in both the Ward and Bland cases⁷ - the notable exception being Lord Mustill's judgement in the Bland Case where he suggested that the use of the concept of 'quality of life' was the "... *the first step on a very dangerous road indeed ...*"⁸

Conclusion 7.1 : *The concept of 'quality of life' is much used in medicine and law to enable the comparison of different treatment options. The concept is not well defined and its claim to rigor and objectivity is largely spurious.*

As stated earlier, the term 'quality of life' is used in everyday clinical medicine as an aid in considering whether medical treatment should or should not be given to a particular patient.⁹ The criterion being that if the proposed treatment does not enhance the 'quality of life' of the patient, it should not be given.¹⁰ However, in applying the term to decisions relating to the continuation of life-sustaining treatment a subtle change occurs; here the principle is interpreted as implying that if the 'quality of life' is adjudged to be so poor as to be practically non-existent, and if medical treatment could not alter this situation, then life-sustaining medical treatment should be not given, or if being currently given, should be withdrawn. This usage possibly originated from attempts to assimilate the methodology used in making treatment decisions for terminally ill patients, into a 'quality of life' framework whereas - as will be argued in Part 3 - an alternative framework is required.

The courts followed this reinterpretation and used the concept of 'quality of life' as a decision-making tool: the judgement that the overall 'quality of life' of a patient was nil,¹¹ or at least minimal, being sufficient to trigger the decision to withdraw treatment including ANH. The judgement of Taylor LJ, in the *In re J (a minor)* is a good example of such a usage:

*"I consider that the correct approach is for the court to judge the quality of life the child would have to endure if given the treatment and decide whether in all the circumstances such a life would be so afflicted as to be intolerable to that child."*¹²

One of the main contentions of this chapter is that this use of the term 'quality of life' is quite distinct from its use in everyday clinical settings and that the distinction between the two uses is of considerable ethical importance. We now examine the proposed distinction.

Section 2: The distinction between 'incremental quality of life' and 'absolute quality of life'.

The distinction between '*incremental quality of life*' judgements and '*absolute quality of life*' judgements is explained in Subsection 1; examples of both types of judgements are given. The argument that 'incremental quality of life' judgements do not require the ability to make a prior 'absolute

⁷ Many of the judgements used the concept of '*best interests*'; the relationship of 'best interests' to 'quality of life' is discussed in Section 3.

⁸ The Bland case at p.894

⁹ For example, a recent comment from the BMA states:

"Withholding and withdrawing life-prolonging medical treatment", builds on the central ethical principle that the primary goal of medicine is to benefit the patient. If a treatment fails or ceases to give a net benefit to the patient, it may ethically be withdrawn or withheld and the focus of medical effort will shift to controlling distressing symptoms and keeping the patient comfortable."

[BMA (1999b) [Press release on new ethical guidance on withdrawal of treatment.](#)]

¹⁰ For the sake of simplicity, I have omitted any consideration of how improved 'quantity of life' but a poorer 'quality of life' might justify a treatment decision.

¹¹ e.g. the statement of a medical expert in *Frenchay Healthcare NHS Trust v S* at p.408 [Appendix C - number 3]:

"His current quality of life is nil ..."

¹² *In re J (A Minor) (Wardship: Medical Treatment)* [Appendix C - number 10].

quality of life' judgement is set out in Subsection 2. The ethical grounds for arguing that 'absolute quality of life' judgements be impermissible are set out in Subsection 3.

Subsection 1: The distinction between 'incremental quality of life' and 'absolute quality of life' judgements.

In an effort to remove some of the ambiguity associated with the concept of 'quality of life judgements' two meanings will be distinguished; they are 'incremental quality of life' judgements and 'absolute quality of life' judgements.

'Incremental quality of life' judgements

Consider a proposed medical intervention on a particular patient - one of those normal everyday medical interventions, the very routine of any hospital; if one's purpose is to assess whether this intervention should be performed then it is necessary to judge whether it would improve the patient's quality of life; if it did so improve his quality of life it should be performed, otherwise not. In other words, the clinician is required to determine the increment, or change - either positive or negative - which is expected to occur in the quality of life of a patient as a consequence of a proposed medical intervention. The intervention should be performed if and only if this increment is positive.¹³ This would be in accord with the injunction to physicians often attributed to Hippocrates, 'to help, or at least to do no harm.'¹⁴ I use the term 'incremental quality of life judgements' to describe such judgements.

'Absolute quality of life' judgements

The concept of 'absolute quality of life' relates to attempts to measure of the *total* quality of life of a patient and adjudge that in certain cases the quality of life is so poor that they would, in everyday language, 'be better off dead'. Such an index or measure may be quite primitive - such as 'good', 'poor', or 'non-existent' - or may attempt a greater sophistication, but irrespective of its complexity it reduces 'quality of life' to a linear scale by means of which comparisons can be made. I use the term 'absolute quality of life judgements' to describe judgements made with the use of such indices. An example of the legal use of an 'absolute quality of life' measure is found in the test proposed by Lord Justice Taylor in the 'In re J' case (quoted in the previous section): "... whether in all the circumstances such a life would be so afflicted as to be intolerable to that child."

Conclusion 7-2 : 'Incremental quality of life' judgements are quality of life judgements which seek to estimate the change in the quality of life of a patient ascribable to a proposed medical intervention; the understanding being that the intervention should be performed if and only if this change is positive.¹⁵

'Absolute quality of life' judgements are quality of life judgements which seek to estimate the total quality of life of a patient; the understanding being that if this quality of life is minimal then life-sustaining medical treatment should be withheld and the patients allowed to die.

¹³ As mentioned earlier, situations where there is an expectation of improved life expectancy but decreased quality of life have been omitted for simplicity.

¹⁴ See Albert R. Jonsen 'Do No Harm: Axiom of Medical Ethics' in S. F. Spicker and H. T. Engelhardt (eds.) Philosophical Medical Ethics: Its Nature and Significance, (1997).

¹⁵ As mentioned earlier, situations where there is an expectation of improved life expectancy but decreased quality of life have been omitted for simplicity.

Examples showing the differing uses of the term 'quality of life'.¹⁶

The Ward and Bland Cases¹⁷

The Bland and Ward Cases justified the withdrawal of ANH¹⁸ mainly on the grounds of it being in the patient's 'best interests'. The relationship between 'best interests' and 'quality of life' judgements is considered in Section 3 and it is there argued that 'best interests' judgements as used in the Ward and Bland cases, are logically equivalent to 'absolute quality of life' judgements.

Frenchay v S¹⁹

In this case there was a conflict of evidence relating to the patient's 'quality of life'. The patient's neuropsychiatrist gave evidence that the patient's quality of life was nil; however, the expert in rehabilitative medicine disagreed and believed that there were respects in which his quality of life could be improved. She argued that this could be achieved by, for example, a reduction of the amount of sedation and by the use of a chair which would better ensure the patient's comfort.

It is clear that the neuropsychiatrist was using the term 'quality of life' in the sense of 'absolute quality of life' whereas the consultant of rehabilitative medicine was using it in the sense of 'incremental quality of life' - thus emphasising the need to distinguish between these meanings and showing that what was interpreted in the judgement as a conflict of evidence, was in reality not so.

Re B²⁰

This case concerned a Down Syndrome infant with an intestinal blockage which was removable by a simple operation; the child's parents refused consent to an operation arguing that even if the operation was successful, the infant would have a minimal quality of life.

It is clear that the distinction between 'incremental quality of life' and 'absolute quality of life' is crucial to the problem at the heart of this case. The parent's position was that the 'absolute quality of life' of the infant was minimal and accordingly that the operation should not be performed but it is equally clear that the operation would improve the 'incremental quality of life' of the infant.

If improvement in 'incremental quality of life' is accepted as the appropriate criterion for treatment decisions then it is clear that the operation should be performed.

Precisely the same distinction is at the heart of the Canadian case *Re Superintendent Of Family*²¹ and the English case *Re T.*²²

¹⁶ N.B.: All examples have been taken from cases listed in Appendix C.

¹⁷ Appendix C - numbers 1 and 2 respectively.

¹⁸ i.e. Artificial Nutrition and Hydration.

¹⁹ Appendix C - number 3.

²⁰ Appendix C - number 7.

²¹ Appendix C - number 15.

²² Appendix C - number 12.

R was seriously disabled and in 'a low awareness state'. His medical consultants were of the view that his quality of life was 'unacceptable' and that a DNR order²⁴ was appropriate; this was contested by the carers at the day centre which the patient attended. It is clear that the consultant's judgement was an 'absolute quality of life' judgement; the carers disagreed with this absolute quality of life judgement, but in their objection there were elements of an 'incremental quality of life' judgement in that they believed that their daily interactions with the patient gave him pleasure and that they could comfort him.

The court considered the evidence of Dr Andrews as crucial to its decision. His evidence concerned the likelihood of ventilation being successful; his view was that this was most unlikely and that attempts at ventilation might cause the patient either further brain damage or broken ribs.

The court's decision in allowing the DNR order to stand could thus be categorised as being based on an 'incremental quality of life' judgement - the intervention itself would not necessarily improve the patient's quality of life. However, the BMA note on this decision²⁵ interprets it in a much broader sense as validating 'absolute quality of life' judgements; in so far as the court also ordered that R be operated on to permit gastrostomy tube feeding, the BMA interpretation seems too sweeping; although it could be argued that it is a consequence of the 'twin track' approach adopted by the English courts whereby the criteria justifying withdrawal of ANH are different from those justifying the withdrawal of other types of treatment.

²³ Appendix C - number 11. This case is also discussed in the BMA report on withholding life-sustaining treatment [BMA (1998) at p.12] from where the following summary is taken:

"An important example of the interaction of law and ethics and the relevance of professional guidelines can be seen in the 1996 case of patient R. In this case, the court considered the circumstances in which steps need not be taken to prolong life. R was 23 years old and had been born with a serious malformation of the brain and cerebral palsy. He also suffered from a range of other problems, including epilepsy, blindness, deafness, incontinence and was unable to walk or sit upright unaided. He had not, according to the court judgement, 'developed any formal means of communication or any consistent interactions with the social environment'. Not in PVS, he was described as being in a 'low awareness state' and was said by medical experts to be 'operating cognitively and neurologically at the level of a newborn infant'. His doctor believed that R was deteriorating neurologically and physically as recurrent chest infections and his other problems necessitated repeated admission to hospital. Although receiving what the judge commended as a very high quality of care, R weighed only 5 stone and suffered from dehydration. His hospital consultant told the court that in her view it could be unethical to continue treating R actively and that 'it is unquestionably in R's best interests to allow nature to take its course next time he has a life threatening crisis'. The health care team and R's family agreed to this and a DNR order was made for R. The case, however, was taken to court by an external agency - the Disability Law Service - who contested that non-treatment was in R's interests. After consideration, the court ruled that it was both lawful and in the patient's 'best interests' for cardiopulmonary resuscitation to be withheld and also for antibiotics to be withheld if R were to develop a potentially life threatening infection. Apparently distinguishing artificial nutrition and hydration as a different category of treatment, however, the court authorized a gastrostomy to be carried out on R."

²⁴ i.e. a Do Not Resuscitate order.

²⁵ BMA (1998) states (p.13):

"Conclusions from 'R':"

The court's endorsement of this framework indicates several important points concerning the withholding of treatment from incapacitated patients including:

- (i) The principle that non-treatment decisions should be taken by health professionals and people close to the patient. In the case of a serious challenge to the clinician's opinion, as occurred with the intervention of the Disability Law Service, cases will probably have to go to court.*
- (ii) Non-treatment decisions can be based either on an assessment that treatment is not medically beneficial or on an assessment of the patient's quality of life. In either case there must be discussion with all those involved in providing care and with people close to the patient.*
- (iii) Artificial nutrition and hydration are perceived as different from other medical treatments which can be withheld, such as antibiotics.*

In the case of patients in persistent vegetative state, the House of Lords has taken the view that decisions regarding withdrawal of artificial nutrition and hydration should be subject to court review. The courts have also considered the case of a patient whose condition resembled PVS but who did not satisfy the diagnostic criteria for the condition laid down in guidelines issued by the Royal College of Physicians. In that case, the BMA took the view that it was not the label attached to the condition which should determine whether non-treatment was justified but rather such decisions should be based on the demonstrable irreversibility of damage to specific neural pathways."

Cases of terminal illness

It was mentioned earlier that 'absolute quality of life' judgements may well have originated from attempts to assimilate the methodology used in making treatment decisions for terminally ill patients into a 'quality of life' framework.

These treatment decisions for terminally ill patients are of two types:

- A. The first type are those where the treatment can be justified in terms of improving a patient's 'incremental quality of life', even though the patient's life is shortened as a (possibly desired) side effect.²⁶ These are the treatment decisions spoken of by Lord Donaldson in *Re J*²⁷ when he stated that the question that doctors have to decide is whether:

*"... a particular decision as to medical treatment should be taken which as a side effect will render death more or less likely. This is not a matter of semantics it is fundamental. ... the use of drugs to reduce pain will often be fully justified, notwithstanding that they will hasten the moment of death."*²⁸

This is an example of the classic double effect argument; however, when cast into the language of incremental and absolute quality of life judgements, a new dimension is revealed. In suggesting that painkillers should be given to the terminally ill even at the risk of shortening their lives Lord Donaldson was emphasising that giving of the pain killer itself required a justification, which was that it reduced pain and thus improved the patient's 'incremental quality of life'; there is no 'absolute quality of life' judgement involved here.²⁹

- B. This contrasts with the second type of treatment decisions which do not, and are not calculated to, improve the patients 'incremental quality of life' but are designed to allow him to die.³⁰ These are justified on grounds either of futility or that they serve the patient's 'best interests' in that the patient is dying. It is clear that such judgements are 'absolute quality of life' judgements. The double effect argument is often employed in such circumstances to justify the withdrawal of treatment, and in so far as there are no 'incremental quality of life' benefits it is clear that such applications are invalid.

The conclusion that 'absolute quality of life' judgements should be avoided on ethical grounds would imply that treatment decisions for the terminally ill, which are of the second type should also be avoided. The concept of 'a good death' - which is discussed in Chapter 9 - would permit these cases to be resolved without the necessity of relying on 'absolute quality of life' judgements.

Conclusion 7.3 : 'Absolute quality of life' judgements have been used by the courts to justify the withdrawal of life-sustaining treatment in two types of cases:

- (i) in cases non-terminal illness.
- (ii) in cases of terminal illness.

It is argued in Part 3 that the conceptual scheme there proposed would (by using the concept of 'a good death') permit an appropriate resolution to all type (ii) cases;

²⁶ It was mentioned earlier that the interplay between 'quality of life' and 'quantity of life' has been omitted from this discussion; this was done to simplify the discussion. A more sophisticated analysis would speak of 'incremental quantity/quality of life judgements' and 'absolute quality/quantity of life judgements' but the basic argument against such absolute judgements would be essentially unchanged.

²⁷ Appendix C - number 10.

²⁸ *Re J* at p.938 [emphasis in original].

²⁹ The irony is that in *Re J*, Lord Donaldson justified the decision not to ventilate on *absolute* quality of life grounds - hardly compatible with calling the resulting death a 'side effect'.

³⁰ Decisions such as the withdrawal of ANH or of ventilation when such is not done to remove a source of discomfort caused by the ventilation or the ANH.

and furthermore, would (by using the concept of personhood) allow some³¹ of the type (i) cases to be resolved; it would not justify the withdrawal of life-sustaining treatment in other cases of type (i)³² such as, for example, cases of Down Syndrome.

Subsection 2: 'Incremental quality of life' judgements do not depend on an ability to make 'absolute quality of life' judgements.

Obviously if 'absolute quality of life' judgements are possible - and ethically permissible - then a clinician could make an 'incremental quality of life judgement' simply by making an 'absolute quality of life judgement' for the circumstances that pertain before the intervention, and again for those circumstances which he believes will exist after the proposed intervention; the 'incremental quality of life' being nothing more than the difference between the 'absolute quality of life' after the proposed intervention and that before it.

However, - and most importantly - the ability to make 'incremental quality of life' judgements does not *depend* on an ability to make 'absolute quality of life' judgements. The fact that this is so allows one to accept the validity of 'incremental quality of life' judgements whilst denying the validity of 'absolute quality of life' judgements. If this was not so the attempted distinction between 'absolute quality of life' and 'incremental quality of life' would be of no interest.

I am not suggesting that the concept of 'absolute quality of life' is not relevant to the concept of 'incremental quality of life'; still less am I suggesting that the concept of 'incremental quality of life' is logically independent of that of 'absolute quality of life'; what I am suggesting is that *changes* in 'absolute quality of life' can be measured even though *it itself* either cannot or, for ethical reasons, should not be measured as a totality. An analogy explains the point clearly: imagine choosing a gift for a friend; one estimates which particular gift would give them the greatest happiness, one examines whether a particular gift would tend to increase or decrease their quantum of happiness and one chooses that which maximises the incremental increase; attempts to estimate their *total* quantum of happiness are neither necessary nor desirable. Some very simple visual examples can also clarify the operative principle and obviate the necessity for an exhaustive verbal explanation though a verbal argument will be subsequently be sketched.

Example 1

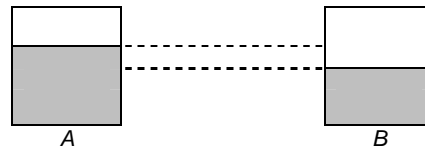
Imagine a glass of water 'A' from which some water is removed by evaporation, leaving the glass as at 'B' in Diagram 7-1. If one wished to determine the amount of water removed then one could certainly measure the amount of water at 'A', then measure the amount of water at 'B' and then subtract these figures. This is illustrated below in Diagram 7-1: Case 1.

If, however, one was unable to measure the total quantities in the glasses - imagine that a piece of card was placed in front of the glasses so that the total quantity was not determinable - then it would still be possible to determine the amount removed by comparing the levels both before, and after, the operation. So that - if one was sure that the only change was that by evaporation - one could determine the amount evaporated. This is the situation illustrated below in Diagram 7-1: Case 2.

³¹ *i.e.* those cases where the ability to communicate is permanently lost.

³² *i.e.* where it is believed that the ability to communicate will be restored.

Case 1



Case 2

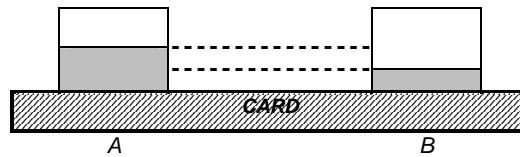


Diagram 7-1: Example showing alternative methods of measuring change.

Example 2

The problem is to measure the population increase of some country between 1990 and 2000. Certainly, the population increase could be determined by measuring the total population in 1990 and again in 2000 and then subtracting these results. However, in the absence of such information the population increase could also be determined simply by noting the changes that have occurred - *i.e.* the births less the deaths (assuming that these were the only changes). This is illustrated in Diagram 7-2 below.

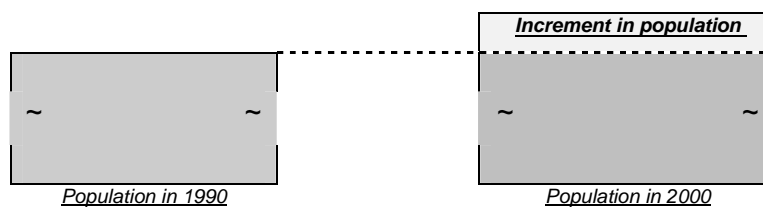


Diagram 7-2: Example showing measurement of a population change.

These examples show that it is possible to measure the incremental changes of a quantity without necessarily being able to measure the total quantity.

Returning to the original discussion, it is clear that a physician can judge whether (within the context of the life of a particular patient and judged from that patient's perspective) a proposed medical intervention will have a positive or negative effect on the quality of life of that patient, whilst at the same time fully accepting that he, the physician, is utterly unable to assess the 'quality of life' - in the sense of 'absolute quality of life' - of that patient; so that 'incremental quality of life' judgements do not depend on the ability to make 'absolute quality of life' judgements.

Conclusion 7.4 : *A physician can judge how a proposed medical intervention will impact on the quality of life of a patient - i.e. he can make an 'incremental quality of life' judgement - without needing to make any assessment as to the total quality of life of the patient - i.e. without making an 'absolute quality of life' judgement.*

'Incremental quality of life' judgements do not require an ability to measure but only to rank

It may be objected that these examples above do not provide true analogies for the discussion about 'quality of life' because, in the examples, there is no difficulty with *measuring* as such: there is no dispute that in the examples given cubic centimetres or individual citizens are the appropriate unit; whereas in discussing 'quality of life', not only is there a problem with measuring 'quality of life' in its totality but there is a difficulty with the very idea of measuring 'quality of life' at all. This objection can be overcome by noticing that what is required in deciding whether a medical intervention should proceed is strictly not a *measure* of 'incremental quality of life' but a *ranking*³³ of the 'quality of life' before the intervention, against that after the intervention. Logically, if measuring is possible, one can certainly define ranking in terms of measure, however, the corollary does not follow; one can logically speak of ranking even though measuring is not possible, 'ranking' being a logically more primitive concept than measuring. Thus, it follows that even if measuring is not possible ranking may still be. Furthermore, 'incremental ranking' does not depend on 'absolute ranking', as can be seen through a consideration of some examples where there is no suggestion that quantification is possible: consider a proposed change in a musical arrangement or in a painting; one could meaningfully ask whether the change would make the piece better or worse, more or less beautiful; such is an 'incremental' quality judgement and is quite distinct from the independent question as to whether the piece of music or art, considered in absolute terms, is a good piece of art, this latter being an 'absolute' quality judgement.

Finally, the ethical objection spoken of earlier against making 'absolute quality of life' judgements is, strictly speaking, not directed against attempts to *measure* the 'absolute quality of life' of an individual but against attempts to *use* that measure for purposes other than the making of incremental quality of life judgements. Thus, the objection that if one is prohibited from measuring 'absolute quality of life', one cannot measure 'quality of life' at all and, *a fortiori*, one cannot measure 'incremental quality of life', is quite beside the point.

Subsection 3: 'Absolute quality of life' judgements should be avoided.

The argument against the use of 'absolute quality of life' judgements is based on two grounds; firstly, that such judgements conflict with egalitarian principles, secondly, that they are unreliable.

'Absolute quality of life' judgements conflict with egalitarian principles.

In attempting to clarify the decision making process in respect of the giving or withholding of medical treatment, the life of a patient is often described in terms of its *quality* and its *quantity*; however, the idea that a human life can be encapsulated in such terms can be a profoundly inequalitarian one.

If quantity of life is equivalent to length of life, then the statement that persons' lives differ in their quantity cannot be disputed. However, if it is conceded that person's lives also differ in their quality, *and that this difference can be measured*, so that it is possible to state of two persons which has the better 'quality of life', then it is difficult to avoid the conclusion that such lives differ in their worth. Consider two persons with an equal life-expectancy whose lives differ only in that one is judged to

³³ to place in order *i.e.* bigger or smaller.

have a 'poor quality of life' and the other a 'good quality of life'; if the value of their lives can be wholly encapsulated in such judgements,³⁴ then would it not follow that it was a lesser evil to kill the one with the 'poor quality of life' than the one with the 'good quality of life' or that it was a good to kill the former in order to save the latter?³⁵ This was the argument of Lord Mustill in the Bland case, when he rejected the suggestion that the 'quality of a life is diminished by disease or incapacity because it would imply that "... one life is intrinsically worth less than another."³⁶ It was also the argument of the Irish Attorney General when, in the Ward case, he submitted that if the State were ever to take 'quality of life' considerations into account then this would imply that it need provide less protection for the most disadvantaged or most vulnerable of its citizens - the very citizens who had most need of its protection.³⁷ Mr Justice Egan in his dissenting judgement in the Ward case shared these views:

*"Cognition in a human being is something which is either present or absent ... Any effort to measure its value would be dangerous."*³⁸

To avoid these conclusions it seems necessary to allow that the quality of a person's life is, in a deep private sense, immeasurable; that between lives, quality is equal - 'equality' *after all means the possession of a like degree of quality* - and that this equality flows from their incommensurability rather than from any equality of measure. It is this perception that is manifested in the suggested prohibition on 'absolute quality of life' judgements.

The recognition that the 'quality of life' of another person is opaque to us at its deeper levels³⁹ does not preclude the use of the term as an aid in deciding on an appropriate intervention. After all we share a common humanity and an awareness of what is likely to be of assistance to another. If the attempt to assist is done, not in a paternalistic sense of acting to 'better' or 'do good to' another, but rather from a sense of empathy⁴⁰ - by entering as far as possible into their world view and, from that perspective, assisting - then it could indeed be said to improve their 'quality of life' but such a usage of the term is clearly in the sense of '*incremental quality of life*' rather than in that of '*absolute quality of life*'.

³⁴ Objections to the use of IQ scores as indicators of the personal worth of individuals, depends on a similar argument.

³⁵ This echoes Raskolnikov's argument in Dostoyevsky's *Crime and Punishment* when - judging the quality of life of an old but wealthy woman neighbour as being poor - he reasoned that to kill and rob her would permit him to have an improvement in his life considerably greater than the worth of life of which the old lady was deprived and that this imbalance justified her murder.

³⁶ The Bland case at p.894.

³⁷ The Ward case at p.448:

"He submitted that the quality of the ward's life is a question of judgement but that that judgement is impermissible to our courts."

³⁸ *ibid.* p.437.

³⁹ "We do not know - cannot know - what lies behind these invisible walls." David Tomkin and Adam McAuley 'Re A Ward of Court: Legal Analysis' *Medico-Legal Journal of Ireland* (1995), p.46

⁴⁰ In Eastern philosophy the belief that morality has its origin in empathy rather than in rationality is common; it is also a view shared by Schopenhauer who argued that:

"... if I do you an injustice I am sinning against myself as well as you. This, said Schopenhauer, is the explanation of morality, because it explains the compassion, fellow-feeling, disinterested concern for others ... Schopenhauer disassociates himself from Kant's doctrine that rationality is the foundation of ethics ..."

Bryan Magee, *Confessions of a Philosopher* (1997), at p.483

I wish to offer two examples which, I suggest, make abundantly clear the radical difference that can exist between the perception of 'quality of life' as judged from within, and as judged from without.

Jean-Dominique Bauby

In 1995 Jean-Dominique Bauby, who was the editor of a French fashion magazine, suffered a severe stroke and became a victim of 'Locked-In Syndrome'⁴²; he was able to move only his left eyelid. His situation was surely such that any dispassionate observer would have judged his 'quality of life' as non-existent, yet he dictated a book The Diving Suit and the Butterfly⁴³ by communicating by signalling with his eyelid. Bauby accomplished this heroic feat by blinking - once for 'yes', two for 'no' - in response to a friend holding up cards on which the letters of the alphabet had been written; thus was the book written - letter by laborious letter. In 1996 Bauby established the French society for patients suffering from locked-in syndrome.⁴⁴ He died in 1997.

After his accident some of Bauby's former acquaintances had described him as a 'vegetable'; he had been told of this and wrote the book partly in response. Shortly after the accident he described his appearance:

"Reflected in the glass I saw the head of a man who seemed to have emerged from a vat of formaldehyde. His mouth was twisted, his nose damaged, his hair tousled, his gaze full of fear. One eye was sewn shut, the other goggled like the doomed eye of Cain. For a moment, I stared at that dilated pupil before I realised it was only mine." ⁴⁵

But, if his body was trapped in the diving suit of the book's title,⁴⁶ his mind would take flight like a butterfly:

"My cocoon becomes less oppressive and my mind takes flight like a butterfly. There is so much to do. You can wander off in space or in time, set out for Tierra del Fuego or for King Midas's court. You can visit the woman you love, slide down beside her and stroke her still sleeping face. You can build castles in Spain, steal the Golden Fleece, discover Atlantis, realise your childhood dreams and adult ambitions. Enough rambling. My main task now is to compose the first of these bedridden travel notes ..." ⁴⁷

The friend to whom he dictated the book has said:

⁴¹ A recent BMA report notes:

"Studies have shown that relatives' perceptions of the patient's likely views often differ substantially from the patient's own wishes."

[BMA (1999a) Withholding and Withdrawing Life-prolonging Medical Treatment : Guidance for decision making. 3C.18.3]

⁴² also known as the *Guillain-Barré Syndrome*.

⁴³ Jean-Dominique Bauby, Jeremy Leggatt (trans.), The Diving Suit and the Butterfly (1998).

⁴⁴ which is known as ALIS (*Association du Locked-In Syndrome*).

⁴⁵ Bauby *op.cit.* p.32.

⁴⁶ It also described the situation of his aged father:

"We are both locked-in cases, each in his own way: myself in my carcass, my father in his fourth-floor apartment."

ibid. p.52

⁴⁷ *ibid.* p.13; see also p.104:

"... when blessed silence returns, I can listen to the butterflies that flutter inside my head. To hear them, one must be calm and pay close attention, for their wing beats are barely audible. Loud breathing is enough to drown them out. This is astonishing: my hearing does not improve, yet I hear them better and better. I must have the ear of a butterfly."

*"He did not want to die. He had so many plans. He wanted to write another book and set up an association for people like himself. You cannot say he had nothing to live for. He loved life more than most able-bodied people."*⁴⁸

Bauby, speaking of his attitude to withdrawal of life-sustaining treatment, had said:

*"When the neurologist asked did I regret that I had been resuscitated, tell him that I don't think like that anymore but that I'm glad that he asked the question."*⁴⁹

Viktor Frankl

Viktor Frankl was a survivor of the Nazi concentration camps who later became a noted psychotherapist and author. His reflections on how people managed to survive and to find a certain dignity in situations such as Auschwitz - which to the outsider seemed of appalling grotesqueness - were published in his book Man's Search for Meaning.⁵⁰ This book emphasised the uniqueness of each human being and in it he used his own experience of the concentration camps to show how meaning could be found in even the most appalling situations, so helping people to come to terms with suffering whatever its causes. He acknowledged that in many cases it took a degree of unscrupulousness to survive the degrading conditions of these camps but he was nonetheless strikingly impressed by the inner freedom created by the condition of possessing nothing:

*"I understood how a man who has nothing left in the world may still know bliss."*⁵¹

In summary, 'absolute quality of life' judgements are incompatible with the egalitarian principle that all persons be treated as equal.⁵² The existence of great disparities between 'absolute quality of life' judgements made from within a life and from outside that life is a further reason for avoiding their use. However, it might be objected that, no matter how persuasive these individual examples might be, they may well be the exception; and that normally the judgement of a life from within and from without are reasonably congruent. Such an objection is undoubtedly valid but the appropriate response is not to assume that such a congruence is the norm, but to attempt to determine the frequency of such disparities in a rigorous scientific fashion. Such a study, although not possible in the context in which 'absolute quality of life' judgements would normally be used - that is in regard to a patient without the capacity to describe their own 'quality of life' - is certainly possible in a wider social context. Such a study could attempt to assess a wide variety of subjects as to their 'quality of life' judging only from the exterior circumstances of their lives; discussion with family and friends of the subject being permitted but not discussion with the subject themselves. A subsequent investigation of the subjects own assessment of their own 'quality of life' would yield data which would permit an informed comparison of these two assessments, and in consequence a judgement of the frequency of disparities. In this regard a recent American study⁵³ which found only a modest correlation between health values and quality of life is of interest, as a high correlation had usually been assumed. This study had questioned elderly American patients and found that, given the

⁴⁸ Quoted in The Sunday Times 16.3.1997.

⁴⁹ *ibid.*

⁵⁰ Viktor Frankl, Man's Search for Meaning (1964).

⁵¹ Quoted in an obituary in The Times 30.9.1997.

⁵² This argument does not apply if personhood is lost. It is argued in Chapter 11 that 'absolute quality of life' judgements are permitted in such cases.

⁵³ Reported in The Irish Times (4.2.1998).

choice, they preferred to live as long as possible in the state of health they were actually in, rather than to live a shorter life but in better health.

More importantly however, valuable information could be found by questioning those patients who have recovered from a PVS. The apparent unwillingness to look for such information - as is evidenced by the lack of research in this area - would seem to suggest that although the language of subjective 'quality of life' is commonly used, it serves to mask different interests. Unfortunately the insistence by the BMA that recovery from PVS is itself evidence of misdiagnosis⁵⁴ effectively precludes if not the carrying out of such studies, at least their relevance; this is because if recovered 'PVS' patients cannot, logically, have been PVS, then their views as to their experience whilst supposedly PVS is of no relevance to patients who are PVS.

One further point needs to be addressed: that 'absolute quality of life' judgements can function as a mechanism of denial so that situations which the observer/decision-maker *themselves* find intolerable are not permitted to continue. An example of such denial is found in the response (quoted earlier) of a medical witness in the Karen Quinlan case, to the suggestion that Karen might be conscious:

*"... it's theoretically possible, in terms of animal experiments. ... but I don't know how you're going to find out. I think it's one of the most horrendous things you can imagine."*⁵⁵

The existence of, and the role played by, denial in medical attitudes to death and dying is examined in Chapter 9 where the pioneering work of Ernest Becker and Elisabeth Kubler-Ross in this area is also discussed.

Conclusion⁷⁻⁵: *There are at least two reasons why 'absolute quality of life' judgements should be rejected: they are unreliable and they are incompatible with the egalitarian principle that all persons be treated as equal.*⁵⁶ *Furthermore 'absolute quality of life' judgements often function as a mechanism of denial so that situations which are unacceptable to the decision-maker are not permitted to continue.*

Section 3: The concepts of 'best interests'.

This Section is divided into two Subsections; Subsection 1 examines the concept of 'best interests' from a general perspective and Subsection 2 considers the meaning to be attributed to the term 'best interests' as used in the Ward and Bland judgements.

Subsection 1 : The concept of 'best interests'

The term 'best interests' is commonly used in discussing the medical treatment options for children and incompetent adults. Speaking of the usefulness of the term, a BMA report is less than fulsome in its praise:

" 'Best interests' presents an apparently reassuring standard by which decisions should be made but can be interpreted in many ways. ... In the past, 'best interests' were often seen as synonymous with the most positive clinical outcome. Prolongation of life at almost any cost

⁵⁴ Which was discussed in Chapter 4.

⁵⁵ Borthwick (1995b) p.208.

⁵⁶ This argument does not apply if personhood is lost and - as is argued in Chapter 11 - 'absolute quality of life' judgements are permitted in such cases.

*was seen to be in the patient's interests. ... The Law Commission's analysis of 'best interests' mentions the importance of taking into account the known wishes of the patient and clearly these must figure in any assessment. Frequently, however, the former wishes or values are unknown and relatives' recollections may be unreliable and so more objective standards must be considered."*⁵⁷

What is this 'more objective standard'? To say to a patient's medical carers that the criterion that they must use in making treatment decisions for that patient is the patient's 'best interests', is to place two obligations on them; these obligations must be disentangled, they are:

- (i) The carers must look *only* to that patient's interest when making their decision. This means that the medical carer's interests or the interests of other patients (as manifested through scarcity of resources) or the interests of the patient's family (in so far as these do not - as they seldom will - fully coincide with the patient's interests) must be disregarded.⁵⁸
- (ii) Given then that only the patient's interests are to be considered, they must act only in his 'best interests'.

How is a decision to be made between two conflicting courses of action both of which, it is contended, are in the patients 'best interests'? It was to resolve this very question that the concept of 'quality of life' was devised. Thus, an analysis of 'best interests' leads to the concept of 'quality of life'. There is, however, no reason why a 'best interests' judgement must be an 'absolute quality of life' judgement; a 'best interests' judgement may well be an 'incremental quality of life' judgement though - as is argued in the following subsection - 'best interests' was used in the Ward and Bland cases, in the sense of an 'absolute quality of life' judgement.

Conclusion 7 - 6 : 'Best interests' judgements necessitate 'quality of life' judgements.

As will be seen in the next subsection some judges in the Bland case, whilst accepting the 'best interests' test, did not accept that the concept of 'quality of life' could also be used. The reasons for this apparent contradiction are to do with a confusion between 'incremental quality of life' and 'absolute quality of life'; however, it is worth pointing out at this stage that much of the appeal of the concept of 'best interests' is due to its vague definition; to its being 'all things to all men'; as such there is a danger that it may function as an umbrella term providing shelter to other, unstated, interests; this is especially so if 'denial' is operative.⁵⁹

Subsection 2 : 'Best interests' as used in the Ward and Bland judgements.

Two events happened to the Ward and to Tony Bland subsequent to the decision to withdraw ANH; the tube feeding was discontinued and they died. These events were intimately connected, so intimately connected that it may seem pedantic to ask which of the two events was in mind when it was decreed to be in each of their 'best interests' that the tube feeding be discontinued; however,

⁵⁷ BMA (1998) p.11; a conclusion which is reiterated in a more recent report:

"Best interests presents an apparently reassuring standard by which decisions should be made but can be interpreted in many ways"

[BMA (1999a) Withholding and Withdrawing Life-prolonging Medical Treatment : Guidance for decision making. 3C.18.1]

⁵⁸ A recent BMA report suggests that this requirement is not always honoured.

"It is obvious, however, that money spent caring for irreversibly and severely brain-damaged patients is money which cannot be used to treat other patients. This is an issue which needs to be acknowledged and addressed on a national scale as part of the debate on rationing and prioritising of resources. The BMA is concerned that, in reality, cost factors probably have a disproportionate influence on decision making for this very vulnerable patient group and is also concerned that the lack of a clear societal consensus on this most vexed area may unfairly leave doctors open to criticism."

[BMA (1999a) Withholding and Withdrawing Life-prolonging Medical Treatment : Guidance for decision making. 3C.18.5]

⁵⁹ As discussed earlier in Conclusion 7 - 4..

if honesty and clarity be the goal of this debate then it is important that the question be at least addressed.

In an earlier chapter⁶⁰ the distinction between direct and indirect intention (and the related doctrine of 'double-effect') were discussed and a test (proposed by R. A. Duff⁶¹) was suggested for determining which of a number of consequences of an action could rightly be called the goal or the intended consequence of the action; the legal position on indirectly intended acts was also clarified: this is that if action A is performed in the hope that result R₁ would occur but in the knowledge that the occurrence of R₁ *necessarily* entails the occurrence of R₂, then R₂ is also intended.⁶²

It has often been suggested that the double-effect argument is pure sophistry; nothing other than an intellectual device to permit the avoidance of responsibility.⁶³ I suggest that Duff's questions (*What is the goal of the action? What is the criterion of success?*) in conjunction with a thought experiment (where the consequences are imagined to be not necessarily connected) can permit a traditional double-effect analysis a further level of elucidation - the question can be asked as to which of the (now separated) consequences would be the criterion of success; the answer to this question identifies the goal of the original procedure.

As an example, consider a woman with an ectopic pregnancy; the current medical treatment is such that the procedure undertaken to protect the life of the mother necessarily results in the death of the foetus. A traditional double-effect analysis is that the killing of the foetus, though foreseen as a necessary consequence, was not the intended consequence of the procedure. A critic of the double-effect analysis will argue that since the death of the foetus was a necessary consequence, it was therefore intended and to suggest otherwise is disingenuous. Imagine, however, a medical advance which permitted the doctor to save the life of the mother without losing the life of the foetus; by posing the question as to whether the surgeon would use the current method or the imagined method, we can quickly identify the true goal of the procedure and see whether it is to save the life of the mother or to kill the foetus. The conclusion in such a case is clearly that the goal of the procedure is not the killing of the foetus.

Let us now apply the same reasoning to the withdrawal of tube feeding from a PVS patients; let us imagine that a new procedure has been invented whereby a patch placed on the arm of a patient allows their nutrition to be absorbed painlessly and effortlessly through the skin. Would such a patch have been used in the Ward and Bland cases? To do so would permit the tube feeding to be discontinued and the patient to live.

It is certainly true that in the Ward case the discomfort which the tube feeding caused was alluded to in many of the judgements; the withdrawal of tube feeding would have been justified on such grounds and the ensuing death recognised as an inevitable but unwanted side-effect. Such a judgement is eminently defensible and would have been an 'incremental quality of life' judgement; the fact that the patient would be in a less troubled state after that tube was removed, amply vindicates the procedure. But such was not the situation in the Bland case simply because none of the judges believed that Tony Bland could feel pain; in fact, as subsequently emerged, the tube was

⁶⁰ Chapter 6, Section 3, Subsection 1.

⁶¹ R. A. Duff, in *Intention, Agency and Criminal Liability* (1990) suggested that to determine the 'goal' of a procedure we need only ask as to what must happen before the procedure would be adjudged to be successful.

⁶² The example was given of a nephew who (reluctantly) poisons his uncle in order to gain his inheritance; legally, the nephew is considered to have intended to poison his uncle.

⁶³ The BMA has acknowledged the existence of such criticism:

"The use of a 'double effect' justification has frequently been criticized and the BMA would welcome views about whether it should or could be replaced."

[BMA 1998 p.7].

not disconnected but was left in place in case it was necessary to administer medication.⁶⁴ Thus, Tony Bland had no better quality of life immediately after the cessation of tube feeding than before so no 'incremental quality of life' judgement was involved. In the Ward case we have seen that the cessation of tube feeding could have been justified as an 'incremental quality of life' judgement. Imagine now the nutrition patch of which we spoke earlier, being introduced into the debate; would it be seized on as the obvious solution? When O'Flaherty J., stated:

*"The ward may be alive but she has no life at all. ... the quality of the ward's life was never in issue; she is not living a life in any meaningful sense."*⁶⁵

would the nutrition patch have allayed his concerns? The answer is an obvious and emphatic no.

The conclusion is that though in the Ward case there may have been 'incremental quality of life' grounds for the withdraw of ANH, these were secondary. We have shown that the Ward and Bland cases adopted primarily a 'best interests' analysis;⁶⁶ we have also shown that a 'best interests' analysis necessitates a 'quality of life' analysis and we have shown that the 'quality of life' analysis implicit in the Ward and Bland cases was primarily one based on 'absolute quality of life' judgements.⁶⁷

Conclusion 7.7 : *The 'best interests' analysis adopted in both the Ward and Bland cases necessitates the use of 'absolute quality of life' judgements.*

Section 4: Conclusions.

The conclusion of the chapter is that two meanings of the term 'quality of life' can be distinguished: '*incremental quality of life*' (a measure of the change in 'quality of life' due to a proposed intervention) and '*absolute quality of life*' (a measure of the totality of 'quality of life'). It has been shown that 'incremental quality of life' judgements do not presume an ability to make 'absolute quality of life' judgements. It has been argued that 'absolute quality of life' judgements should be avoided because they are unreliable and because they conflict with accepted norms of equality; no such objections were made against the use of 'incremental quality of life' judgements. It has been shown that the concept of 'best interests' is dependant on that of 'quality of life'; and that 'best interests' judgements as used in the Ward and Bland cases were primarily 'absolute quality of life' judgements; the deaths of the Ward and of Tony Bland being not only the legally intended result but the very goal of the withdrawal of ANH.

⁶⁴ As mentioned earlier this came to light in a radio interview given by Dr. Howe (the neurologist in charge of Tony Bland) to RTE Radio on 26.5.1999.

⁶⁵ The Ward case p.432.

⁶⁶ *Conclusion 6.8* : *The Ward and Bland cases held that treatment decisions for incompetent patients should be made on the basis of the patient's 'best interests'.*

⁶⁷ It is necessary to enter one proviso to this analysis: in the Bland case Lord Mustill spoke strongly against the use of the term 'quality' of life and the suggestion that, if the quality of life of a patient was diminished by disease or incapacity that the state's interest in preserving that life is attenuated; such a line of argument implies:

"... that because of incapacity or infirmity one life is intrinsically worth less than another. This is the first step on a very dangerous road indeed, and one which I am not willing to take." [the Bland case p.894]

He argued that the judgement to withdraw ANH must be the result of a balancing of the conflicting interests of the patient and not the result of a judgement of the 'quality of life' of the patient - thus suggesting that 'absolute quality of life' judgements are impermissible.

To pursue this perspective in tandem with a 'best interests' analysis required that Lord Mustill adopt a novel and closely argued approach:- he suggests that *Tony Bland has no interests of any kind*. When ANH was initially commenced Tony Bland had interests - as there then was the expectation of recovery - and the giving of ANH was then in his best interests. In order to be lawful there is the requirement that such medical intervention be in the patients best interests; thus the commencement of ANH was lawful. Now, in so far as he has no interests - and *a fortiori* no best interests - to continue with the treatment is necessarily unlawful. Hence it must cease.

A statement by Lord Goff in the Bland case brings the questions discussed in the chapter into sharp focus; having noted that the question before the court can sometimes be put in '*striking or emotional terms, which can be misleading*',⁶⁸ he continued:

*"The question is not whether the doctor should take a course which will kill his patient, or even take a course which had the effect of accelerating his death. The question is whether the doctor should or should not continue to provide his patient with medical treatment or care which, if continued, will prolong his patient's life. ... And then it is asked: can it be in the best interests of the patient that a doctor should be able to switch the life support system off, when this will inevitably result in the patient's death? Such an approach has rightly been criticised as misleading, ... This is because the question is not whether it is in the best interests of the patient that he should die. The question is whether it is in the best interests of the patient that his life should be prolonged by the continuance of this form of medical treatment or care."*⁶⁹

Lord Goff was anxious to draw a distinction between saying on the one hand that

- * '*the patient is better off dead*' (which is an 'absolute quality of life' judgement); and
- * '*the patient is better off without ANH even though it is a necessary consequence of the withdrawal of life support that he will die.*' (which is an 'incremental quality of life' judgement).

A distinction is indeed possible if the patient immediately after the withdrawal of ANH is in a less troubled state than whilst ANH was being administered. Such could be the case with a sentient patient particularly if being fed by a nasogastric tube which, unlike the gastrointestinal tube, causes considerable discomfort. But this is not relevant to the situation of Tony Bland as described in the judgements. Thus, although the distinction sought to be made by Lord Goff is valid, his use of the distinction is not. It is one of the aims of this thesis to show that it will only be possible to avoid the misuse of such subtle distinctions when the role of death - and, in particular, the idea of '*a good death*' - is acknowledged as being central to any resolution of 'end-of-life' decisions for PVS patients.

The conclusions which were established in this chapter are:

*Conclusion*₇₋₁ : *The concept of 'quality of life' is much used in medicine and law to enable the comparison of different treatment options. The concept is not well defined and its claim to rigor and objectivity is largely spurious.*

*Conclusion*₇₋₂ : *'Incremental quality of life' judgements are quality of life judgements which seek to estimate the change in the quality of life of a patient ascribable to a proposed medical intervention; the understanding being that the intervention should be performed if and only if this change is positive.*⁷⁰

⁶⁸ The Bland case p.868.

⁶⁹ *ibid.*

⁷⁰ As mentioned earlier, situations where there is an expectation of improved life expectancy but decreased quality of life have been omitted for simplicity.

'Absolute quality of life' judgements are quality of life judgements which seek to estimate the total quality of life of a patient; the understanding being that if this quality of life is minimal then life-sustaining medical treatment should be withheld and the patients allowed to die.

Conclusion 7.3 : *'Absolute quality of life' judgements have been used by the courts to justify the withdrawal of life-sustaining treatment in two types of cases:*

(i) in cases non-terminal illness.

(ii) in cases of terminal illness.

It is argued in Part 3 that the conceptual scheme there proposed would (by using the concept of 'a good death') permit an appropriate resolution to all type (ii) cases; and furthermore, would (by using the concept of personhood) allow some⁷¹ of the type (i) cases to be resolved; it would not justify the withdrawal of life-sustaining treatment in other cases of type (i)⁷² such as, for example, cases of Down Syndrome.

Conclusion 7.4 : *A physician can judge how a proposed medical intervention will impact on the quality of life of a patient - i.e. he can make an 'incremental quality of life' judgement - without needing to make any assessment as to the total quality of life of the patient - i.e. without making an 'absolute quality of life' judgement.*

Conclusion 7.5 : *There are at least two reasons why 'absolute quality of life' judgements should be rejected: they are unreliable and they are incompatible with the egalitarian principle that all persons be treated as equal.⁷³ Furthermore 'absolute quality of life' judgements often function as a mechanism of denial so that situations which are unacceptable to the decision-maker are not permitted to continue.*

Conclusion 7.6 : *'Best interests' judgements necessitate 'quality of life' judgements.*

Conclusion 7.7 : *The 'best interests' analysis adopted in both the Ward and Bland cases necessitates the use of 'absolute quality of life' judgements.*

⁷¹ i.e. those cases where the ability to communicate is permanently lost.

⁷² i.e. where it is believed that the ability to communicate will be restored.

⁷³ This argument does not apply if personhood is lost and - as is argued in Chapter 11 - 'absolute quality of life' judgements are permitted in such cases.

Chapter 8: Could the Ward case engender a 'slippery slope'?

This chapter examines the form of argument known as the '*slippery slope*' and discusses its possible application to the Ward case. More specifically, it examines whether the judgements in the Ward case were framed in such a fashion as to lay the grounds for the future widening of the categories where the withdrawal of life-sustaining treatment is considered to be an acceptable means of providing a solution from, as at present, cases of PVS and 'near-PVS', to cases of disability.

The chapter comprises five sections. Section 1 sets out the form of the slippery slope argument and considers its validity. Section 2 examines recent developments in English Case law in relation to the withdrawal of life-sustaining treatment in cases of non-terminal illness other than PVS and 'near-PVS'.¹ Section 3 considers whether the Ward case laid the grounds for developments in Irish law similar to those outlined in Section 2 and whether this could be interpreted as a 'slippery slope'. Section 4 considers some proposals made by the BMA in July 1999 on the withdrawal of ANH.² Section 5 draws some conclusions from the discussion.

Section 1: The 'slippery slope' - a valid form of argument?

The 'slippery slope' argument³ is often invoked in relation to a proposed policy change to suggest that - although the policy change is, in itself, desirable - other changes, which are not desired, will inevitably result if it is accepted. The validity of this argument is often questioned; David Lamb⁴ speaks of valid and invalid applications and he notes that some philosophers regard the slope argument as an example of fallacious reasoning. Such terminology seems misplaced - a confusion of categories.

In considering the argument it is important to distinguish between the slope argument considered as an abstract form of argument, and the argument considered in a particular concrete setting. Strictly speaking, questions as to the *validity* of an argument relate to its logical *form* i.e. the logical argument abstracted from any particular context, thus '*modus ponens*' - If *P* then *Q*; *P*; therefore *Q*. - is a valid argument irrespective of the propositions *P* and *Q*. The slippery slope argument - perhaps with the exception of the so-called 'logical form of the argument' discussed below - does not exhibit any particular abstract logical structure; it exists only in its particularity and accordingly questions of its 'validity' are inappropriate. In a particular setting one can of course discuss the *truth* of a suggested slippery slope but this is nothing more than to acknowledge that if, in a particular social and political situation certain changes occur, then the predication that other changes will follow, may be true or false. But it is important to realise that this is a political, or sociological, or legal question; it is not a logical question.

This contrast between the argument considered in its abstract setting (where it is vacuous) and in a particular setting (where it may be considered true, not however because of any formal qualities

¹ The English legal judgements dealing with PVS and 'near-PVS' have been discussed in Chapter 6, Section 4; see also Appendix C.

² BMA, *Withholding and Withdrawing Life-prolonging Medical Treatment : Guidance for decision making*, July 1999

³ This form of argument is also called the '*thin end of the wedge*', the '*sorites*', or the '*heap*' argument.

⁴ David Lamb, *Down The Slippery Slope: Arguing in Applied Ethics* (1988).

of the argument but because of certain other circumstances that also exist in that particular setting) is also to be found in the so-called '*Principle of Induction*', a brief examination of which may be helpful.

The Principle of Induction

The principle of induction is often suggested as the mechanism which allows us to move from the recognition that certain regularities occur in nature to a conclusion that they *must* recur. This, however, is something of a sleight of hand. It is not possible to *deduce* from the fact that the sun arose in the east yesterday morning, and indeed every morning since time immemorial, that it will do so tomorrow morning.⁵ Logic gives us no assistance in resolving such doubts. We know from our experience that there are⁶ regularities in the universe, and from the very nature of regularity we assume that they will continue. If every time a child has met his generous uncle, a gift of sweets was forthcoming, then that child, in looking forward to a visit from his beloved uncle, will come to *expect* a gift of sweets; we, like Pavlov's dogs, structure our lives on such expectations; indeed it is doubtful that we could remain sane in the absence, if not of the regularity, at least the expectation of such regularity. However, it is of no assistance to clear thinking to assume that there is some 'Principle of Induction' by whose help we can *deduce* that the sun will rise tomorrow, nor by whose help the child can *deduce* that his uncle will eternally produce confections. The postulation of such a principle can doubtlessly give some psychological comfort, and we can use it, like a favourite amulet, to attempt to hold the winds of chaos at bay but when standing on shifting sands, although words can allay the fear, they cannot still the sands.

P.F. Strawson has argued⁷ that it is absurd to suppose that induction can ever be justified by showing that it is really a part of deductive reasoning; any attempt to justify it by its success is to justify induction by induction itself, for any such attempt involves the presumption that what was successful in the past will be successful in the future. Thus, having recognised certain regularities in a particular series of occurrences, we may anticipate that these will continue to occur; in this we may be correct or incorrect; however, any attempt to appeal to some principle of induction from which we can deduce the future occurrence by arguing in the fashion -

'X has occurred with regularity'

hence, by the principle of induction, there is some general law guaranteeing these occurrences from which we can deduce that:

'X will continue to occur'

is pure sophistry. Wittgenstein argues similarly: Russell, in his introduction to Wittgenstein's Tractatus Logico-Philosophicus and speaking of Wittgenstein's views, says:

*" 'The events of the future,' he says, 'cannot be inferred from those of the present. Superstition is the belief in the causal nexus.' That the sun will rise to-morrow is a hypothesis. We do not know whether it will rise, since there is no compulsion according to which one thing must happen because another happens. "*⁸

However, in any particular instance of regularity of an occurrence 'O', we can (perhaps, by scientific means) investigate and attempt to establish some theoretical connection between the

⁵ Though the opening sentence of Samuel Beckett's novel Murphy offers a different perspective:

"The sun shone, having no alternative, on the nothing new."

⁶ More accurately 'have been'.

⁷ John Passmore, A Hundred Years of Philosophy at p.459.

perceived regularity and some other regularity 'R' which we conceive of as being more fundamental. Having established a link between 'O' and the more fundamental regularity 'R', we can, perhaps, be somewhat more confident in our predictions in relation to 'O'. Thus, for example, the perceived regularity in the tides when theoretically linked to the movements of the moon, is thereby linked to what is perceived to be a deeper rhythm and one more worthy of being relied upon.

Similarly, to suggest that there is some theoretical 'slope argument' which, from a proposed social change 'X' guarantees the occurrence of events 'Y', is erroneous. Events similar to 'Y' may have occurred subsequent to changes similar to 'X', in times past; however, we have no guarantee that they will do so in the future. At best we can attempt to analyse the past occurrences in the light of some theoretical model and - applying this same model to the present situation - attempt to predict future developments. It may well be that - as, perhaps, happened in the past - a *particular* proposed social change has economic consequences which in their turn may occasion further changes of social attitudes, which may lead to a demand for 'Y'. However, there is no *general* slippery slope law; all is in the particular, a perfect case of 'the devil being in the detail'.

This does not take from the historical recognition that social change often has particular characteristics; it often occurs, not in a uniform process of steady accretion, but in spurts of activity. It is much like an imagined battle between mediaeval armies over a terrain that is flat and difficult to defend, but where there are occasional ramparts. In such a battle the fighting will be concentrated on the ramparts as these are easily defended; once a rampart has been lost then the land behind it - being difficult to defend - will quickly be overrun and the armies will tend to regroup at the next defensible rampart. But the study of the 'laws' governing any such process of military advance or social change - if such exist - belongs to the fields of psychology or sociology but not to logic or philosophy.

Conclusion ₈₋₁ : *The slippery slope argument considered as a general form of argument, cannot be considered to be valid. However, in particular circumstances the argument may imply true conclusions, the truth of the conclusions following by virtue of the particular circumstances rather than by virtue of any formal logical argument.*

A logical form of the 'slippery slope' argument.

There is, however, one form of the argument which transcends the particular and can be considered as a general form of argument; Lamb calls it the '*logical form of the slippery slope argument*'.⁹ If the making of a proposed change 'X' is justified by recourse to certain principles 'P' and if 'Y' is equally justifiable in terms of the same principles 'P' but it is asserted that 'X' will not lead to 'Y', then the argument takes the form:

"If 'X' is conceded there are no rational grounds for not conceding 'Y', because 'P' which was used to justify 'X', also justifies 'Y'."

Is this a valid form of argument? Is there any way to avoid the conclusion 'Y'. Rachels suggests¹⁰ that some distinguishing characteristic 'C' can often be found which applies to 'Y' but not to 'X'; but surely such can occur only if the absence of 'C' was logically necessary to justifying 'X'; if it was, then the true principle was 'X and not-C' and there can be no question of a justification of 'Y'; if it was not, then 'Y' follows irrespective of the distinguishing characteristic. Lamb believes that the

⁸ Ludwig Wittgenstein, Tractatus Logico-Philosophicus at p. xvi [emphasis in original].

⁹ Lamb *op. cit.* (p.3) ascribes this analysis of the argument to Rachels.

'logical version of the slippery slope argument' is best thought of as a warning against loose concepts:

*"And that is the point behind the logical version of the slope argument: once clear cut absolutes are replaced by indeterminate concepts moral boundaries can become a playground for sophistry."*¹¹

Hence, to avoid 'Y' we must seek to justify 'X' on some ground 'Q' which is narrower than 'P' and which will not carry the unwanted implication 'Y'. For example: imagine a young child who wishes to stay up late on his birthday; the parent yields, conceding that it is a 'special occasion'; a favourite uncle comes to visit and stays late, the child argues that this is equally a 'special occasion'. The solution of course is to choose grounds just sufficient to justify what is required but no wider; in the child's case he is allowed to stay up late because it is 'his birthday which is his most special day of the year'.

Conclusion 8-2 : *The so-called 'logical form of the slippery slope argument' is to the effect that in justifying a particular conclusion the narrowest grounds possible should be used in order to avoid the danger of occasioning a 'slippery slope'.*

In relation to the Ward case, for example, this implies that the withdrawal of life-sustaining treatment be justified on the narrowest grounds possible: justifying the withdrawal on the grounds of 'best interests' or by virtue of an 'absolute quality of life' judgement does not preclude the withdrawal of life-sustaining treatment in cases of even mild disability; whereas justifying the withdrawal on the grounds that the Ward had permanently lost the ability to communicate would limit the applicability of the argument.

Let us now examine how the 'absolute quality of life' judgements have been used in English law to justify the withdrawal of life-sustaining treatment from patients who were not terminally ill, were not PVS nor 'near- PVS', but who were disabled. The focus of the examination is to see whether these decisions to justify withdrawal of life-sustaining treatment in cases of disability, *necessitated* the introduction of any principles in addition to those already implicit in the Ward judgement.

Section 2: The withdrawal of life-sustaining treatment from non-terminally ill patients: the English experience.¹²

Of the submissions made by the Official Solicitor in Bland case, one concerned the danger of generating a 'slippery slope':

"It is important to appreciate just how far the courts in this country have moved in relation to the treatment of the mentally incompetent in the course of less than four years. The first step was to hold that a mentally incompetent adult could be sterilised ¹³ ... The next development was the holding that life-sustaining treatment could be withheld from the dying ... The third step was the holding that life-sustaining treatment could be withheld from the patient who was not dying, on the ground that he should be spared pain and suffering¹⁴ ... the Court of Appeal have now held that life-sustaining treatment can be withheld from an adult patient who is

¹⁰ *ibid.*

¹¹ *ibid.* p.4

¹² The cases referred to in this section are considered more fully in Appendix C.

¹³ *In re F* Appendix C - number 6.

¹⁴ *Re J* Appendix C - number 10.

*neither dying nor suffering pain and distress: the justification for this advance from In re J is said to be that there is no quality to the patient's life. The House of Lords should not shirk the question: what will the next step be, and where will the process end?"*¹⁵

Before looking at the other English cases concerned with withdrawal of life-sustaining treatment it is necessary to first consider how these cases should be classified. Should the line of distinction be drawn between those cases concerned with PVS as against those dealing with severe disability or should the distinction be drawn differently?

The categorisation of cases dealing with withdrawal of life-sustaining treatment

It is possible to consider the English decisions on the withdrawal of life-sustaining treatment from non-terminally ill patients by dividing them into two categories: those with PVS, and those who were not PVS but were seriously disabled. Such a dichotomy suggests that the PVS and the disability cases were not of a kind; this is a distortion of the actual development because in both types of cases, the English courts:

- (i) analysed the cases from within a medical conceptual framework;
- (ii) saw a resolution of the cases as lying in the withdrawal of treatment; and
- (iii) declared the ground for this withdrawal of treatment, as being in the 'best interests' or in the poor 'absolute quality of life' of the patient.

It is possible to argue that 'absolute quality of life' judgements were more a feature of the disability cases than of the Bland case (where 'best interests' was the preferred ground) and that a distinction can be drawn between them on this basis. This can be answered by noting, firstly, that Tony Bland was considered by the courts to be completely insensate so that to speak of his 'best interests' did not present quite the same difficulties as to speak of his 'quality of life';¹⁶ secondly, the Bland judgements relied on the case of *Re J*¹⁷ which decision was based on an 'absolute quality of life' judgement; thirdly, (as was shown in Chapter 7) 'best interests' judgements in cases such as the Bland case *necessitate* the use of 'absolute quality of life' judgements.¹⁸

The correct distinction between the Bland case and the earlier cases of disability is that the Bland case involved not just the withdrawal of life-sustaining treatment but *withdrawal of ANH*. Had the Bland case been concerned simply with the withdrawal of life-sustaining treatment (other than ANH) then it could quite easily have been decided within the framework laid down by earlier cases.¹⁹

Conclusion 8-3 : *In classifying the English cases of withdrawal of life-sustaining treatment from non-terminally ill patients; the most meaningful distinction is that between withdrawal of ANH and withdrawal of other medical treatment, and not that between PVS and cases of disability.*

¹⁵ The Bland case at p.839 [emphasis in original].

¹⁶ Lord Mustill refused to base his judgement on the concept of 'quality of life' but based it on the grounds of 'best interests' arguing that the 'best interests' of Tony Bland originally justified the commencement of ANH but that Tony Bland had, at the time of the hearing, no interests of any kind; therefore the 'best interests' which justified the giving of ANH had ceased; hence the ANH should be withdrawn. This argument would not have been available to Lord Mustill had Tony Bland been near-PVS (as was the Ward).

¹⁷ Appendix C - number 10.

¹⁸ Conclusion 7-6 : 'Best interests' judgements necessitate 'quality of life' judgements.

Conclusion 7-7 : *The 'best interests' analysis adopted in both the Ward and Bland cases necessitates the use of 'absolute quality of life' judgements.*

¹⁹ The Bland case also has importance in that it was the only case concerning the withdrawal of life-sustaining treatment to be decided by the House of Lords (which is the highest court in England) as such it has a special authority.

This classification is confirmed by the fact that, in England, application to the High Court is required in all cases where withdrawal of ANH is contemplated but that there is no such requirement in relation to the withdrawal of other forms of medical treatment.²⁰

Let us now return to the question posed by the Official Solicitor: “*What will the next step be, and where will the process end?*” We first look at developments in English law in allowing the withdrawal of ANH and then examine cases where the withdrawal of other forms of life-sustaining treatment was permitted.

The next step: withdrawal of ANH

Subsequent to the Bland case, a number of cases concerning the withdrawal of ANH came before the English courts. Three of these cases concerned PVS or ‘near- PVS’ patients and have been discussed in Chapter 6, Section 4 and are listed in Table 8-1.

<i>Frenchay v S.</i>	1994	<i>PVS - Emergency decision on treatment withdrawal without the opportunity for independent medical assessment.</i>	3
<i>Re G</i>	1994	<i>PVS - more profound vegetative state than Tony Bland; family not unanimous on the withdrawal of ANH.</i>	4
<i>Re D (Medical Treatment)</i>	1997	<i>‘borderline’ PVS - tube had become disconnected; whether an operation to reinsert the tube should be performed.</i>	5

Table 8 -1: Some reported English cases of PVS patients (subsequent to Bland) from whom ANH was withdrawn.²¹

The facts of *Frenchay v S* and *Re D* appear similar to the Ward case and are suggestive of ‘near- PVS’ rather than PVS; though in *Frenchay v S* there was (somewhat equivocal) medical testimony to the effect that the patient might have some ability to communicate. However, notwithstanding these facts the courts held that, in permitting the withdrawal of ANH, they were not widening the categories set out in the judgements in the Bland case.²² The conclusion drawn in Chapter 6 was that the criteria had, in fact, been widened to include ‘near- PVS’.²³

There is one reported case where the withdrawal of ANH was considered and which did not concern a PVS patient: *Re R (Adult: Medical Treatment)*.²⁴ ‘R’ was a 23 year old who had been born with a serious malformation of the brain and with cerebral palsy; he was unable to chew and his food was syringed into the back of his mouth. The original court application had asked for permission to withhold life sustaining treatment including ANH; the summons was subsequently amended to seek only permission to withhold cardio-pulmonary resuscitation and antibiotics from R in the event of his developing a potentially life threatening infection. It was agreed by all parties that it was in R’s ‘best interests’ to have a gastrostomy tube inserted and that accordingly it would be premature to consider withdrawal of ANH at this stage. The fact that the medical opinion changed

²⁰ The requirements are set out in the Bland case (Appendix C - number 2) and also in a *Practice Direction* of March 1994. cf. *Current Law Year Book* (1994) at p.1028.

In Scotland, however, prior application to the court is not required; BMA (1996) states (at p.59):

“In Scotland, the *Law Hospital* case of 1996 (*Law Hospital v The Lord Advocate and Others April 1996*) laid down a procedure whereby authority can be obtained from the Court of Session for the withdrawal of life-sustaining treatment from patients who are diagnosed as having been in PVS for at least 12 months. It was made clear in the *Law Hospital* case that, in contrast to Bland, the court does not require each future PVS case to come before it before treatment is withdrawn.”

²¹ This table is abstracted from Table C-2, Appendix C. Numbers in Column 4 relate to numbering in Appendix C.

²² The Bland case had been decided by the House of Lords which is superior to, and whose decision binds, the courts which decided *Frenchay v S* and *Re D*.

²³ *Conclusion 6-12*: The criterion which the Bland case deemed necessary for the withdrawal of ANH namely that no ‘glimmerings of awareness’ be present, has in subsequent cases effectively been widened to include ‘no possibility for a meaningful life whatever’ or ‘absence of significant cognitive function’

²⁴ Appendix C - number 11.

from being in favour of ANH being withdrawn to unanimously in favour of tube feeding being commenced, *without apparently any change in R's medical condition*, appears on its face to be designed to manipulate the facts to fit into accepted legal categories:²⁵ once tube feeding had been commenced then a fresh application could be brought²⁶ for its cessation thus circumventing the objection that the criteria in the Bland case for the withdrawal of ANH were being widened to include withdrawal of syringe feeding (though not, however, circumventing the objection that R was not PVS).

The current situation in England appears to be that the courts have given permission to withdraw ANH only in cases of PVS or 'near-PVS' and not in cases of disability.

Conclusion 8 - 4 : *In England, the withdrawal of ANH has been restricted to cases of PVS or 'near-PVS'; prior approval of the court is required in all such cases.*

The next step: withdrawal of life sustaining medical treatment other than ANH

Grubb writing in 1996²⁷ found it surprising that so few cases had come before the English courts since the Bland decision and he suggested as a possible reason, that doctors chose to 'manage' PVS patients by not treating acute infections or other life threatening conditions (such decisions do not require prior court approval) rather than by the withdrawal of ANH (which, in England, do require such approval). To the best of my knowledge the only reported cases dealing with the withdrawal of life-sustaining treatment (other than ANH) concern non-terminally ill patients who were disabled; none relate to PVS patients; some of these cases are now considered; they are listed in Table 8-2 and are summarised in Appendix C.

<i>Re B (a minor)</i> (wardship: medical treatment)	1981 (reported in 1990)	<i>A baby born with Down Syndrome also had an intestinal blockage which could be cured without difficulty. The parents opposed the operation ; whether the parents wishes should be respected.</i>	7
<i>Re J (a minor)</i> (wardship: medical treatment)	1990	<i>Withholding life-saving treatment from a 4-month old baby who was grossly handicapped but who was not dying</i>	10
<i>Re R (Adult: Medical Treatment)</i>	1996	<i>R, a 23 year old, had malformation of the brain and cerebral palsy; his psychiatrist had signed a 'do not resuscitate order'; whether such an order appropriate.</i>	11
<i>T (A Minor)</i> (Wardship: Medical treatment)	1996	<i>The High Court supported a mother's right to refuse consent to a life saving operation for her 18-month-old child, against the judgement of the child's doctors; 'best interests' can include non-medical factors.</i>	12
<i>Ex parte Glass</i>	1999	<i>Mother objected to withdrawal of ventilation from her 12-year-old severely disabled son.</i>	14

Table 8 -2: Some reported English cases of non-terminally ill, disabled patients from whom life-sustaining treatment was withdrawn.²⁸

In *Re B* the decision to withdraw life-sustaining treatment was originally upheld by the courts but overturned on appeal on the grounds that the withdrawal of treatment - although in accord with the

²⁵ The application to withdrawal of ANH from a patient being fed by syringe and able to swallow appears to be in breach BMA policy:

*"The guidance is very specific in its advice that oral nutrition and hydration (food and fluids) should continue to be offered to **all** patients who are able to swallow. This is part of basic care and should **never** be withheld or withdrawn."*

BMA (1999c) Policy report on the Medical Treatment (Prevention of Euthanasia) Bill. [emphasis in original]

²⁶ The judgement contemplated such a fresh application.

²⁷ Grubb *et al* (1996a) at p.39; this observation was mentioned earlier in Chapter 6, Section 4.

More recent information is given in BMA (1999a) Withholding and Withdrawing Life-prolonging Medical Treatment : Guidance for decision making. 3C.18.1:

"In each case of patients in persistent vegetative state (pvs) that the law has considered, it has decided that it would not be unlawful to withdraw artificial nutrition and hydration, on the basis that its provision was not in the best interests of the individual patient (by the end of 1998, 18 such cases had been considered by the Courts)."

²⁸ This table is abstracted from Table C-2, Appendix C. Numbers in column 4 relate to numbering of cases in Appendix C.

wishes of the parents - was not in the 'best interests' of the child. This decision laid down the principle that the parent's interests were separable from those of the child and that the child's interests were paramount. In *Re R* the decision of the court to withhold life-sustaining treatment can be justified as an 'incremental quality of life' judgement;²⁹ all of the other cases listed in Table 8 - 2 involved 'absolute quality of life' judgements. These 'absolute quality of life' judgements (in conjunction with the medical conceptual framework which had been adopted by the courts) were sufficient to justify the withdrawal of life-sustaining treatment; no additional legal principle was required. The essential principle underlying all of these cases is that:

*"... the correct approach is for the court to judge the quality of life the child would have to endure if given the treatment and decide whether in all the circumstances such a life would be so afflicted as to be intolerable to that child."*³⁰

Conclusion⁸⁻⁵ : *The English judgements which permitted the withdrawal of life-sustaining treatment from non-terminally ill, but disabled, patients were based on a consideration of the 'best interests' or the 'absolute quality of life' of the patients and required no application of principles of law additional to those which are implicit in the Ward judgements.*

Section 3: The Ward case and the 'slippery slope'

There has been no counterpart in Irish law to the English case *In re J*,³¹ in fact, the withdrawal of life-sustaining treatment for reasons of disability or marginal awareness *per se* has never been directly considered by the Irish courts, hence the Ward case is seminal to the future development of Irish law relating to the withdrawal of life-sustaining treatment for non-terminally ill patients.³² Such cases must eventually arise and - by virtue of the doctrine of precedent - be decided within the framework set out in the Ward judgements.

I will first consider the possibility that the Ward decision could be used to justify the withdrawal of life-sustaining treatment in cases of disability similar to the English cases discussed in Section 2, and then consider other aspects of the Ward decision which favour the development of a 'slippery slope'.

The application of the Ward decision to cases of disability.

In the Ward case, counsel for the Attorney General (referring to *Re B*³³): submitted that

*"... the case uniquely illustrates why the quality of life should not be adopted as a test."*³⁴

None of the judgements in the Ward Case give any detailed consideration to the decision in *Re B* nor suggest how it might be distinguished from the Ward case; although there were judicial

²⁹ See Chapter 7, Section 2 where the BMA's overly wide interpretation of the decision was noted.

³⁰ *per* Taylor L.J. in *Re J* at p.945.

In the Bland case Lord Goff distinguished the circumstance of *Re J* from those of Tony Bland in that Tony Bland was totally unconscious and not in pain thus precluding any weighing operation; had Tony Bland been 'near- PVS' then no such distinction would have been possible.

³¹ Appendix C - number 10.

³² The Ward case has been the only Irish case to deal with the withdrawal of life-sustaining treatment. This is presumably because of the absence in Irish law (unlike in English law) of a requirement to apply to the courts for prior permission to withdraw ANH.

³³ Appendix C - number 7.

³⁴ The Ward case at p.449.

pronouncements to the effect that the Ward decision was to be construed strictly on its facts and had no applicability to cases of disability.³⁵ Hamilton C.J., for example, said:

*"... my ruling in this matter will be based on and relate only to the circumstances and rights of this particular ward. ... It is important to emphasise that the court can never sanction steps to terminate life ... Even in the case of the most horrendous disability, any course of action aimed at terminating life or accelerating death is unlawful."*³⁶

O'Flaherty J. was equally forthright:

*"It must be clear that our decision should not be regarded as authority for anything wider than the case with which we are confronted ... the circumstances of the current case are distinguishable from the position as regards, for example, a seriously mentally handicapped person. A mentally handicapped person is conscious of his or her situation and is capable of obtaining pleasure and enjoyment from life. It is fanciful to attempt to equate the position of the ward in this case with that of a person whose life has been impaired by handicap. The analogy is both false and misleading; the quality of the ward's life was never in issue; she is not living a life in any meaningful sense. We are concerned here only with allowing nature to take its course and for the ward to die with dignity. We are not thereby going down any slippery slope or stepping into any abyss."*³⁷

However, these statements were not integral to the judgements; they are of a type known as '*obiter dicta*'³⁸ (that is, not strictly necessary to the ruling of the court) which do not constitute a precedent and are not of binding authority in future cases. For example, the Bland court was as assertive as the Ward court in stating that its decision was to be strictly construed - Sir Thomas Bingham in *Frenchay v S* noted that :

*"The courts made plain that their decisions were to be understood as strictly applying to the Bland situation and no other. A number of the judges were at pains to emphasise that they should not be taken as approving anything falling outside the factual situation which was then before the court."*³⁹

Yet having noted this strict admonition, the learned judge then went on to apply the Bland decision to the facts in Frenchay despite the fact that one medical expert witness had suggested that it might be possible to establish communication with the patient - a radically different scenario from the Bland case.

It is obvious that the Ward court regarded with disapproval the possibility that its decision might subsequently be applied to cases of disability; however, it is difficult to avoid the conclusion that the statements of disapproval - though, without doubt, sincerely made - are purely rhetorical. No logically coherent attempt is made to draw operative distinctions between cases of severe disability and the situation of the Ward - O'Flaherty J. seeks to draw a distinction by noting that a mentally handicapped person is conscious,⁴⁰ yet the (albeit limited) consciousness of the Ward is not disputed!⁴¹

³⁵ As has been already noted in the Introduction to Part 2.

³⁶ *ibid.* p.423.

³⁷ *ibid.* p.432.

³⁸ '*Obiter dicta*' contrast with the '*ratio decidendi*' of a case (which describe the kernel of the judgement) and which is binding on lower courts. These distinction were discussed in the Introduction to Part 2.

³⁹ *Frenchay v S* at p.409.

⁴⁰ The Ward case p.432.

Conclusion⁸⁻⁶ : *Although the judges in the Ward case did not wish their decision to be used to justify the withdrawal of life-sustaining treatment in cases of disability, they provided no coherent reason why, in situations similar to the English disability cases, it could not be so used.*

Other aspects of the Ward decision favouring the development of a 'slippery slope'

Four such aspects are identified:

- (i) The withdrawal of life-sustaining treatment is not restricted to cases where consciousness is believed to be absent.
- (ii) The withdrawal of ANH is, in law, assimilated to the withdrawal of other life-sustaining treatments.
- (iii) The ethical importance to be attached by medical practitioners to the withdrawal of ANH is obscured by its assimilation to other medical treatments; this tendency is exacerbated by the court's insistence that the withdrawal of ANH is not a cause of death.
- (iv) The unanimous decision of an incompetent patient's⁴² family and medical carers to withdraw life-sustaining treatment is (if made *bona fide* and in the patient's 'best interests') legally binding.

(i) The withdrawal of ANH is not restricted to cases where consciousness is absent.

Whereas the Bland judgements were insistent that their decision applied only to insensate patients the Irish court not only applied the Bland principles to a case where there was some level of awareness⁴³ but surprisingly this very awareness became - in the words of Lynch J. - a motivating force for the withdrawal of life-sustaining treatment:

*"... but if such minimal cognition as she has includes an inkling of her catastrophic condition, then I am satisfied that that would be a terrible torment to her and her situation would be worse than if she were fully PVS."*⁴⁴

The concept of 'consciousness' is playing a truly paradoxical role in discussions of withdrawal of life-sustaining treatment: on the one hand, when discussing PVS patients its supposed absence serves as a further reason for treatment withdrawal; yet in considering 'near-PVS' patients its existence is considered as a reason for treatment withdrawal. Egan J. (in his dissenting judgement) noted that all parties appeared to accept that if there were no cognitive function then treatment could be withdrawn; he distanced himself from this proposition, and continued:

*"... this is not a case of no cognitive function ... If slightly more cognitive function existed, would a right to withdraw sustenance still be claimed to be permissible? Where would the line be drawn?"*⁴⁵

To this question there is no answer, nor hint of an answer, in the judgements of his colleagues.

"Thus, the circumstances of the current case are clearly distinguishable from the position as regards, for example, a seriously mentally handicapped person. A mentally handicapped person is conscious of his or her situation and is capable of obtaining pleasure and enjoyment from life."

⁴¹ "... this is not a case of no cognitive function." per Egan J., the Ward case at p.437.

⁴² An incompetent patient is one who is unable, for reason of incapacity or otherwise, to consent.

⁴³ The patient in the Ward case was not PVS but 'near-PVS' in that she had some level of consciousness.

⁴⁴ The Ward case at p.8.

⁴⁵ The Ward case p.437.

If, to the judges in the Bland case, being insensate was the Rubicon which was not to be crossed,⁴⁶ to the judges in the Ward case, such a boundary was crossed without even an acknowledgement.

Conclusion 8-7 : *The fact that the court acknowledged that the Ward had some level of awareness removes the most important barrier to the application of its decision to cases of disability.*

(ii) The assimilation, in law, of withdrawal of ANH to withdrawal of other treatments.

The Ward court, unlike the Bland court,⁴⁷ did not stipulate that a prior application be made to the court in cases where the withdrawal of ANH was contemplated⁴⁸ and drew no distinction between the withdrawal of ANH and the withdrawal of other forms of life-sustaining treatment. The conclusion follows that:

Conclusion 8-8 : *In that the Ward judgements - unlike the Bland judgements - made no distinction between the withdrawal of ANH and the withdrawal of other forms of life-sustaining medical treatment, the withdrawal of ANH would be justified under Irish law in cases of disability where it would not be justified under English Law.*

For example, in a situation similar to *Re R*⁴⁹ (where under England law it was necessary to distinguish between withdrawal of ANH and a decision not to resuscitate) no such distinction would be required under Irish Law.

(iii) The assimilation, in medical practice, of ANH to other medical treatments.

The BMA has noted that, to the courts:

*"Artificial nutrition and hydration are perceived as different from other medical treatments which can be withheld, such as antibiotics."*⁵⁰

This difference must, of course, be reflected in English medical practice and doubtlessly results in decisions to withdraw ANH being regarded with considerably greater seriousness than are other treatment - including treatment withdrawal - decisions.⁵¹ The refusal of the Ward court to make this

⁴⁶ The Bland case; Lord Browne-Wilkinson (at p.885):

"I must again emphasise that this is an extreme case where it can be overwhelmingly proved that the patient is and will remain insensate ... Unless ... Parliament reviews the law, the courts will be faced with cases where the chances of improvement are slight, or the patient has very slight sensate awareness ... my decision does not cover such a case."

Lord Mustill (at p.899):

"This is not at all to say that I would reach the same conclusion in less extreme cases, where the glimmerings of awareness may give the patient an interest which cannot be regarded as null. ... Every step forward requires the greatest caution."

⁴⁷ There was unanimity in the view that future cases of withdrawal of ANH concerning PVS patients be brought before the courts for scrutiny:

"... the President held that in cases of this kind application should be made to the court to obtain its sanction for the course proposed. This was in my respectful view a wise ruling, directed to the protection of patients, the protection of doctors, the reassurance of patient's families and the reassurance of the public."

[The Bland case: Sir Thomas Bingham MR. at p.815.]

⁴⁸ To say, as did Hamilton C.J., that the judgement relates only to the particular facts and yet not to insist that all similar cases come before the courts is surprising; the clarity of the Bland case in its insistence that its decision applied only to insensate cases was lost and nothing put in its place.

See also Conclusion 6-2: *Part of the attractiveness of the 'WMT' to the Ward court was that it offered to the court the possibility of evading responsibility for occasioning the death of the Ward. This evasion was accentuated by the decision of the Ward court not to require that in all future cases where the withdrawal of ANH was contemplated, an application be made to the court; this was in contrast to the Bland court which did make such a requirement.*

⁴⁹ Appendix C - number 11.

⁵⁰ BMA (1998, p.13) in discussing *re R*.

⁵¹ See BMA (1999a)3D.20.:

"Although the BMA welcomes the categorisation of artificial nutrition and hydration as a form of medical treatment, it accepts that many people perceive there to be an important distinction between this and other treatments. In

distinction has as a consequence that medical decisions to withdraw ANH are assimilated to more routine medical decisions and their ethical importance is obscured. The insistence by the Ward court - in contrast to the Bland Court - that the withdrawal of life-sustaining treatment is not the cause of the death⁵² further exacerbates this tendency particularly in situations where withdrawal of ANH occurs in the absence of court supervision.

Conclusion⁸⁻⁹ : *The ethical importance to be attached by medical practitioners to the withdrawal of ANH is obscured by its assimilation to other medical treatments; this tendency is exacerbated by the Ward court's insistence that the withdrawal of ANH is not a cause of death.*

(iv) The legal competency of the family and medical carers, if unanimous.

The unanimous decision of an incompetent patient's family and medical carers to withdraw life-sustaining treatment appear to be legally binding, if made *bona fide* and in their 'best interests'; there is no requirement that any application be made to the courts before treatment is withdrawn.⁵³ This appears to be the position set out by Lynch J. in the High Court and approved of by Denham J. in the Supreme Court:

recognition of this fact and in order to reassure patients, their families and society as a whole that decisions to withhold or withdraw artificial nutrition and hydration are taken only in the most extreme cases, where its provision would not provide a net benefit to the patient, it is recommended that additional procedural safeguards should be followed."

BMA (1999b):

"The classification of artificial nutrition and hydration as medical treatment is now established common law but the BMA recognises that this definition is not universally accepted."

BMA (1999a)1.3.4:

"Whilst classifying artificial nutrition and hydration as treatment, the House of Lords conceded that its withdrawal was a particularly sensitive matter. For the protection of patients and doctors and for the reassurance of the patients' families and the public, it was decided that additional safeguards should be put in place."

⁵² Hamilton CJ. stated (at p.429):

"The true cause of the Ward's death will not be the withdrawal of such nourishment but the injuries which she sustained ... in 1972."

Denham J. stated (at p.462):

"If this court determines that the order of the High Court be upheld then ... the ward would die shortly as a result of the medical catastrophe which occurred 23 years ago."

⁵³ Lynch J., in his judgement set out, and approved, the current medical practice in relation to disputes between family and carers concerning the withdrawal of treatment from incompetent patients. The options are summarised in Table C-3

Line	<u>Patient terminally ill</u>	<u>Family want withdrawal</u>	<u>Medical carers want withdrawal</u>	<u>2nd medical opinion required</u>	<u>Treatment can be withdrawn without the need for a Court application</u>
1.	Yes	Yes	Yes	<i>not obligatory</i>	Yes
2.	Yes	No	Yes	<i>obligatory</i>	Yes
3.	Yes	Yes	No	<i>not obligatory</i>	Court application required
4.	No	Yes	No	<i>not obligatory</i>	Court application required
5.	No	No	Yes	<i>(situation unclear)</i>	<i>(situation unclear)</i>
6.	No	Yes	Yes	<i>(situation unclear)</i>	Yes

Table C-3: Legal requirements for treatment withdrawal as set out in the Ward case (cf. Appendix C).

Unlike the situation that pertains in England; the court laid down no general obligation to apply to the court in cases of treatment withdrawal. This is of importance because the court has thus ensured that it is unable to monitor the development of medical practice in relation to treatment withdrawal. It could be suggested that it abdicated its legal responsibility in favour of the medical profession; Lord Hoffman's words (The Bland case p.834) are apposite:

"I would expect medical ethics to be formed by the law rather than the reverse."

Doubtlessly in cases - such as that envisioned in line 5 - an aggrieved family could apply to the courts for a review of any proposed medical decision; nonetheless the court does not have an ongoing supervisory role except in such cases. The cases envisaged in line 5 are much more problematic. These relate to cases where both family and carers are in agreement that treatment should be withdrawn. In such cases in the opinion of Lynch J. court application is not required.

The English situation appears to differ from the Irish in that according to the BMA [BMA (1999b)] the decision to withdrawal of life-sustaining treatment rests wholly with the medical carers:

"There is a widely held misperception that the next of kin may give, or withhold consent on behalf of an adult patient who lacks the capacity to make or communicate decisions. In fact, no such legal power is given to the next of kin."

Deleted: ¶

*"If they⁵⁴ are unanimous that a form of treatment should not be continued, they are competent to make such a decision and carry it out in accordance with law. If there is no unanimous agreement, then an application should be made to the court for directions."*⁵⁵

Although it is clear that in all but the most exceptional cases the patient's interests find full expression in the wishes of the family and the medical carers particularly when these are in agreement; it is important to realise - as is shown by the English case *Re R*⁵⁶ - that this is not necessarily so. R was a 23 yr. old man with severe cerebral palsy and malformation of the brain, both his family and his medical carers were in agreement that it was in his 'best interests' that treatment should be withdrawn, the case came before the courts by way of application to the court by a group concerned with the rights of the disabled. Denham J.'s decision that the family and carers are, if they are unanimous, competent; suggests that third parties may have no *locus standi* to apply to the courts on behalf of the patient unless they can cast doubt on the *bona fides* of the judgements of either the family or the carers. This would militate against a case such as *Re R* ever coming before the Irish courts; it would also hinder cases such as *Re B*⁵⁷ - which concerned a simple operation to remove an intestinal obstruction in a Down Syndrome baby - from being brought to the attention of the courts because in that case there was initial agreement between the family and the medical cares not to proceed with the operation.

Conclusion⁸⁻¹⁰ : *The Irish courts, by relinquishing their supervisory jurisdiction over cases where a patient's family and medical carers unanimously agree that the withdrawal of life-sustaining treatment is in a patients 'best interests', may facilitate the development of a 'slippery slope'.*

Section 4: BMA (1999) proposals on the withdrawal of life-sustaining treatment.

The problematic nature of the definition of PVS was discussed at length in Chapter 4 and it was noted that PVS was often conflated with other medical conditions which were theoretically distinct from it. The Tresch study on misdiagnosis,⁵⁸ for example, expressed surprise at the high level of dementia⁵⁹ amongst a test population of patients who had been previously diagnosed as PVS. Childs noted that 'PVS' was '*an area fraught with confusion*'.⁶⁰ It seemed that 'PVS' was in danger of becoming a 'catch all' term which could be used to refer to any prolonged state of minimal awareness where recovery was seen as unlikely. Such a development was noted by McQuillan who, writing as far back as 1991, commented:

"In recent years, some researchers have emphasised the essentially clinical nature of the 'vegetative state' and have attempted to extend its limits to include the end stage of any

⁵⁴ i.e. the patient's family and medical carers.

⁵⁵ The Ward case p.452.

⁵⁶ As discussed in the previous Section and in Appendix C - number 11.

⁵⁷ Appendix C - number 7.

⁵⁸ Discussed in Chapter 4, Section 3.

⁵⁹ Tresch *op.cit.* p.932:

"This large number of patients in a PVS in our study who were diagnosed as having end-stage dementia is surprising. Patients with dementia rarely develop the profound and complete loss of awareness characteristic of PVS, and it is important to distinguish between PVS and the usual dementia state."

⁶⁰ Childs p.1465.

see also p.1466:

"We suspect that misdiagnosis in most of these patients was due to the confusion in the terminology used to describe alterations in states of consciousness in the brain injured ... Confusion over terminology may have caused misapplication of the diagnosis of PVS in most of our patients."

*chronic, progressive, neurodegenerative disorder at one end of life and to compare it with anencephaly at the other.”*⁶¹

These problems have been considerably exacerbated by the use of the concept of ‘near-PVS’ which by its very nature has less well-defined boundaries than PVS. The danger was that since withdrawal of ANH was permitted in cases of PVS, a ‘slippery slope’ would be created whereby withdrawal of life-sustaining treatment (and of ANH) would also be seen as a solution to cases of dementia and other cases of minimal awareness.⁶²

The BMA - in guidelines on PVS issued in 1996 - insisted that because PVS was a distinct condition separable from other cases of minimal awareness there was no risk that, in permitting the withdrawal of ANH in cases of PVS, a ‘slippery slope’ would be generated:

*“It*⁶³ *considers PVS to be sufficiently discrete and extreme that its management can be defined, without raising implications for other categories of severe handicap.”*⁶⁴

Yet within two years the BMA had stated:

*“However, the Association recognizes the difficulties associated with saying with certainty that patients are in PVS as opposed to any other low responsive state, ... The BMA has expressed the view that the important factor making withdrawal of artificial nutrition and hydration ethically acceptable is the loss of specific and definable neurological pathways leading to permanent loss of sensitivity to external stimuli and difficulty in swallowing.”*⁶⁵

I wish to suggest that the BMA is not an impartial commentator in this debate but has specific proposals on the use of withdrawal of ANH as a mechanism for resolving ‘end-of-life’ decisions for patients in low awareness states and that the BMA have manipulated the debate on the withdrawal of ANH from PVS patients in furtherance of its own proposals. These are serious charges which I wish to examine separately, but before doing so I wish to outline the proposals made by the BMA in 1999 on the withdrawal of ANH.

The BMA (1999) proposals

The BMA make two main proposals:

- (i) That the requirement for prior court approval for the withdrawal of ANH be removed⁶⁶ and replaced by additional medical safeguards.⁶⁷
- (ii) That the withdrawal of ANH be permitted in cases other than PVS.

⁶¹ McQuillen *op.cit.* at p.375.

⁶² Under English law the withdrawal of ANH has been confined to cases of PVS (at least in theory; in practice the withdrawal of ANH has been permitted in cases of ‘near-PVS’ *cf.* Conclusion 6-12) and because prior application to the courts is required before ANH is withdrawn the development of clinical practice in relation to the withdrawal of ANH has, in England (unlike in Ireland) been under the supervision of the courts.

⁶³ *i.e.* the BMA.

⁶⁴ BMA (1996) p.58.

⁶⁵ In its response to the Lord Chancellor’s green paper, ‘Who Decides?’

See BMA 1998 p.12; see also the discussion on *Re R* in the same document.

⁶⁶ BMA (1999a)3D.21.1:

“... the BMA can see no reason to differentiate between decisions for patients in PVS and those for patients with other serious conditions where artificial nutrition and hydration is not considered to be a benefit, which are currently governed by established practice without the need for legal review. The BMA hopes that in future the Courts will decide that PVS cases no longer inevitably require Court review, where consensus exists, ...”

⁶⁷ BMA (1999a)3C.17.12:

“... decisions to withhold or withdraw artificial nutrition and hydration should be subject to additional safeguards.”

These are outlined in 3D.22 and include the necessity ‘for a formal clinical review by a senior clinician ... not part of the treating team.’ These additional medical requirements are more stringent than required under the Ward decision.

The medical conditions for which withdrawal of ANH might be considered to be appropriate are not clearly specified and the BMA proposals differ not only between documents but even within the same document; they appear to include:

*"... other low responsive state ... permanent loss of sensitivity to external stimuli ..."*⁶⁸

*"... severe dementia or who have suffered a severe stroke and have little or no awareness of their surroundings and no prospect of recovery."*⁶⁹

*"... Alzheimer's disease or Motor Neurone Disease ... no hope of recovering more than very minimal levels of awareness of their surroundings. They may lack ability to interact with others or capacity for self-directed action."*⁷⁰

*"... profound and irreversible dementia or have suffered a stroke which has left them similarly irreversibly brain damaged."*⁷¹

*"... low awareness states which prevent patients from interacting in any way with people around them ..."*⁷²

A third area of discussion concerns the effect of scarcity of resources on decision making but the BMA does not appear to have made any specific proposals in this area.⁷³

It is ironic that both of the BMA proposals outlined above are, to some extent, already part of Irish law⁷⁴ whilst neither of the BMA proposals are consonant with current English law.

⁶⁸ BMA (1998) p.12. The full quotation is:

"However, the Association recognizes the difficulties associated with saying with certainty that patients are in PVS as opposed to any other low responsive state, ... The BMA has expressed the view that the important factor making withdrawal of artificial nutrition and hydration ethically acceptable is the loss of specific and definable neurological pathways leading to permanent loss of sensitivity to external stimuli and difficulty in swallowing."

Note that the proposal speaks of 'loss of sensitivity' as distinct from 'loss of response'.

⁶⁹ BMA (1999b). The full quotation is:

"But where patients are unable to express their wishes, doctors, in consultation with relatives and other carers, have to decide whether providing life-prolonging treatment would be in their best interests. Examples include patients with severe dementia or who have suffered a severe stroke and have little or no awareness of their surroundings and no prospect of recovery."

⁷⁰ BMA (1999a), Introduction. The full quotation is:

"Patients with progressive conditions such as Alzheimer's disease or Motor Neurone Disease can have their lives prolonged considerably by the application of technology, yet their irreversibly deteriorating conditions will eventually result in death. The condition of other patients, for example those with very severe brain damage, may remain stable for many years if life-prolonging treatment is provided but with no hope of recovering more than very minimal levels of awareness of their surroundings. They may lack ability to interact with others or capacity for self-directed action. In such severely damaged patients, treatment to prolong life by artificial means may fail to provide sufficient benefit to justify the intervention and the proper course of action may be to withhold or withdraw further treatment."

⁷¹ BMA (1999a)3D.21.4. The full quotation is:

"Decisions about artificial nutrition and hydration sometimes arise in connection with common conditions which currently are not taken to Court but around which a body of practice has evolved. Such cases arise, for example, when elderly patients suffer from profound and irreversible dementia or have suffered a stroke which has left them similarly irreversibly brain damaged."

⁷² BMA (1998) p.15. The full quotation is:

"Quality of life judgements are particularly difficult and particularly sensitive. They require broad consultation and a consideration of the options from the patient's viewpoint. Irreversible brain damage resulting in low awareness states which prevent patients from interacting in any way with people around them are likely to give rise to quality of life assessments."

⁷³ BMA (1999a) 3C.18.5:

"It is obvious, however, that money spent caring for irreversibly and severely brain-damaged patients is money which cannot be used to treat other patients. This is an issue which needs to be acknowledged and addressed on a national scale as part of the debate on rationing and prioritising of resources. The BMA is concerned that, in reality, cost factors probably have a disproportionate influence on decision making for this very vulnerable patient group and is also concerned that the lack of a clear societal consensus on this most vexed area may unfairly leave doctors open to criticism."

This appears to acknowledge that the legally sanctioned criterion for decision making in this area - i.e. the patient's 'best interests' - is not always adhered to in clinical practice.

⁷⁴ By virtue of the Ward case no prior court application to sanction the withdrawal of ANH is required and withdrawal of ANH is permitted in cases other than PVS (the Ward case concerned a 'near-PVS' patient with some awareness).

Conclusion 8 - 11 : *Current BMA (1999) proposals on the withdrawal of ANH are more compatible with existing Irish law than with current English Law in that the Ward decision permits*

- (i) *the withdrawal of ANH from patients who are not strictly PVS.*
- (ii) *the withdrawal of ANH without prior application to the courts.*

The BMA: an impartial commentator?

The partiality of the BMA has been questioned in earlier chapters: in Chapter 4, in relation to the BMA's insistence that cases of recovery from PVS were in reality cases of misdiagnosis;⁷⁵ in Chapter 7, in respect of the overly wide interpretation of *Re R* where the decision to withhold cardio-pulmonary resuscitation is capable of being justified *solely* on 'incremental quality of life' grounds.⁷⁶ Two other examples are worthy of note:

(i) The BMA have suggested that:

*"... some court cases which have authorized the withdrawal of artificial nutrition and hydration have done so from patients who could not be said to be in PVS as defined in clinical guidance from the Royal College of Physicians."*⁷⁷

BMA have drawn the conclusion that it is not the concept of 'PVS' that is the crucial ingredient in these cases, but the 'loss of specific and definable neurological pathways leading to permanent loss of sensitivity to external stimuli and difficulty in swallowing.'⁷⁸

Thus the imprecision in the definition of PVS has been used, not as a reason for seeking greater clarity in the definition of PVS, but for its jettisoning.

(ii) The BMA appear to argue that because the Bland case - in laying down the requirement that court approval was necessary before ANH withdrawn - concerned a case of PVS, the requirement applies *only* to such patients:

*"Existing guidance from the Courts on the withdrawal of artificial nutrition and hydration refers only to patients in persistent vegetative state and United Kingdom Courts have not yet considered other cases. ... the BMA does not consider that all such decisions require legal review."*⁷⁹

⁷⁵ See Chapter 4, Conclusion 4 - 10 *The suggestion by the BMA Guidelines that patients who recovered, having been previously diagnosed as PVS, were to be classified as cases of misdiagnosis is destructive of honest debate. Furthermore, in that such patients are implicitly reclassified as being Locked-In Syndrome patients, the coherence of the definition of the Locked-In Syndrome is threatened.*

⁷⁶ See Chapter 7, Section 2, Subsection 1.

The court also considered the withholding of antibiotics in case of a life threatening infection and whilst such a decision is doubtlessly an 'absolute quality of life' judgement, the court felt that it -

"... is a decision which can only be taken at the time by the patient's responsible medical practitioners in the light of prevailing circumstances. This requires a clinical judgement in the light of the prevailing circumstances. ... The decision to withhold antibiotics in a given situation falls fairly and squarely within the clinical responsibility of the consultant treating the patient."

[*Re R* pp. 108-9].

⁷⁷ BMA (1998) p.12. Despite the fact that the medical expert opinion given to the courts in all the reported cases appears to have been that the patients were either PVS or 'near- PVS'.

⁷⁸ BMA (1998) p.12.

⁷⁹ BMA (1999a)3D.21.4. The full quotation is:

"Existing guidance from the Courts on the withdrawal of artificial nutrition and hydration refers only to patients in persistent vegetative state and United Kingdom Courts have not yet considered other cases. Clearly this situation may change over time. If, subsequent to the publication of this guidance, authoritative legal rulings are made, doctors must respect them. In the absence of any serious conflict of opinion or uncertainty about the patient's prognosis, however, the BMA does not consider that all such decisions require legal review."

See also:

BMA (1999a)1.3.4:

"Confusion has arisen from the fact that the guidance issued by the courts, following the Bland judgment, specifically referred to patients in persistent vegetative state without making reference to other serious conditions in which a decision to withhold or withdraw artificial nutrition and hydration might arise. With some conditions, such as advanced dementia or very severe stroke, a practice has developed where, in some cases, a decision is made that life-prolonging treatment, including artificial nutrition and hydration, would not be a benefit to the patient and should not be provided or continued. The BMA does not believe that these cases should routinely be subject to court review."

This interpretation seeks to locate the importance of the Bland judgement in the fact that it dealt with a PVS patient rather than in its sanctioning the withdrawal of ANH. Such an interpretation is bizarre; particularly so in view of the exhaustive discussion in the judgements in the Bland case on whether ANH could be considered to be a 'food' (and accordingly its withdrawal prohibited as being tantamount to murder); the BMA interpretation would imply that an application to the court for permission to withdraw ANH was required if *no* awareness is present but not required if *some* awareness were present and this despite Lord Browne-Wilkinson's assertion that:

*"I must again emphasise that this is an extreme case where it can be overwhelmingly proved that the patient is and will remain insensate ... Unless, as I very much hope, Parliament reviews the law, the courts will be faced with cases where ... the patient has very slight sensate awareness. ... my decision does not cover such a case."*⁸⁰

Conclusion 8 - 12 : *The BMA's overly wide interpretations of Re R and its insistence that the requirement (laid down in the Bland case) that the permission of the courts be sought before ANH was withdrawn, applied only to cases of PVS, are suggestive of a lack of impartiality in these matters.*

The BMA: manipulating the debate on the withdrawal of life-sustaining treatment?

The BMA (1999) proposals on withdrawal of life-sustaining treatment can be formulated independently of the concept of PVS:

- (i) The criterion for withdrawal of life-sustaining treatment (other than ANH) should be 'minimal awareness';
- (ii) Food, whether administered by syringe or spoon or cup, should not be withdrawn once a patient retains the ability to swallow.⁸¹
- (iii) ANH may be withdrawn in circumstances where the withdrawal of other life-sustaining treatment is permitted provided that specific additional *medical*⁸² safeguards have been observed.

BMA (1999a) 5.3.27:

"The Courts have not specified that declarations should be sought before withholding or withdrawing artificial nutrition and hydration from patients who are not in persistent vegetative state. Although a body of medical opinion has developed that such action would be appropriate in some cases (such as some patients who have suffered a serious stroke or have severe dementia), United Kingdom Courts have not yet considered such a case. This arguably leaves doctors in an area of legal uncertainty and therefore open to challenge."

BMA (1999b):

"The UK courts have not yet considered a case in relation to a patient with other irreversible conditions such as severe dementia or stroke. Current practice varies and the new guidance aims to help doctors by providing a consistent set of principles for decision making."

It should be noted that the BMA proposals - and the quotations above - are *not* discussing cases where the patient's death is imminent as, in such cases, the withdrawal of ANH is not contentious and would not require prior application to the court:

"Once an individual's condition has reached the stage where death is imminent, ... active treatment and the provision of artificial nutrition and hydration may become unnecessarily intrusive and merely prolong the dying process rather than offering a benefit to the patient. ... Where death is believed to be imminent an unavoidable ... the patient would be expected to die of his or her condition before the effect of ceasing nutrition and hydration was operative."

[BMA (1999a)3D.21.3]

⁸⁰ the Bland case p.885.

⁸¹ BMA (1999b) Press release on new ethical guidance on withdrawal of treatment:

"The BMA guidance says that oral nutrition using a cup, spoon or syringe and the moistening of the patient's mouth for comfort, forms part of basic care and should not be withdrawn."

BMA (1999a) Withholding and Withdrawing Life-prolonging Medical Treatment : Guidance for decision making. 1.3.5:

"Many patients, such as babies, young children and people with disability, may require assistance with feeding but retain the ability to swallow if the food is placed in their mouth; this forms part of basic care."

⁸² as distinct from legal.

Thus, the concept of PVS has been effectively jettisoned from the debate on the withdrawal of life-sustaining treatment. This raises the question:

Could the withdrawal of ANH from the 'minimally aware' elderly have been placed on the political agenda in the absence of the Ward and Bland cases?

I suggest that it could not and that, in the debate on the withdrawal of life-sustaining treatment, PVS has functioned simply as a stepping stone to enable the wider issue of the withdrawal of life-sustaining treatment from the minimally aware to be raised; this shows the magnitude of the 'slippery slope' implicit in the Ward and Bland cases.

The BMA (1999) proposals have caused widespread controversy: The Times reported that:

*"More than 6,000 doctors are expected to support the launch of the Medical Ethics Alliance, an umbrella group that aims to fight the proposals ..."*⁸³

The proposals were made against a background of widespread concern in the English press that ANH (and indeed food and water) was being withdrawn from some elderly patients in circumstances which appeared to be unlawful. For example, the BBC news reported that:

*"Police are reported to be investigating 60 cases involving pensioners who died after allegedly being deprived of food and water by hospital staff."*⁸⁴

There also have been allegations - by such as the Down Syndrome Association - of discrimination by doctors in the treatment of disabled infants.⁸⁵

In a climate where it appears that the current regulations as to the withdrawal of life-sustaining treatment are being flouted, proposals to further widen the categories where the withdrawal ANH and other life-sustaining treatment is permitted appear even less capable of being ring-fenced from the disabled than were earlier proposals.

Conclusion ⁸⁻¹³: *The BMA (1999) proposals on the withdrawal of ANH are not restricted to PVS patients but appear to encompass all patients who have minimal awareness. These proposals are even more capable of being extended to the disabled than were the original proposals to restrict withdrawal of ANH to PVS patients - proposals which at the time the BMA insisted had no "implications for other categories of severe handicap".*⁸⁶

Section 5: Conclusions

The 'slippery slope' argument is to the effect that in permitting certain social changes to occur (changes which may in themselves be desirable) other changes which are less desirable will

⁸³ The Times 12th August 1999 under the heading 'BMA's policy condemned as 'euthanasia'.'

⁸⁴ BBC News 6th Dec 1999 under the heading 'Elderly left to die'. [www.bbc.co.uk/news].

A similar report was included in The Times 7th Dec 1999 under the heading 'Doctors call for deaths inquiry'.

The Sunday Times of 19th August 1998 (under the heading 'Police probe 'euthanasia' hospital deaths') reported police investigations of suspicious hospital deaths in Cardiff.

BBC News reports from 15th March 1999 and 26th March 1999 entitled 'GP suspended by GMC for 6 months for starving patient' [Internet source: www.bbc.co.uk/news] concerned a GP who had ordered the cessation of feeding from an 85-year-old woman who had been fed by syringe. Nursing staff had objected to the decision and had called police when the woman eventually died. She had taken 58 days to die and had weighed 54 lbs. when she died. The Home Office pathologist told the inquest that he had never seen anyone who had lost so much weight. The police decided not to prosecute but the GMC initiated disciplinary proceedings.

⁸⁵ The Times 9th September 1999 under the heading 'Surgeon cleared of slur over deaths.'

⁸⁶ BMA (1996) p.58:

"It considers PVS to be sufficiently discrete and extreme that its management can be defined, without raising implications for other categories of severe handicap."

necessarily follow. In the context of the Ward decision, the 'slippery slope' argument implies that once the withdrawal of life-sustaining treatment is permitted from one group of non-terminally ill patients (such as PVS patients) then legal arguments for the withdrawal of life-sustaining treatment from other groups of non-terminally ill patients - such as the severely disabled or the elderly or those with 'minimal awareness' - will be more difficult to rebut.

Considered as a purely logical argument, the 'slippery slope' argument cannot be given an abstract formulation and cannot be considered to be valid; however, one form of the argument (the so-called 'logical form') can be abstractly formulated but, on analysis, is seen to be not a general form of argument, but rather a principle to the effect that when deciding contentious questions the narrowest possible grounds should be offered in their justification. The Ward decision, in that it was not decided on the narrowest possible grounds, breaches this principle. Though the 'slippery slope' argument - as a general form of argument - lacks validity it may nonetheless in particular circumstances imply true conclusions; however, the truth of such conclusions follows by virtue of particular sociological or political circumstances and not by virtue of any formal logical rule.⁸⁷

On analysing the English judgements which permitted the withdrawal of treatment from non-terminally ill patients the most meaningful distinction is found to be *not* that between the PVS cases and those cases of severe disability - because both of these are dependent on the same theoretical framework namely permissibility of using 'absolute quality of life' judgements in the making of medical treatment decisions - but between cases of withdrawal of ANH and the withdrawal of other forms of life-sustaining treatment. English law - unlike Irish law - safeguards this distinction in that the withdrawal of ANH is permitted only in cases of PVS and then only with the prior approval of the courts.⁸⁸

This leads to the main conclusion of this chapter which is that the decision in the Ward case facilitated the development of a 'slippery slope' despite the protestations to the contrary in the various judgements. This was not because of the decision to withdraw ANH *per se* but primarily because of the ground used to justify the decision; other aspects of the judgements also contributed to the same effect, in particular:

- (i) The Ward case - unlike the Bland case - did not insist that application be made to the court for permission to withdraw of ANH in subsequent cases; this meant that the Irish courts relinquished their supervisory role in this area.
- (ii) The Ward case - unlike the Bland case - did not distinguish between withdrawal of ANH and withdrawal of other medical treatments. This had the effect that the ethical importance to be attached by medical practitioners to the withdrawal of ANH is obscured by its assimilation to other medical treatments; this tendency is exacerbated by the Ward court's insistence that the withdrawal of ANH is not a cause of death.⁸⁹

The magnitude of the implications of the Ward decision are also made manifest when viewed in the light of current BMA (1999) proposals on the withdrawal of life-sustaining treatment; for it then becomes evident that these proposals - which would considerably widen the categories where, and the conditions under which withdrawal of ANH is permitted - are more compatible with existing Irish law than with current English law.⁹⁰

⁸⁷ See Conclusion 8 - 1 and Conclusion 8 - 2.

⁸⁸ See Conclusion 8 - 3, Conclusion 8 - 4, and Conclusion 8 - 5.

⁸⁹ See Conclusion 8 - 6, Conclusion 8 - 7, Conclusion 8 - 8, Conclusion 8 - 9, and Conclusion 8 - 10.

⁹⁰ See Conclusion 8 - 11 and Conclusion 8 - 12.

The conclusions which were established in this chapter are:

Conclusion ₈₋₁ : *The slippery slope argument considered as a general form of argument, cannot be considered to be valid. However, in particular circumstances the argument may imply true conclusions, the truth of the conclusions following by virtue of the particular circumstances rather than by virtue of any formal logical argument.*

Conclusion ₈₋₂ : *The so-called 'logical form of the slippery slope argument' is to the effect that in justifying a particular conclusion the narrowest grounds possible should be used in order to avoid the danger of occasioning a 'slippery slope'.*

Conclusion ₈₋₃ : *In classifying the English cases of withdrawal of life-sustaining treatment from non-terminally ill patients; the most meaningful distinction is that between withdrawal of ANH and withdrawal of other medical treatment, and not that between PVS and cases of disability.*

Conclusion ₈₋₄ : *In England, the withdrawal of ANH has been restricted to cases of PVS or 'near-PVS'; prior approval of the court is required in all such cases.*

Conclusion ₈₋₅ : *The English judgements which permitted the withdrawal of life-sustaining treatment from non-terminally ill, but disabled, patients were based on a consideration of the 'best interests' or the 'absolute quality of life' of the patients and required no application of principles of law additional to those which are implicit in the Ward judgements.*

Conclusion ₈₋₆ : *Although the judges in the Ward case did not wish their decision to be used to justify the withdrawal of life-sustaining treatment in cases of disability, they provided no coherent reason why, in situations similar to the English disability cases, it could not be so used.*

Conclusion ₈₋₇ : *The fact that the court acknowledged that the Ward had some level of awareness removes the most important barrier to the application of its decision to cases of disability.*

Conclusion ₈₋₈ : *In that the Ward judgements - unlike the Bland judgements - made no distinction between the withdrawal of ANH and the withdrawal of other forms of life-sustaining medical treatment, the withdrawal of ANH would be justified under Irish law in cases of disability where it would not be justified under English Law.*

Conclusion ₈₋₉ : *The ethical importance to be attached by medical practitioners to the withdrawal of ANH is obscured by its assimilation to other medical treatments; this tendency is exacerbated by the Ward court's insistence that the withdrawal of ANH is not a cause of death.*

Conclusion ₈₋₁₀ : *The Irish courts, by relinquishing their supervisory jurisdiction over cases where a patient's family and medical carers unanimously agree that the withdrawal of life-sustaining treatment is in a patients 'best interests', may facilitate the development of a 'slippery slope'.*

Conclusion ^{8 - 11} : *Current BMA (1999) proposals on the withdrawal of ANH are more compatible with existing Irish law than with current English Law in that the Ward decision permits*

- (i) the withdrawal of ANH from patients who are not strictly PVS.*
- (ii) the withdrawal of ANH without prior application to the courts.*

Conclusion ^{8 - 12} : *The BMA's overly wide interpretations of Re R and its insistence that the requirement (laid down in the Bland case) that the permission of the courts be sought before ANH was withdrawn, applied only to cases of PVS, are suggestive of a lack of impartiality in these matters.*

Conclusion ^{8 - 13} : *The BMA (1999) proposals on the withdrawal of ANH are not restricted to PVS patients but appear to encompass all patients who have minimal awareness. These proposals are even more capable of being extended to the disabled than were the original proposals to restrict withdrawal of ANH to PVS patients - proposals which at the time the BMA insisted had no "implications for other categories of severe handicap".⁹¹*

⁹¹ BMA (1996) p.58:

"It considers PVS to be sufficiently discrete and extreme that its management can be defined, without raising implications for other categories of severe handicap."

Part 2: Conclusions

Chapter 6 was concerned with the Ward case and the decision to permit the withdrawal of ANH and other life-sustaining treatment from a 'near-PVS' patient. However, the discussion was not concerned with the decision *per se* but with the grounds used by the courts to support the decision. The grounds used in a legal judgement are part of the conceptual framework within which the problem is placed and it was argued in Chapter 6 that the problem at the heart of the Ward case was capable of being understood and resolved by means of a number of different frameworks:

- (i) as a problem concerned with medical treatment and the conditions under which it may be withdrawn,
- (ii) as a problem concerned with the legal rules for assigning responsibility for the causing of death; or
- (iii) as a problem concerned with the best use of scarce resources.

The English courts (in the Bland case) were faced with a problem similar to the Ward case: the withdrawal of ANH from Tony Bland who was in a PVS. The judgements in the Bland case - particularly those in the House of Lords - recognised that the most fitting resolution of the problem lay through a reformulation of the rules relating to the assignment of culpability for the causing of death; however, they believed that such a reformulation would require a revision of the law of so radical a nature as to be beyond their jurisdiction and to require the intervention of Parliament. Recognising that their decision was based on *'narrow, legalistic, grounds which provide no satisfactory basis for the decision of cases which arise in the future'*,¹ they reluctantly interpreted the problem as one of medical treatment and its withdrawal.

The judgements in the Ward case showed no such hesitation; they were unequivocal in their acceptance of a medical treatment framework and indeed, gave no indication of even being aware of alternative methods of analysing the problem.²

Once the decision had been made to view the problem underlying the Ward case as being concerned with the withdrawing of medical treatment then certain preconditions had (for legal reasons) to be satisfied before the problem could be resolved by this method - it had to be accepted that:

- (i) ANH is a 'medical treatment' rather than a 'food'.
- (ii) The consent of a patient is required for all, including life-sustaining, medical treatment. (A corollary is that a patient can refuse all, even life-sustaining, medical treatment.)
- (iii) A patient does not lose the right to refuse life-sustaining treatment by virtue of their incompetency.

The judgements in the Ward case upheld all of the above preconditions; they specified the rules as to who should make the decision to permit the withdrawal of life-sustaining treatment from an incompetent patient and they set out the criterion that should be used in the making of such decisions - *i.e.* the 'best interests' of the patient. The judgements also stated that the court's decision engendered no 'slippery slope' which might lead to withdrawal of life-sustaining treatment in cases of disability; however, such assertions were more in the nature of avowals than reasoned

¹ The Bland case p.885 *per* Lord Browne-Wilkinson.

² with the possible exception of the dissenting judgement of Egan J.

arguments and bore little relation to the underlying rationale behind the decision; as such they are *obiter dicta* and not of binding authority in any subsequent case.

Chapter 7 considered the concept of 'best interests' as used in the Ward case and found that its explication required the use of the concept of 'quality of life'. Two meanings of the term 'quality of life' were distinguished; medical judgements based on these different meanings were called '*absolute quality of life*' judgements (which sought to measure the *totality* of a patient's quality of life) and '*incremental quality of life*' judgements (which sought to measure the *change* in a patient's quality of life due to some proposed medical intervention). It was shown that 'incremental quality of life' judgements did not logically require the ability to make 'absolute quality of life' judgements and it was argued that, for ethical reasons, 'absolute quality of life' judgements should not be used. However, it was noted that the 'best interests' judgements, as used in the Ward and Bland cases, *necessitated* the making of 'absolute quality of life' judgements.

Chapter 8 considered the 'slippery slope' arguments and the possible use of the Ward decision to justify withdrawal of life-sustaining treatment in cases of severe disability. English legal developments in relation to the withdrawal of life-sustaining treatment in cases of disability (such as occurred in *Re B* and *In re J*)³ were examined and were shown not to require the use of any legal principle additional to those accepted in the Ward decision. The main legal principle needed for deciding such cases was that 'absolute quality of life' judgements are permissible in the making of medical treatment decisions and such judgements had been sanctioned by the Ward decision.

It was concluded that the Ward decision did create the danger of a 'slippery slope' and that this arose principally because:

- (i) it sanctioned the use of 'absolute quality of life' judgements;
- (ii) it allowed the withdrawal of ANH to be assimilated to normal treatment decisions especially in its insistence that the withdrawal of ANH did not *cause* the patient's death;
- (iii) its refusal (unlike the Bland court) to stipulate that application be made to the courts in future cases where the withdrawal of ANH was proposed.

It was argued that this was an abdication of responsibility and effectively removed the supervision of medical developments in this area from the courts.

The magnitude of the changes wrought in Irish law by the Ward decision is evidenced in the fact that recent BMA (1999) proposals which favour the widening of the categories where the withdrawal of ANH is permitted, to cases such as those of the 'marginally aware' and stroke victims, are more compatible with existing Irish law than with current English law. The conclusion to be drawn is that the Ward case did engender a 'slippery slope' - not by the decision *per se* but by the grounds used by the court in justifying its decision.

Could the danger of a 'slippery slope' be avoided if 'absolute quality of life' judgements were prohibited?

The short answer is yes and it is the task of Part 3 to show how this is so; however, without the use of 'absolute quality of life' judgements, the Medical Conceptual Framework is not sufficiently powerful to generate a solution and a new conceptual framework is required; this alternative framework is developed in Part 3 and is based on the concepts of '*a good death*' and '*personhood*'.

³ Appendix C - numbers 7 and 10 respectively.

Part 3: Introduction

"Who is there today who still cares about a well-finished death? No one ... the desire to have a death of one's own is becoming more and more rare. In a short time it will be as rare as a life of one's own ... You come, you find a life, ready-made, you just have to slip it on. You leave when you want to, or when you are forced to: anyway, no effort: Voilà votre mort, monsieur. ... [in times past] you knew that you had your death inside you as a fruit has its core."

Rilke⁴

The conclusion to Part 2 of this thesis⁵ was that the Ward case - not because of its decision to permit the withdrawal of ANH *per se*, but because of the *grounds* used to justify this decision - risked developing a 'slippery slope' in which the withdrawal of life-sustaining treatment could be withdrawn from disabled patients on the basis of their supposed poor '(absolute) quality of life'. The goal of this part of the thesis is to develop a conceptual scheme which will permit cases such as Ward and Bland, to be resolved without the risk of developing a 'slippery slope'. More particularly, a conceptual structure will be developed which will enable the withdrawal of life-sustaining treatment, including ANH, to be justified in cases of PVS or 'near- PVS' but not in cases of disability such as that of a Down Syndrome infant with an easily curable intestinal blockage (as in *Re B*⁶). A case such as *Frenchay v S*⁷ - in that there was some tentative evidence that the patient had an ability to communicate - would mark the boundary between cases where withdrawal of life-sustaining treatment is permitted for reasons of 'best interests' and cases where such decisions negate⁸ a patient's rights.

The structure to be developed depends on two concepts: '*death*' and '*personhood*'; from these concepts three strands will be woven:

- (i) The concept of 'a good death':

It will be argued that the proposition '*Death is an evil*', if unqualified, is unsustainable; it follows that some deaths are a 'good'; the conditions under which a death may be called 'a good death' will be clarified.

- (ii) A *necessary condition for the ascription of personhood*:

It will be argued that the '*ability to communicate to some minimal standard*' is a necessary condition for the ascription of personhood.

- (iii) *Obligations flowing from Justice as distinct from those flowing from Charity*:

I have adopted and developed a distinction (used by Phillipa Foot⁹) between the obligations that flow from the virtue of Justice and those that flow from Charity. A term is introduced - '*Objects of Intrinsic Moral Worth*'¹⁰ - to describe those objects/individuals to whom

⁴ Rainer Maria Rilke, *The Notebooks of Malte Laurids Brigge*, p.9-10.

⁵ See Part 2: Conclusions; also *Conclusion 8-6* to *Conclusion 8-11* inclusive.

⁶ Appendix C - number 7.

⁷ Appendix C - number 3.

⁸ not only 'negate' but - as will be argued - effectively revoke *all* of the patient's rights and thus destroy their personhood.

⁹ In her essay '*Euthanasia*' included in Phillipa Foot, *Virtues and Vices*, pp 33-62; this essay is summarised in Appendix D.

¹⁰ 'OMW's' for short. The following brief explanation is reproduced from Part 1:

The term 'Objects of Intrinsic Moral Worth' denotes objects, effects on which are considered relevant in assessing the morality of a proposed action. Thus in the example of an assailant who accosts a man who is out walking his dog, and beats them both to death with a stick; the effects on the man, and (most probably) on the dog would be considered relevant to any assessment of the morality of the assault. However, it is most unlikely that the damage to the stick would, for its own sake, be considered relevant in any particular moral assessment of the action. This

obligations are due based on Charity. Those to whom obligations are due based on the virtue of Justice are called 'persons' (the obligations are called 'rights'). It will be argued that the obligations flowing from Justice preclude any steps being taken, whether by act or omission, to end the life of anyone to whom such obligations are owing without their consent; obligations flowing from Charity (*i.e.* 'moral obligations' and which - in the context of medical care - are to always act in the best interests of a patient), in contrast, carry no such implications in relation to the causing of death provided only that the actions are motivated *solely* by compassion.

A summary of the argument to be developed

PVS patients, in that they have permanently lost the ability to communicate, have lost their personhood. However, (as argued in Part 1)¹¹ such patients must be treated as *if* they are conscious; hence - in so far as the possession of consciousness or the ability to feel pain is accepted as a criterion for being an 'Object of Intrinsic Moral Worth' - PVS patients are 'OMW's'. Thus, whereas obligations owing to PVS patients based on Justice have lapsed, those based on Charity still persist. Accepting Foot's argument that intentional killing offends both against Justice (in that it is a non-consensual interference) and Charity (in that it does not flow from motives of compassion); it follows that the killing of a PVS patient, if done *solely* from motives of compassion would not offend against either virtue.

The meaning of the term 'a good death' is examined and it is argued that a moral obligation exists on medical carers to enable a patient to achieve 'a good death'. It is argued that the intentional killing of a person against their wishes could never constitute 'a good death'; however, it may constitute 'a good death' if - as in cases of assisted suicide - it is consensual; even then there may be weighty social reasons, as Foot has argued, for prohibiting such intentional killing of persons.

The non-consensual, intentional, killing of individuals who have lost their personhood (such as PVS patients) may constitute 'a good death' if the killing is motivated solely by compassion and done solely in their 'best interests'.¹² Thus, there may in certain circumstances be an *obligation* on medical carers to kill their patient. This conclusion, however, is based *only* on an analysis of the rights and obligations of the patient¹³ and their medical carers; other parties¹⁴ are also affected by such decisions and the inclusion of their interests in the ethical equation may ensure that intentional killing is deemed to be unjustified in all circumstances.¹⁵

One important consequence of this analysis is that the making of a medical treatment decision for a patient who is not permanently unable to communicate (for example, a Down Syndrome infant

situation could be described by saying that the man and his dog - but not the stick - were, in the particular moral theory under discussion, 'Objects of Intrinsic Moral Worth'.

¹¹ Conclusion 5.5: *All patients diagnosed as PVS, should be treated as if they are conscious and can experience pain.*

¹² The prohibition on 'absolute quality of life' judgements advocated in Part 2 relates to *persons*.

See Conclusion 7.5: *There are at least two reasons why 'absolute quality of life' judgements should be rejected: they are unreliable and they are incompatible with the egalitarian principle that all persons be treated as equal.*¹² Furthermore 'absolute quality of life' judgements often function as a mechanism of denial so that situations which are unacceptable to the decision-maker are not permitted to continue.

¹³ *i.e.* a patient who had lost their personhood.

¹⁴ *i.e.* the wider society whose interests may be termed the 'common good'; these wider social interests could be considered as flowing from 'Social Justice'; thus, in judging whether an action ought to be performed it must be examined under the aspect of Charity and under the aspect of Justice (both in its individual and social expressions). These ideas are developed in Chapter 9 and 10.

¹⁵ The development of euthanasia in pre-war Germany - which is briefly sketched in Appendix E - is of some assistance in considering the wider social implications of permitting assisted suicide.

who will, in time, have the ability to communicate to the requisite standard¹⁶) which foreseeably results in the death of that patient is effectively an annihilation of their personhood and as such is morally equivalent to their murder; this is so *even if the decision is made in the patient's 'best interests' and motivated solely by compassion.*

Structure of Part 3

Part 3 is divided into three chapters and three appendices:

- Chapter 9 : examines the concept of 'a good death'.
- Chapter 10 : considers the concept of personhood and establishes a necessary condition for its ascription; the concept of 'Objects of Intrinsic Moral Worth' and Foot's analysis of the obligations flowing from the virtues of Justice and Charity are also discussed.
- Chapter 11 : sets out and develops the conceptual structure being proposed in this thesis.

- Appendix D : contains a summary of Foot's essay on euthanasia.
- Appendix E : examines the development of euthanasia in pre-war Germany.
- Appendix F : contains summaries of some modern definitions of personhood.

¹⁶ or a 'minimally aware' patient who might be expected to become lucid at some future stage.

Chapter 9: A Good Death

The aims of this chapter are:

- (i) to establish that it is meaningful to speak of a death as being 'a good death'
- (ii) to clarify the concept of 'a good death' and to consider whether it can have any relevance to the making of 'end-of-life' decisions for PVS patients, and
- (iii) to establish that 'a good death' is a moral - as distinct from an aesthetic - 'good'.¹

Once these points are established, the conclusion readily follows that:

"Carers have a moral obligation to a patient, who has entered onto the threshold of their own death, to help that patient achieve 'a good death'."

Because to assert that 'a good death' is a (moral) good necessarily implies the existence of such a moral obligation.²

In attempting to accomplish these aims, it is certainly possible to address them directly - that is to attempt to define 'a good death' and to show that it is a 'good'.³ Paradoxically, however, an indirect approach - to challenge the truth of the proposition '*Death is an evil*'⁴ where this is asserted without qualification - is both more powerful and more instructive.

The proposition 'Death is an evil' is itself of pivotal significance in any discussion of assisted suicide and euthanasia and, I suggest, 'end-of-life' decisions for PVS patients, because once this proposition is accepted, it *determines* the response to many of the ethical questions relating to 'end-of-life' decisions in that the answers follow by necessary logical implication; a statement by James Rachels exemplifies this point:

*"We do, of course, commonly assume that death is a bad thing. That is why we regard murder as a heinous crime, and why we anticipate our own deaths with dismay and weep over the deaths of those we love."*⁵

Rachael's statement is not true: the basis for condemning murder lies *not* in the fact that death is a bad thing - as is clear when we consider that the victim would have died in any case⁶ - but rather in that *untimely* death is a bad thing.⁷ Thus, before embarking on any wider ethical discussion concerning death and dying, it is important that the proposition 'Death is an evil' be not

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¹ To obviate the need for a continued repetition of this distinction the term 'good' will, in the remainder of this chapter and unless otherwise stated, be used to signify 'good' in its ethical sense; though perhaps both uses of the term 'good' can be subsumed under the one concept of 'aptness' or 'fitness for purpose'. This appears to have been the practice in Greek philosophy as evidenced in a quotation from Rex Warner who, in his *The Greek Philosophers* states (p.114):

"There is a sense in which Aristotle does not employ at all our concept of 'morality'. Here again one is apt to be misled by difficulties of translation. The Greek word arete in this context is usually rendered as 'virtue', and we naturally think of virtue as a moral affair. But this implies a restriction that is not present in the Greek. 'Moral Virtues' in Aristotle are simply good qualities of character displayed in right conduct; and any good qualities of character may be so called - good manners, affability, wit, proper dignity of bearing, as well as honesty, truthfulness, temperance, or charity. It is not, of course, that Aristotle does not discuss what we should regard as moral questions; it is only that he does not specially distinguish them from other questions of what is good in conduct and character, and indeed he has not the linguistic means of doing so." [emphasis in the original]

² though Foot's distinction between the 'goodness' and 'oughtness' of a proposed action complicates this implication. The implication itself will be discussed later.

³ An examination of the concept of 'good' - and the more basic concept of 'value' - would doubtlessly be helpful, but is not possible within the narrow ambit of this thesis.

⁴ The proposition '*Death is an evil*' is ambiguous in that it may mean '(Some) death is an evil' or '(All) death is an evil'. The proposition, as used in this chapter, is used in the second sense, - i.e. as '*Death is an evil*' (*simpliciter*); however, the precise meaning can also be captured by the proposition '*Human mortality is an evil*'; this latter proposition not having any of the intuitive plausibility of '*Death is an evil*'.

⁵ James Rachels (ed.), *Moral Problems*, at p. 446.

⁶ It would be a valid reason if only *some* (including those who were murdered) but not *all*, persons died.

⁷ One might quibble with the term 'untimely' the important point is that it is some types of death - untimely or violent or whatever - that are evil, not death itself.

accepted as part of the conventional wisdom but be critically analysed as a proposition in its own right. The untruth or *'inappropriateness'*⁸ of the proposition 'Death is an evil' - considered as a universally true proposition - will be shown by arguing that, although it is meaningful to speak of *some* deaths as being evil, it is not meaningful to speak of *all* deaths as being evil. Once this is demonstrated, the existence of 'good deaths' follows as a corollary - because if not all deaths are evil then either some deaths are morally neutral or some deaths are good, or both. It is relatively easy to see that not all those deaths, which are not morally evil, are morally neutral - in the sense that a moral agent would be indifferent as to whether they occurred or not - hence, it will follow that some deaths are morally good. This would establish the logical existence - but not the content - of morally good deaths. A death which is morally good - that is, ought to be striven for - I term 'a good death'.

This chapter is structured into four Sections:

Section 1: seeks to establish that the proposition 'Death is an evil' is, if unqualified, untrue.⁹

Section 2: considers some of the consequences that flow from an unqualified acceptance of the proposition 'Death is an evil', both in regard to the role played by death in the practice of clinical medicine and the denial of death,¹⁰ these being intimately connected.¹¹

⁸ In speaking of a proposition as *'inappropriate'* I wish to refer to the idea that a word structure may have the form of a proposition and yet have no meaning: e.g. *'Good is yellow'* or *'All runners in the race were losers'*, *'I am jealous of myself'*; the underlying idea is also captured by a question such as *'What is the universe near?'* I do not wish to argue that *'Death is an evil'* is not a proposition, as this would have the consequence that its negation was not a proposition and the negation of *'Death is an evil'* is unproblematic, however stating that *'Death is an evil' is untrue* does not appear to be sufficiently strong.

⁹ A more detailed schema for Section 1 is as follows:

- Section 1: The proposition *'Death is an evil'* (simpliciter) is untrue.
 - Subsection 1: Death being an intrinsic part of the human condition cannot be considered to be an evil.
 - Subsection 2: Religion and the evil of death.
 - The Christian attitude to death
 - Eastern religious attitudes to death
 - Contrast between Eastern and Christian myths on the origin of death
 - Christian attitude to killing
 - Subsection 3: Philosophical arguments disputing the proposition 'Death is an evil'
 - Plato
 - Spinoza
 - Jaspers
 - Heidegger
 - Derrida
 - Foot - 'Death is an evil' - The role of death in Foot's argument
 - Scruton
 - Conclusions
 - Subsection 4: Philosophical arguments asserting that death is an evil
 - Nagel - Nagel: The View from Nowhere - Nagel: Mortal Questions - Summary of Nagel's Arguments
 - Mothersill: Death
 - Conclusions
 - Subsection 5: The Fear of Death
 - The fear of death is irrational
 - The existence of the fear of death implies that 'Death is an evil'

¹⁰ The phrase 'denial of death' will be discussed below in relation to Ernest Becker's writings. It means the refusal to fully accept - both intellectually and emotionally - one's own mortality.

¹¹ A more detailed schema for Section 2 is as follows:

- Section 2: Manifestations of the denial of death.
 - Subsection 1: What is the 'denial of death'?
 - Becker and the denial of death
 - Kübler-Ross and the denial of death
 - Kübler-Ross: Is death to be considered an evil?
 - Subsection 2: Medical manifestations of the 'denial of death'
 - Kübler-Ross
 - More recent commentators
 - The pervasiveness of death denial amongst medical carers
 - The role of medicine: cure or care?
 - Callahan
 - Current attitudes to death and dying
 - The beliefs underlying current attitudes to death and dying
 - Callahan's proposals

- Section 3* clarifies the meaning of the concept of 'a good death'¹² and examines whether the usage of the term 'a good death' as here proposed - *i.e.* as a death which is a moral good - is in accord with the vernacular usage of the term and, if not, the nature of the distinction between these usages.¹³
- Section 4* draws some conclusions from the discussion.

Section 1: The proposition '*Death is an evil*' (*simpliciter*) is untrue.

There appears to be a wide consensus amongst philosophers - with some few, but notable, exceptions - that the proposition that 'Death is an evil' is not only true, but so obviously true as to be unworthy of serious consideration. Some have given reasons for considering death as an evil - William James, for example, suggests that the acceptance of life as a good implies that death must be an evil:

*"In short, life and its negation are beaten up inextricably together. But if the life be good, the negation of it must be bad. Yet the two are equally essential facts of existence; and all natural happiness thus seems infected with a contradiction. The breath of the sepulchre surrounds it."*¹⁴

However, most philosophical discussion has centred on the fear of death and as to whether such a fear is 'rational', the implicit corollary being that if such a fear is rational then death is in fact an evil.

To enable a more structured discussion, Section 1 is divided into five subsections:

Subsection 1 sets out to establish that, because death is an intrinsic part of the human condition¹⁵ - that is, because it is one of the parameters within which a life is lived - it cannot, without further qualification, be considered to be evil.

Subsection 2 seeks to explain the prevalence in Western culture of the proposition 'Death is an evil' by showing its origin in Christian belief. A brief sketch of Eastern religious attitudes to death - which appear not to support the belief that 'Death is an evil' - will also be included in this subsection.

Subsection 3 considers the arguments of some philosophers who dispute the proposition 'Death is evil' (*simpliciter*).

Subsection 4 considers the arguments of some philosophers who assert that death is an evil.

¹² The relevance of the concept of 'a good death' to the making of 'end-of-life' decisions for PVS patients will be considered in the Chapter 11.

¹³ A more detailed schema for Section 3 is as follows:

Section 3: The moral obligations implied in stating a death is 'a good death'.

A possible ambiguity

'a good death' is not 'a least worse death'

In stating that 'a good death' is a 'good', what obligations are implied?

General considerations

In relation to occasioning the death itself

In relation to occasioning the 'goodness' of the death

Obligations flowing from Justice

What if communication was not possible?

Callahan's position

Some further characteristics of 'a good death'

¹⁴ William James, *The Varieties of Religious Experience*, p. 139.

¹⁵ It might be contended that this argument also implies that since illness is also an intrinsic part of the human condition it too should not be considered to be evil; the point, however, is that though illness and death are both intrinsic to the human condition (viewed in its generality) only death is intrinsic to the human condition (viewed in its particularity): a particular individual may not experience illness but he will certainly experience death.

Subsection 5 considers those philosophical arguments which are based on the fear of death and which - from the very existence of such fears or by considering their rationality - seek to draw conclusions on the question of whether death is an evil.

Subsection 1: Death being an intrinsic part of the human condition cannot be considered to be an evil.

It is said of Diogenes of Sinope that he masturbated in the marketplace saying

*"If only heaven let us rub our bellies too, and that be enough to stave off hunger!"*¹⁶

The ability to dispel one's hunger by rubbing one's belly would seem to be of unconditional benefit to any individual; it might be suggested that an individual with such a facility would be deprived of the pleasures of the table but we may assume that the imagined ability to be in addition to and not in place of existing pleasures. Would it be meaningful to talk of this newly imagined ability as a 'good' and its absence as an 'evil'? What sense could be ascribed to such propositions?

In an attempt to answer this question consider a less extreme example. Imagine that a biologist has managed to isolate a new food substance of hitherto unimagined potency such that a single tablet is sufficient to sustain an individual for many months. Furthermore, the substance is inexpensive and simple to produce. This new substance holds out the promise of ending world hunger. Would such a substance be universally regarded as a good? Would not the multinational company, who purchased the patent to this new substance in order to ensure that it was not developed so that its own market dominance might be protected, be universally regarded as evil? Similar judgements would also apply to an imagined cure for cancer. Why is it that the terms 'good' and 'evil' appear to have a ready applicability to the development of a universal cure for cancer but seem inappropriate when applied to Diogenes' belly rubbing cure for hunger?

The reason I suggest is that one aspect of the terms 'good' and 'evil' is that they distinguish between *possible* choices. In an actual situation some of the choices open to us are good, some are evil, and we are urged to choose the good. A universal cure for cancer appears to us as a distinct possibility, Diogenes' belly rubbing cure as a flight of fancy, an impossibility. The term 'good' is applicable to the first but not to the second. Morality and ethics belong to the sphere of the contingent, not to that which is considered as necessary.¹⁷ Furthermore, if the terms 'good' and 'evil' could be used in relation to situations which *must* exist, then they could be used in relation to situations which *could not* exist, for these are but the negative of the first. This would result in nonsense. Consider how one who accepts that the killing of animals is evil, could answer the question:

"Is it evil to kill unicorns?"

Is it not possible to assert *both* that *"Is it evil to kill unicorns?"* and *"Is it good to kill unicorns?"* simultaneously and without contradiction, since unicorns do not exist? This leads us to the conclusion that the contingency of X - i.e. the possibility of X occurring - is a precondition for the asserting either that 'X is good' or that 'X is evil'.

However, an assertion that 'X is good' or that 'X is evil' not only requires that X must be neither inevitable nor impossible, but also that its occurrence must be dependent on some human agency. To suggest otherwise is surely to adopt the standpoint of the child who having tripped over a stone

¹⁶ Quoted in E. M. Cioran, A Short History of Decay p.63.

¹⁷ Spinoza, for example, was considered by many to be a destroyer of morality in that he denied human freedom and considered that human actions were necessary consequences of existing situations.

attempts to blame and punish the stone. But is the adult who, looking on the damage wrought by a hurricane, says '*hurricanes are evil*' different from that child who says '*the stone is evil*'? And what of the person who says '*Death is evil*'? Thus, not only is a belief that death is not intrinsic to the human condition required before the proposition 'Death is an evil' can be meaningfully asserted, but also the belief that such death that does occur is attributable to human agency.¹⁸

Conclusion ₉₋₁ : *The belief in the contingency of X and that the occurrence of X is, to some extent, dependent on human agency are preconditions for asserting either 'X is good' or 'X is evil'.*

The belief that death is not intrinsic to the human condition is precisely what is meant by the phrase '*the denial of death*'. Thus, the proposition '*Death is an evil*' implies a denial of death. Conversely, an acceptance of death as an intrinsic part of the human condition implies that the predicates 'good' or 'evil' cannot be applied to death without further qualification.

A different argument to the same conclusion can be based on the observation that the term 'good' can be applied *in* a life but not *of* a life and that to attempt to do so results in logical difficulties. Some of the logical paradoxes studied by Russell and others occurred because predicates, which although unproblematic when applied to the elements of a set or collection, become so when applied to the collection itself. The example of the concept of '*a journey*' clearly shows the difficulties. One might well ask of a particular event in a journey whether it helped or hindered the journey but one may not ask the same of the journey itself; thus - if one considers that to be a 'good' which helps one to live one's life - one may ask whether an event in life was 'a good' but one cannot ask the same of life itself. Furthermore, one may not ask whether it is 'a good' that a journey has an end in that the concept 'journey' *entails* that it has an end; thus, to assert that '*Ends of journeys are evil*' is to indulge in nonsense, though, of course, this does not preclude us asking whether a particular destination was a fitting end to a specific journey; similarly, though we may ask whether a specific death was a good or an evil, we may not ask that of death itself. Wittgenstein observed¹⁹ that our death is not an event in our lives but is, to our lives, rather like the frame or horizon is to a picture. Thus, if 'good' is a term which can be applied to events, or possible choices, in our lives, it is by no means clear that it has meaning when applied to the limits of such a life. Although this may appear to argue against the use of the term 'a good death', it doesn't. It argues against regarding death (*simpliciter*) as either good or evil; the term 'a good death' is - as shall be seen - defined to a considerable extent by the process or series of events which precedes it - *a good dying*; such events are doubtlessly *in* the life in question.

Conclusion ₉₋₂ : *The predicates 'good' or 'evil' cannot meaningfully be applied to 'death' without further qualification. The assertion that 'Death is an evil' (simpliciter) implies a denial of death in that it implies a refusal to accept human mortality.*

¹⁸ It is ironic that these precise beliefs - i.e. that death is contingent and dependent on human intervention - are, in Elizabeth Kübler-Ross's view [(1970) p.2], a logical consequence of death denial; furthermore, they imply the logical equivalence of the propositions 'Death is evil' and 'Killing is evil'. This is discussed further in Section 2 of this chapter.

¹⁹ Wittgenstein *Tractatus Logico-Philosophicus* 6.4311

"Death is not an event in life. We do not live to experience death."

see also Brian Magee *Confessions of a Philosopher* p.584;

"As Wittgenstein so well put it, death will not be an event in our lives ... The limits of our lives will be as un-clear-cut, as unlike a drawn line, as the limits of our visual field (again an analogy drawn by Wittgenstein)."

Steiner (p.105) notes Heidegger's agreement with Wittgenstein's observation:

"Thus 'death is, in the widest sense, a phenomenon of life'; indeed, it may well be the identifying phenomenon, though it cannot itself 'be lived' (a point on which Heidegger concurs explicitly with Wittgenstein)."

If, as has just been argued, the proposition 'Death is an evil' (simpliciter) is meaningless then why is it so commonly asserted, particularly in Western societies? I suggest that there are principally two reasons: our Western Christian heritage and a denial of death which is prevalent in Western society. The denial of death is not necessarily connected with religious belief; it can be found even in a 'scientific' guise in cryonics²⁰ and in the belief that medicine will soon conquer death;²¹ the denial of death is examined in Section 2. We now examine the interrelationships in Christianity between the cluster of ideas: 'death is an evil', 'death is not intrinsic to the human condition', 'the existence of death is dependent on human agency'.

Subsection 2: Religion and the evil of death.

The Christian attitude to death

In Christianity death was a punishment inflicted by God on man for his disobedience. Three consequences follow. Firstly, that because death was a punishment, it must be evil; secondly, its very coming into being is due to man; thirdly, because there was a time in the Garden of Paradise before the Fall when man was not mortal, death is contingent. Its contingency is also emphasised in the doctrines of the resurrection of the body and the immortality of souls.²²

In Christian doctrine one of the chief consequences of the Fall was the introduction of death. Milton, in his Paradise Lost, describes it thus:

*"Of Mans First Disobedience, and the Fruit
of that Forbidden Tree, whose mortal taste
Brought Death into the World, and all our woe,
With Loss of EDEN, ..."*²³

However, in Christianity death was not regarded as permanent because man would have eternal life either in heaven or on earth after the resurrection of the body:

*"He will swallow up death in victory ... Thy dead men shall live, together with my dead body
shall they arise. Awake and sing, ye that dwell in dust; for thy dew is as the dew of herbs,
and the earth shall cast out the dead."*²⁴

Neither was death regarded as intrinsic to man's condition:

*"And God shall wipe away all tears from their eyes; and there shall be
no more death, neither sorrow, nor crying, neither shall there be any more
pain: for the former things are passed away."*²⁵

²⁰ The practice or technique of deep-freezing the bodies of those who have died of an incurable disease, in the hope of a future cure.

²¹ Such a belief is exemplified in a Sunday Times article of 4th July 1999 the headline of which stated *"Immortal" genes found by science*. The article continued by arguing that it was now possible (by using genetic manipulation) to extend the life of fruit flies threefold and that such technology would soon be available to humans.

²² The interrelatedness of the supposed evil of death and religious belief may also be seen by attempting - with the aid of a thought experiment - to interpret the proposition *'Death is an evil'* literally; this allows the metaphorical nature of the proposition to quickly become apparent. Imagine that in some imaginary world it was possible to banish death. What then of the incurable cancer victim racked by pain? Is there to be no end to their torment? No hope of merciful release from their suffering? What of the problem of overcrowding in such a world without death? Wherefrom the resources to tend the sick? Could it be said of such an imaginary world that it is unequivocally better than our existing world? Standing behind an imaginary veil - that is, not knowing our own particular circumstance - and acting only from motives of compassion, could we unequivocally say that such a banishing of death was a 'good'? Does this not imply that when it is said that death is an evil, it is not death, as such, that is being discussed but death as a metaphor for suffering, loss and pain, for the loss of some imagined paradise?

²³ John Milton, Paradise Lost Book 1(i), (the opening lines).

[Available on Internet: <http://www.literature.org/authors/milton-john/paradise-lost/chapter-01.html>]

²⁴ The Bible, Book of Isaiah, 25.8 - 26.19.

Eastern religious attitudes to death

The understanding of death amongst Eastern religions is quite different to that found in Christianity. For example, in Chinese Taoist philosophy, dualities such as 'good and evil', 'high and low', 'life and death' necessarily exist as dualities. 'Good' can no more exist without 'evil', nor 'death' without 'life' than 'left' without 'right'.²⁶ This viewpoint can be interpreted in two ways; firstly, as a statement of logic - the concept 'good' cannot exist without its opposite 'evil'; secondly, as a maxim for a philosophy of life: one should not attempt to cleave to any one half of a duality otherwise suffering will inevitably ensue. The Hindu attitude to death is not dissimilar:

*"For to the one that is born death is certain,
and certain is birth for the one that has died.
Therefore, for what is unavoidable thou shouldst not grieve."*²⁷

The Indian poet Rabindranath Tagore²⁸ in his essay The Four Stages of Life beautifully elaborates on this theme:

*"We have come to look upon life as a conflict with death - the intruding enemy, not the natural ending - in impotent quarrel with which we spend every stage of it. When the time comes for youth to depart, we would hold it back by main force. When the fervour of desire slackens, we would revive it with fresh fuel of our own devising. When our sense organs weaken, we urge them to keep up their efforts. Even when our grip has relaxed we are reluctant to give up possession. We are not trained to recognise the inevitable as natural, and so cannot give up gracefully that which has to go, but needs must wait till it is snatched from us. The truth comes as conqueror only because we have lost the art of receiving it as guest ... The flower must shed its petals for the sake of fruition, the fruit must drop off for the rebirth of the tree. The child leaves the refuge of the womb in order to achieve the further growth of the body ..."*²⁹

Contrast between Eastern and Christian myths on the origin of death

It is clear that the Eastern attitude to death differs markedly from current Western attitudes. I have suggested that modern Western attitudes derived from earlier Christian beliefs on the origin of death as punishment; not surprisingly Eastern religious beliefs on the origin of death are quite different from the Christian. Elisabeth Kübler-Ross in her Death The Final Stage Of Growth, includes an essay which discusses the Hindu and Buddhist views of the origin of death:

²⁵ The Bible, The Revelation of St John 21:4.

²⁶ See, for example,

Thomas Merton, The Way of Chuang Tzu p.88:

*"Consequently: he who wants to have right without wrong,
Order without disorder,
Does not understand the principles
Of heaven and earth. ...
They are correlative: to know one
Is to know the other.
To refuse one
Is to refuse both."*

and Thomas Cleary (trans.), Chuang Tzu p.106:

"Death and Life are destiny; the existence of consistency in the night and day is Nature. The existence of that which humans can do nothing about is the condition of things."

²⁷ The Bhagavad-Gita Ch. II - 27; included in Radhakrishnan and Moore (eds.), A Sourcebook of Indian Philosophy p.108.

²⁸ Elisabeth Kübler-Ross is said to have believed that no one had thought more deeply on death and dying than Tagore.

(Dutta and Robinson, Rabindranath Tagore at p.88)

²⁹ Included in William Gerber, The Mind of India at p.184,

*"Brahma created so many beings that the earth began to fill up to the point that 'there was no room to breath'. Since Death had not yet entered the world, multitudinous creatures were being born but none were dying. As a result of the absence of Death, Mother Earth began to feel so overburdened by the weight of this excessive number of creatures that she pled with Brahma to lighten her load by 'removing' a reasonable number of his progeny. He repressed a portion of his creative energy in order to provide for creation and destruction."*³⁰

Out of the intensification of this repressed energy a goddess was born whom Brahma named 'Death'. However, out of love for the creatures of the Earth, she refused to remove any of these creatures and she retired from the world. Brahma, out of desperation and after much unsuccessful pleading with Death to fulfil her role, finally decreed that Death's tears of grief be changed into diseases and that these diseases be used to remove creatures from the earth.

The contrast between the religious myths of the East and the West on the origin of death, is fully reflected in the attitudes found in their modern-day cultures and philosophies and goes a considerable distance to explain their contrasting attitudes to death.

Conclusion 9-3 : *Christianity considers 'death' to be a punishment inflicted on man and as not intrinsic to the human condition; it - unlike many Eastern religions - subscribes to the proposition 'Death is an evil'.*

It is convenient at this stage of the discussion on Christian attitudes to death to examine the Christian attitude to killing.

Christian attitude to killing

Rachels, in discussing the Christian attitude to killing, contrasts it with the ancient Greek which considered it *'perfectly acceptable to kill newborn babies if they were deformed'*³¹ The Greeks however, regarded suicide as cowardly; not so the Romans, who considered it an acceptable option whenever a person considered their life to be a burden. In contrast to these attitudes, to the Christian *all* killing³² was an evil because it presumed on the power of God; no one having the right to shorten a divinely ordained life span. However, as Hume pointed out, this reasoning has as a further consequence that any *lengthening* of one's life span also offends the divine will; Rachels suggests³³ that Christianity does not recognise this latter implication in that it accepts the morality of medical assistance in attempts to stave off death. A contrary view is that the implication is partly embodied in the distinction between *'ordinary and extraordinary means'* and the injunction that one need not³⁴ use extraordinary means to keep someone alive. The Christian beliefs concerning death and killing could be synthesised in the proposition that *'the gift of death'* - to use Derrida's phrase³⁵ - is *solely* within the power of God and that whilst one may 'work with the will of God' any attempt to

³⁰ Kübler-Ross (1975) p.63.

³¹ James Rachels Moral Problems p.444.

The ethicist Peter Singer has similarly argued that infanticide is permissible for parents of very deformed children during the first few days after birth. (Radio interview on BBC World Service 16.1.00)

³² The early church was resolutely pacifist; however, on becoming a state religion its attitudes to state violence - such as war and execution - changed. See Rachels, Moral Problems, p.444.

³³ *ibid.* p.446.

³⁴ Could it be that the injunction was once interpreted as being that extraordinary means *should not* be used? If so, this would accord with the Taoist perspective where one is also urged to work with, or take advantage of, circumstances but never to attempt to force them.

³⁵ Jacques Derrida, The Gift of Death.

direct the situation - either by killing or overzealously trying to keep alive - presumes on the power of God.

Rachel's point - that modern, supposedly secular, attitudes unconsciously reflect much of Christian teaching and are a '*reminder of the extent to which our attitudes are a product of historical Christianity*'³⁶ - is useful to bear in mind in our subsequent discussion of 'end-of-life' decisions for PVS patients.

Subsection 3: Philosophical arguments disputing the proposition 'Death is an evil'

The unqualified proposition '*Death is an evil*' is disputed by many philosophers: for example, in classical philosophy: Plato and Spinoza; in modern Continental philosophy: Jaspers, Heidegger and Derrida; in modern British philosophy: Foot and Scruton. The reasons offered by each of these philosophers for disputing the evil of death are separately considered and some conclusions are drawn at the end of this Subsection.

Plato

in *Phaedo* Plato describes how Socrates spent his last hours in the company of his friends and disciples in discussing death, philosophy and the immortality of the soul. Philosophy was portrayed in these discussions as that discipline which enabled man to gain a stability and balance in his life so that he might not be as easily swayed, as are others, by the fears and pleasures of life; most importantly, it permitted him to overcome the fear of death.³⁷ Some who are not philosophers - in particular, the 'prudent' and the 'courageous' - can also overcome the fear of death but these do so because of a greater fear; only the philosopher overcomes his fear of death through wisdom, through the recognition that death is not an evil:

"... all others think death is a great evil?"³⁸

That death cannot be universally regarded as an evil is again recognised when the morality of suicide is discussed. Socrates argues -

"... that although sometimes and for some people death is better than life."³⁹

³⁶ Rachels *op.cit.* p.445.

³⁷ Plato, Benjamin Jowett (trans.), *Phaedo*, (Section 12):

" 'In reality then, Simmias,' he said,
'the correct philosophers practice how to die,
and death is less feared by them of all people.' "

³⁸ *ibid.* (Section 13) which continues:

" 'Quite so,' he said.
'Then do not the courageous face death
in fear of greater evils, when they do face it?'
'This is so.'
'Then by fearing and need are all courageous
except the philosophers.' "

³⁹ *ibid.* (Section 6):

" 'But you must be ready,' said he;
'for possibly you might also hear.
Perhaps however it will appear strange to you,
if this alone of all the others is absolute
and it never happens to mankind, as in other things,
when it is better to die than to live;
and to whom it is better to die,
perhaps it appears strange to you,
if for these people it is not holy for them
to do what is good for themselves,
but they must wait around for the good work of another.' "

and that, although normally it would be right for someone to act to their advantage, they should not do so if it required taking their own life. Plato's attitude to the dualities of 'pain and pleasure'⁴⁰ and 'life and death'⁴¹ is similar to the Taoist attitude:⁴² life and death are so intimately connected, each being a precondition for the other then to attempt to hold fast to just one - to argue for example that 'life is a good' and 'death is evil' - is doomed to failure.

Spinoza

Spinoza argued that that which enables the continued existence of an individual is, for that individual, 'a good'; indeed he takes it as the very definition of 'good':

*"Rather than desiring something because we judge it to be good, we call it good because we desire it. 'Consequently, what we are averse to we call evil.' "*⁴³

On the basis of such a definition it would appear that death was, to the individual concerned, an evil. However, Spinoza, regards such a view as a distorted and limited perspective; he considers that to adhere to such a partial view is to be in '*bondage*' to illusion. He argues that we must strive to see the larger whole of which we form but a part. To him, freedom, such as it is, lies in the recognition and willing acceptance of the wider necessities of the universe. Spinoza believes that if one sees one's misfortunes as they are in reality, as part of a concatenation of causes stretching from the beginning of time to the end, then one will see that they are only *personal* misfortunes, not misfortunes to the universe to which they are merely passing discords which heighten the ultimate harmony. He believes that only when such a perspective is achieved can contentedness - which to him is the goal of philosophy - be reached. The fear of death is dissipated not by imagining an immortal existence in some eternal heaven but by freeing ourselves from the desire for immortality by fully accepting the inevitability of our death.⁴⁴

In conclusion, Spinoza starts from the standpoint of the unreflective individual for whom death is indeed an evil and shows how this judgement must yield to one which regards death as neither good nor evil but simply part of the structure of the universe and of the human condition and, as such, to be willingly accepted. There is a very modern flavour to Spinoza's philosophy; his refusal to countenance any denial of death is echoed in the writings of Ernest Becker; the importance that

⁴⁰ *ibid.* (Section 3):

*" Socrates sitting up on the bed
bent his leg and rubbed it with his hand,
and while rubbing he said, 'How odd, men,
seems to be this thing, which people call pleasure;
how wonderfully is it related
to what seems to be the opposite, pain,
in that they will not come to a person at the same time,
but if someone pursues the one and gets it,
he usually is forced to get the other also,
as though out of one head the two are joined.' "*

⁴¹ *ibid.* Sections 15, 16.

*" is it necessarily so
that the same things born are generated
both out of each other and out of each into the other?'
'Certainly.'
'What then?' he said. 'Is there an opposite to life,
just as sleeping is to waking?'
'Certainly,' he said.
'What?'
'Death,' he said.' "*

⁴² Discussed in the previous Subsection.

⁴³ Lloyd *Spinoza*, p.77.

⁴⁴ *ibid.* p.118.

Spinoza attaches to the individual appropriating his own death and using it as the anvil on which to forge his own philosophy of life foreshadows the Existentialists.

Jaspers

Karl Jaspers, in common with Plato and Spinoza, sees the primary task of philosophy - not in some abstract study of substance or perception - but in learning '*how to live and to know how to die*'.⁴⁵ However, whereas to Plato man discovers his true nature in the general (for example, as a philosopher) his individuality being a defect or a departure from the ideal; to Jaspers - and to the existentialists generally - man and philosophy are irredeemably rooted in the life of the *particular* individual.⁴⁶ To philosophise is to forgo the generalities of life and to come into hard collision with the actual conditions and limitations of one's own life. Once I remain in the realm of the imagination and possibility, I encounter no limits, it is only when I come face to face with my actual situation in the world that these are encountered. I can refuse to accept these limits, I can imagine my death as contingent, but then I have lost myself in the world and lost myself to myself. I have refused to encounter my own life. These limits in my life are not:

*"... dead-ends but frontiers where being-in-itself is to be encountered. Death, for example, so long as I am forgetting it or fleeing from it or merely taking note of it as the inevitable end, is just an empirical fact about an empirical object in the world of being-there; it is not constitutive of my life, and in so far as it is not I am not living at the level of being-oneself."*⁴⁷

To enter into my own life, I must not only resign myself to these limits but - as it were - consent to them; for Jaspers, to speak of death as an evil is to refuse to consent to these limits.

Heidegger

Martin Heidegger is primarily concerned with the problem of '*Being*' - not in the metaphysical sense of attempting to catalogue and categorise the abstract principles of some generalised 'being' - but in the sense of the problem of being as it manifests to the individual '*thrown*' into the world. Such an individual can live in an '*inauthentic*' sense, by acting as '*they*' do - by being busy and active and taking his definition of himself from the role ascribed to him by others - or he can set out on a lonely journey to attempt to excavate his '*being-in-the-world*' for himself.⁴⁸

The existence of death, not as a general concept or an empirical fact but as *his very own* death,⁴⁹ is one of those ultimate questions which, if clearly faced, forces an individual out of the easy acceptance of general answers and leads him towards his own '*authenticity*'.⁵⁰ Death thus

⁴⁵ Karl Jaspers, Way To Wisdom, p.125:

"To philosophise is then at once to learn how to live and to know how to die."

⁴⁶ John Passmore, A Hundred Years of Philosophy, p.467.

⁴⁷ H.J. Blackham, Six Existentialist Thinkers, p.52.

⁴⁸ George Steiner, Heidegger (p.94):

"Inauthentic Dasein lives not as itself but as 'they' live. ... It 'is lived' in a hollow scaffolding of imposed, anonymous values. In inauthentic existence we are constantly afraid (of other men's opinions, of what 'they' will decide for us, of not coming up to the standards of material or psychological success ...). Fear ... of this order is part of the banal, prefabricated flux of collective sentiment. Angst is radically different. ... Angst is a mark of authenticity, of the repudiation of 'theyness'."

⁴⁹ Reinhard May, Heidegger's Hidden Sources quotes (at p.84) Heidegger paraphrasing Jaspers:

"There is a general 'experiential relation to death', which is not to be confused with a 'general knowing about death', only 'when death has entered into experience as a limit-situation', ..."

⁵⁰ Joshua Schuster argues that it gives man not only '*authenticity*' but the very concept of '*me*' and '*mineness*':

"... for any 'me' to exist, one must already have a pre-theoretical understanding of mineness, and of death. There is no death without mineness either. Only a being with mineness can die (much later Heidegger will later remark that animals do not die, they only perish). We cannot 'give' someone our death since mineness is not something 'I' can exist without; mineness is a given and not giveable."

'Death Reckoning in the Thinking of Heidegger, Foucault, and Derrida' (at p3)

becomes an *existential* phenomenon for the individual - his own inalienable death, a means whereby he can flesh out his own existence - and is no longer just a sociological or physiological phenomenon. *"This full-blooded acceptance of death, lived out, is authentic personal existence."*⁵¹

George Steiner, in discussing Heidegger's philosophy, describes the 'authentic death' as one that must be striven for, particularly against:

*"... the rhetoric of medical optimism and social taboo. To think on death is regarded as a sign of morbid insecurity and pathological inadequacy ... The chattering 'they' 'does not allow us the courage for anxiety in the face of death.' ... those who would rob us of this anxiety - be they priests, physicians, mystics or rationalist quacks - by transforming it into either fear or genteel indifference alienate us from life itself."*⁵²

Steiner suggests that death may well be *the* identifying phenomenon of life:

*"The point to be stressed is at once existential and logical: the possibility of Dasein depends on and makes sense only in respect of the 'impossibility of Dasein' which is death. The one cannot be without the other."*⁵³

The Taoist flavour of this last quotation is inescapable⁵⁴ and it comes as no surprise to discover that Heidegger, through his acquaintance with Japanese philosophers, was knowledgeable of Taoism - to the extent of beginning (though he did not complete) a translation of the Taoist text '*Tao Te Ching*'.⁵⁵

Derrida

Jacques Derrida in his extended essay *The Gift of Death*⁵⁶ seeks to examine the concept of 'responsibility'; however, it is the conflict between the particularity of the responsibility of the individual to himself or to his God⁵⁷ on the one hand, and the generality of the norms of ethical responsibility on the other, that is his main concern. Derrida is interested in exploring the preconditions of this conflict - what is it that brings this conscience or interior voice into being and that allows it to assert its preeminence over, what society considers to be, the rules of ethics. The

⁵¹ Blackham *op.cit.* p.96.

⁵² Steiner *op.cit.* p.105.

⁵³ *ibid.* see also p.102:

"Dasein has access to the meaning of being - this is an immensely important point - because and only because that being is finite. Authentic being is therefor a being-toward death, a Sein-zum-Tode (one of the most often cited, least understood tags in modern thought)."

[emphasis in the originals]

⁵⁴ Compare the quotation from Thomas Merton given earlier in a footnote to Subsection 2.

⁵⁵ May *op.cit.* p.6.

May discusses the Asian influences on the development of Heidegger's thought; these influences were substantial and were unacknowledged by Heidegger. May's principle conclusion is that:

"... in particular instances Heidegger even appropriated wholesale and almost verbatim major ideas from the German translation of Daoist and Zen Buddhist classics." (p. xviii)

Graham Parkes, in an essay entitled '*Rising sun over Black Forest: Heidegger's Japanese connection*,' (published with the translation of May's work mentioned above) discusses how the Japanese philosopher Tanabe and Heidegger mutually influenced each other. A flavour of the Japanese philosopher's views - which also shows their similarity to Heidegger's - is given in the following quotations from Tanabe:

- *"In the having of certain death (a having that takes hold), life becomes visible in itself."* [*ibid.* p.83]
- *"Just as life is not merely a passage [of time], so death is not the mere termination or breaking off of such a passage. Rather death stands before Dasein as something inevitable. One can even say that it is precisely in the way life regards death and deals with it in its concern that life displays its way of being. If it flees from the death that stands before it as something inevitable, and wants to conceal and forget it in its concern with the world of relations, this is the flight of life itself in the face of itself ... One must rather emphasise that it is just there, where life voluntarily opens itself to certain death, that it is truly manifest to itself."* [*ibid.* p.82]

⁵⁶ Jacques Derrida, David Wills (trans.), *The Gift of Death*.

⁵⁷ He uses the term 'God' as meaning one's deepest inner conscience:

"God is the name of the possibility I have of keeping a secret that is visible from the interior but not from the exterior." [*op.cit.* p.108]

essay is an extended meditation on the biblical story of Abraham who was commanded by God to sacrifice his son but whose life was reprieved at the last moment. Had Abraham sacrificed his son - as he was willing to do - he would have been a murderer in the eyes of his family and of society; his actions would have been unjustifiable to them, beyond explanation, truly Abraham's 'secret'⁵⁸. However, had Abraham not been willing to do his duty to God, he would then have been condemned in his own eyes. Thus, he could only do what he perceived as his duty by 'sacrificing ethics';⁵⁹ this is because ethics, in so far as it deals with general rules, is oblivious to the individual *qua individual*, and sees him only in his *role*.⁶⁰

From whence this singularity, or uniqueness, of the individual which is the very precondition of *individual* responsibility? What sets the individual apart from the general rules governing all others? Why does he feel himself exempt from these, or rather why does he feel constrained to rebel, so that he can become 'the irreplaceable uniqueness of the responsible self' ?⁶¹ To Derrida, it originates in the acceptance of one's own mortality: 'the identity of oneself is given by death'.⁶²

*"... to have the experience of one's absolute singularity and apprehend one's own death, amounts to the same thing. Death is very much that which nobody else can undergo or confront in my place. My irreplaceability is therefore conferred, delivered, 'given', one can say, by death. ... In this sense only a mortal can be responsible."*⁶³

and again:

*"... responsibility demands irreplaceable singularity. Yet only death or rather the apprehension of death can give this irreplaceability, and it is only on the basis of it that one can speak of a responsible subject, of the soul as conscience of self, of myself etc."*⁶⁴

Thus, to Derrida, the acknowledgement and acceptance of the inevitability of my dying is the gateway not only to my individuality but to my innermost being.

Foot

Phillipa Foot's essay on euthanasia⁶⁵ - particularly her distinction between the differing obligations that flow from Justice and from Charity - has been of considerable assistance in formulating the conceptual scheme proposed in this thesis; because of this and because her article embodies a particularly subtle logical argument it is summarised in Appendix D. The distinction between the obligations due to Justice and to Charity is developed in Chapter 10 and is of considerable assistance in formulating the conceptual scheme to be proposed in Chapter 11. Her argument on the proposition '*Death is an evil*' is set out below and is followed by a critique which focuses on the role she assigns to the concept of 'death' (tantamount to a 'denial of death') in the formulation of her argument.

⁵⁸ The concept of 'secrecy' and its being a precondition to responsibility, plays a central role in the essay.

⁵⁹ *ibid.* p.68.

⁶⁰ *ibid.* p.36.

⁶¹ *ibid.* p.36.

⁶² *ibid.* p.45.

see also: "... it remains for everyone to take his own death upon himself." [op.cit. p.44]

Joseph Campbell (in his *The Masks of God: Oriental Mythology* p.57) quotes an observation by Oswald Spengler to the same effect:

"The child suddenly grasps the lifeless corpse for what it is, something that has become wholly matter, wholly space, and at the same time it feels itself as an individual being in an alien extended world."

⁶³ Derrida op.cit. p.41.

⁶⁴ *ibid.* p.51

⁶⁵ The essay is entitled '*Euthanasia*' and is included in Foot, *Virtues and Vices and Other Essays in Moral Philosophy*.

'Death is an evil'

Foot begins her essay by first noting that the usual dictionary definitions of euthanasia concentrate on the *manner* of the death, i.e. its being '*gentle and easy*', and thus unintentionally but nonetheless logically encompassing, for example, the murderer who kills his victim in their sleep; it was this sense of the term that allowed the Nazis to speak of their 'euthanasia' programmes. Foot insists that the term 'euthanasia' cannot be characterised *solely* by the manner of death but must encompass the condition that the death be occasioned '*for the sake of*' the one who dies.

In formalising this latter condition Foot considers two possibilities; firstly, that the '*Death shall be a good*' and secondly, that '*Death shall not be an evil*' for the one who dies. She argues that the second of these options - although favoured in the current usage of the term 'euthanasia' - should be rejected because the condition that '*A not be an evil for Y*' does not require that '*A benefits Y*' but is satisfied simply by Y being indifferent to A. Current usage would thus cover actions which result in the death of Y even if the motivation for the actions, though not seeking to harm Y, were quite indifferent to Y and to his welfare.

Foot is thus led to define 'euthanasia' not only in terms of the *manner* of death, but also by insisting that the '*Death shall be a good*' for the one who dies. She abjures the distinction between '*act*' and '*omission*' usually made in discussing the moral responsibility for death, insisting that the essential point is the choice of a behavioural strategy - whether act or omission - which is sufficient to result in death, to choose such strategies *is* to cause the death. Having clarified the meaning she ascribes to the term euthanasia, Foot then considers whether this is just an empty definition or whether actual deaths are capable of satisfying it. The criterion relating to the 'manner of death' presents no problem but the stipulation that the '*Death shall be a good*' for the one who dies, is problematic. She uses the example of a victim of torture, who on the brink of death was always revived so that the torture might continue, to show that in certain conditions death is indeed a good and that for such a person death would be a merciful release.

The role of death in Foot's argument

One surprising aspect of Foot's analysis is that, in discussing death and the human situation, the fact that humans are mortal is not mentioned. Imagine a race of demigods who are immortal in all circumstances but one - they can be killed by their fellow beings. Some of these demigods, however, perhaps through misfortune or the caprice of some higher gods, are subject to illness. Conjure up some philosophers to these celestial realms who ponder on the difficulties of these unfortunates and wonders whether it would be moral to kill them; the arguments set out in Phillipa Foot's '*Euthanasia*' well express their ethical dilemma! But we do not live in such celestial realms, death is not a contingent event in our lives, each and every one of us must die. It is surely ironic that in Foot's discussion of euthanasia, the mortality of man not only does not play a central role but plays *no* role; such would suggest that the original statement of the problem is seriously deficient. One consequence of this omission, which goes some way to explain the tortuous nature of Foot's analysis, is that by considering death as contingent,⁶⁶ the task of showing that there are circumstances in which death is a good can *only* be satisfied by showing that in these same circumstances life is an evil. This is indeed the direction taken by Foot's analysis and is exemplified in the torture case discussed above.

⁶⁶ The treating of death as contingent implies a 'denial of death'; cf. *Conclusion 9-1* and *Conclusion 9-2*.

Foot's attempt to explicate the judgement '*Death is a good*' through an analysis of the judgement '*Life is a good*' and its exceptions is ultimately unsatisfactory. One reason for her difficulties lies in the fact that her conceptual framework is too abstract for her discussion. By beginning with the polarities '*Life is a good*' and '*Death is an evil*', she is forced to find grounds to justify these general propositions and she is not wholly successful in her search. The canvas she has chosen on which to paint her picture, is too broad; furthermore, she is forced to treat these propositions - i.e. '*Life is a good*' and '*Death is an evil*' - as logically equivalent; thus implying that once an exception to the proposition '*Life is a good*' is found this establishes that '*Death is not evil*' is not universal. Certainly 'death' and 'life' are opposites in the trivial sense that what is alive is not dead but to suggest that the assertion that '*My life is not good*' logically implies '*My death is a good*' is not only a *logical error*⁶⁷ - in the sense that one cannot deduce one from the other - but is also a *linguistic error* in that it overlooks the range of subtle psychological meanings implicit in the use of such propositions. The fact that the propositions '*My life is a good*' and '*My death is a good*' are not generally perceived to be incompatible - as is seen in the quotation following - makes this abundantly clear:

*"The more positively one evaluated life the more positively one tends to evaluate death; the less positively one views life, the more negatively one views death. An acknowledgement of our finiteness intensifies our awareness of life and acts as a force, propelling us towards the realization of our desires."*⁶⁸

Thus, there is a fundamental flaw at the heart of Foot's analysis. Had she disavowed the general proposition '*life is a good*' and '*death is an evil*', and restricted her analysis⁶⁹ solely to a consideration of the situations when death could be considered a good, her analysis might have been more fruitful. A further problem hovers in the background which seems to be a problem entirely caused by language. In asserting that '*Death is a good for X*', this '*good*' cannot wander about in a dissociated fashion but must be 'owned' - there is however no one to 'own' the death, for the X - for whom death is a good - when he receives the death, no longer *is*; one longs for the insights of a Wittgenstein to disentangle such a problem; however, it is clear that an initial step might be towards decreasing the level of abstraction so that propositions like '*Death is an evil*' and '*Life is a good*' are avoided.

Another peculiarity of Foot's analysis - and which I believe to be her most valuable contribution to the debate on euthanasia - is that the conclusion that '*X is a 'good' for Y*' (which she defines in terms of X being done '*for the sake of*' Y) and the moral obligation to do X are separated; the first does not imply the second which must be independently established; this is necessitated by her definition of '*good*' and is embodied in her conclusion that:

*"It is important to emphasise that a man's rights may stand between us and the action we would dearly like to take for his sake"*⁷⁰

This aspect of her argument is developed in Chapter 10.

⁶⁷ '*X is not-G*' does not imply that '*not-X is G*'

⁶⁸ J. D. Morgan, who was commenting on the link between attitudes to death and creativity, draws extensively on the works of Ernest Becker and Daniel Callahan considered later in this chapter; he teaches Thanatology at the University of Western Ontario and has edited *Readings in Thanatology*. Amityville: Baywood, (1996). [Internet source: <http://www.wwdc.com/death/morgan.html>].

See also: Epicurus "*The art of living well and the art of dying well are one.*" [Quoted in Schuster *op.cit.* at p.1]

⁶⁹ This criticism has more validity in relation to the first part of her essay than to the second part; see Appendix D.

⁷⁰ Foot *op.cit.* p.49.

In contrast to Foot's approach, this chapter seeks to place man's mortality centre stage. If death *must* happen to man, then the description of 'a good death' - and the moral obligation to seek it for another - arise out of the fact that, of all possible deaths for this other, this particular one is the best.

Scruton

Roger Scruton in his Modern Philosophy, argues⁷¹ that when judged from a third person perspective, death is not always an evil and that it is sometimes a good.⁷² He gives as examples:

* *Death as a rightful punishment*

Though he comments, somewhat unphilosophically:

*"Think of Hitler or Stalin: not only were their deaths good in themselves; more miserable deaths would have been even better."*⁷³

* *Death as a fitting end to a life of great undertakings*

* *Death as a liberation from suffering*

His first category requires no further comment. His second category appears to be a use of the term 'good' in an aesthetic sense in that it does not imply a moral obligation on others to ensure its achievement, an implication which is usually⁷⁴ implicit in the concept 'good' when used in its moral sense (as in his third category).⁷⁵ Scruton's discussion of death is ultimately unsatisfactory, never transcending the fear of death and the possibilities of immortality:

*"... the feeling persists that my own death is not, and cannot be, the end of me. What is the source of this feeling? ... The arguments are not conclusive, ..."*⁷⁶

Conclusions

The philosophers just considered fall into three groups in their attitude to death.

The first group, represented here by Foot and Scruton, conceive of circumstances - such as torture or severe illness - where death may be a good; this view conceives of death as a friend enabling escape from suffering; it is, however, set against a background of uncritical acceptance of the proposition '*Death is an evil*' and is tantamount to a denial of death.

The second group, represented here by Plato and Spinoza, recognise that we each fear death and may not wish to die but they argue that we must restrain our desires and fears in order that we become attuned to the *facts* of the universe. Human mortality is part of the innate structure of the world and to pretend or to hope otherwise - as happens when we speak of death as evil - is destructive of a harmonious life. Our mortality must be willingly accepted; death and life transcend the categories of good and evil.

⁷¹ Roger Scruton, Modern Philosophy, an Introduction and Survey, p.314.

⁷² This is reminiscent of the comment by the American judge (quoted in the Introduction to Part 2) who said:

"There is a strident cry in America to terminate the lives of other people - deemed physically or mentally defective ... " and also to the comment by Lord Mustill that in discussing such matters, it is essential to have in mind *"... the distinction between the right to choose one's own death and the right to choose someone else's."* [The Bland case p.886]

⁷³ *ibid.* at p.314.

⁷⁴ though not in Foot's analysis.

⁷⁵ The attitude to death suggested by Scruton's last category is well captured by the 18th century German writer Lessing who, writing on the pre-Christian attitude to death, said:

"The ancients did not picture death as the grim skeleton which haunts the dances macabres of the Middle Ages ... but as the brother of gentle sleep, with torch reversed. Death is a friend.

'Give me thy hand, thou fair and gentle creature.

I am a friend and come not to punish thee.

Be of good cheer! I am not fierce.

Thou shalt sleep peacefully in my arms.' "

[Quoted in Alfred Einstein Schubert the Man and his Music, at p.350.]

The third group represented by Jaspers, Heidegger and Derrida, assign a positive role to death, crucial to the development of individuality⁷⁷ and personal responsibility. The knowledge that I must face my own death and that, at the moment of death I will be the judge of how I have lived my life forces a recognition that *this* - and not the conventionally accepted social norms - is the standpoint to be adopted in deciding all important questions that arise in my life: I must choose so that when on my deathbed and reviewing my life, I will be proud of my choice; these choices must not be made using the norms of others as such would be an abdication of individual moral responsibility. It is from this viewpoint that Heidegger sees death as forcing a cleavage between the 'I' and the 'they', thus giving birth to a true individuality with its own tasks distinct from the tasks that 'they' consider of importance. It is from this same standpoint that Derrida argues that individual moral responsibility flows from, what he calls, '*the gift of death*'.

Others (whose views have not been discussed in this Subsection) have argued that many of the qualities that are considered to be quintessentially human - such as creativity⁷⁸ and spirituality⁷⁹ - flow from the conscious acceptance of our own mortality: our death being the very salt of our lives; the prospect of immortality, a tedium removing all sense of urgency. Judged from this perspective it is imperative that our mortality - this most fundamental of facts - must not be evaded or denied but be willingly accepted; we must, as it were, consent to our mortality.

Conclusion ₉₋₄ : *The arguments against the proposition 'Death is an evil' (simpliciter) are varied:*

- (i) *that, in times of suffering, death can be a friend. (Foot, Scruton)*
- (ii) *that human mortality is a fact of the universe and, as such, must be accepted. (Plato, Spinoza)*
- (iii) *that the gateway to an 'authentic' life which embodies individual moral responsibility, lies in the willing acceptance of our individual mortality; it is incompatible with the denial of death implicit in the proposition 'Death is an evil'. (Jaspers, Heidegger, Derrida)*
- (iv) *that the gifts of creativity and spirituality flow from, and are sustained by, a full intellectual and emotional acceptance of our individual mortality. (Becker,⁸⁰ Koestler)*

Subsection 4: Philosophical arguments asserting that death is an evil.

Thomas Nagel's arguments are here taken as being representative of philosophical arguments to the effect that '*Death is an evil*'. Nagel sets out his arguments in The View from Nowhere⁸¹ and in Mortal Questions;⁸² these arguments, and Mary Mothersill's critical response, are considered in this Subsection; for convenience, they are considered separately.

Nagel: The View from Nowhere.

The problem at the core of the chapter entitled '*Birth, Death, and the Meaning of Life*' is the disparity between the *subjective* view of a life - in which the individual is at the centre of the world,

⁷⁶ Scruton *op.cit.* p.311-2.

⁷⁷ 'individuation' (as used by Jung) would be a more accurate term.

⁷⁸ See, for example, the writings of Dr. J. D. Morgan (mentioned above) and Arthur Koestler who stated:

"If the word death were absent from our vocabulary, our great works of literature would have remained unwritten, pyramids and cathedrals would not exist, nor works of religious art. ... All art is of religious or magic origin. The pathology and creativity of the human mind are two sides of the same medal, coined by the same mintmaster."

[Quoted at <http://www.trinity.edu/~mkearl/death.html>]

⁷⁹ e.g. Joseph Campbell, Historical Atlas of World Mythology. p. xiii

"The mystery of death and the mind's requirement to come to terms with it have been everywhere the prime inspiration of spiritual inquiry and practice,"

⁸⁰ The writings of Ernest Becker are discussed in Section 2.

⁸¹ In the final chapter which is entitled '*Birth, Death, and the Meaning of Life*'.

⁸² In Chapter 1 which is entitled '*Death*'.

supreme in his importance - and the *objective* view - in which his being is utterly contingent, he is of no great moment to the wider community and of even less importance to the universe seen as a whole. From the subjective viewpoint, death is an affront, a total catastrophe; from the objective viewpoint, death is as inconsequential as the falling of a leaf.

Nagel has set himself the task of reconciling these viewpoints and of finding a philosophy which he can live by and in this he is unusual, certainly amongst English speaking philosophers. The problem he sets himself is more often considered in a religious context, it is a central theme of Eastern religions especially Buddhism; it is also the focal point of philosophies such as Spinoza's. Nagel is aware of these contributions, both of which, he believes, deny the claim of the subjective world; the Buddhist view has been commended to him by Parfit, but Nagel feels that the contemplated loss of ego would be an "... *amputation of so much of oneself ... [with] some of these cures more absurd than the disease.*"⁸³ Spinoza's solution - of attempting to see all *sub specie aeternitatis* - leads, suggests Nagel, to nihilism because from such an elevated perspective, nothing that an individual can do matters - our life and our efforts seem absurd. Nagel also rejects the opposite solution - the '*denial of the objective unimportance of our lives*'.⁸⁴

Nagel's difficulty arises because he seeks a *conceptual* answer rather than an *experiential* answer to the problems which he has posed. Buddhism, and to a lesser extent Spinoza's philosophy, are *lived* philosophies in the sense that they offer the expectation that by *living* in a certain manner, contentment - the resolution of the problem of the 'meaning of life'; the release from being in thrall⁸⁵ to the emotions - will follow; it is not suggested that such results will flow from an understanding of particular intellectual arguments.⁸⁶ Such arguments are offered only to whet the appetite, they cannot satisfy the thirst; the traditional Buddhist metaphor is that one must not mistake the finger pointing at the moon for the moon.

It is certainly true that, as Nagel argues: '*The external standpoint and the contemplation of death lead to a loss of equilibrium in life.*'⁸⁷ but it is a loss of equilibrium which is necessary because adherence to solely the subjective viewpoint is based on an unsustainable fiction. The growing child, in shedding its innocent belief that '*God's in his heaven and all is right with the world*', also suffers a loss of equilibrium but it is a loss which is equally necessary; out of this loss a new point of balance can be achieved and a new equilibrium developed but based this time on more secure foundations. To argue otherwise is to constrict our consciousness and our intellectual, and ethical, development.

Nagel is finally driven to believe that there is no credible way of resolving the inner conflict.⁸⁸ However, - as in an afterthought - he finds a resolution in the '*nonegocentric respect for the particular*'⁸⁹ as occurs, for example, when one loses oneself in music, in art, or in the simple pleasure of life; as Nagel says "*One can simply look hard at a ketchup bottle ...*"⁹⁰ The huge irony is that this resolution of Nagel's - *i.e.* the immersion in the 'particular' or, in an alternative formulation, an immersion '*in the present moment*' - is, unknownst to Nagel, precisely the core Buddhist practice of '*mindfulness*'; the ability to rest in this state, is '*egolessness*'.

⁸³ Nagel, *The View from Nowhere*. p.219.

⁸⁴ *ibid.*

⁸⁵ The '*human bondage*' of which Spinoza speaks.

⁸⁶ No more so than a thorough intellectual grasp of the principles of art, makes one into an artist.

⁸⁷ Nagel, *The View from Nowhere*. p.210.

⁸⁸ *ibid.* p.221.

⁸⁹ *ibid.* p.222.

⁹⁰ *ibid.* p.222.

For Nagel, however, this is only a temporary respite; in discussing 'death'⁹¹ the conflict between 'subjective' and 'objective' views re-emerges in full vigour:

*"... death is nothing, and final. I believe there is little to be said for it: it is a great curse, and if we truly face it nothing can make it palatable except the knowledge that by dying we can prevent an even greater evil."*⁹²

He then explains that 'death is a bad thing' because

*"Life can be wonderful, but even if it isn't, death is usually much worse. If it cuts off the possibility of more future goods than future evils for the victim, it is a loss no matter how long he has lived when it happens. death is a misfortune even when life is no longer worth living."*⁹³

On these grounds Nagel asserts that death is worse than unconsciousness because the latter 'includes the possibility of experience'.⁹⁴ It is difficult to fully disentangle Nagel's reasons for regarding death as an evil. One reason lies in the suggestion that the possibility of experience is an *unconditional* good and death in destroying this possibility is an evil - but what about the practice of anaesthesia? A second reason is that death shatters the subjective view of the world and creates a disharmony - but does the fact that maturity shatters the illusions of childhood imply that maturity is evil? A third reason - though hardly distinct - is that 'for each person his death is awful' but this seeks to prove the evil of death from the desire for immortality:

*"... given the simple choice between living for another week and dying in five minutes I would always choose to live for another week; and by a version of mathematical induction I conclude that I would be glad to live for ever."*⁹⁵

To seek to prove from the existence of desire, the goodness of that which is desired seems fatuous. Is my lack of unlimited wealth an evil? Surely a more subtle analysis is required.

Toward the end of this essay Nagel does acknowledge that:

*"... human death itself is a given which like the fact that hawks eat mice, it makes no sense to deplore."*⁹⁶

But this is dismissed as it offers no consolation to one about to die. Nagel concludes his essay on a note of abject defeat:

*"When we acknowledge our containment in the world, it becomes clear that we are incapable of living in the full light of that acknowledgement."*⁹⁷

Certainly, if this essay has been a walk around 'Mount Nagel,' the most charitable thing to be said is that the mountain has been covered in mist.

⁹¹ i.e. as distinct from the conflict between the subjective and objective views of life which was the focus of the earlier part of the discussion.

⁹² *ibid.* p.224. That, to which he refers in speaking of the 'greater evil', is not clear; it may be dying in the defence of another.

⁹³ *ibid.* p.225.

⁹⁴ Such a perspective would imply, for example, that patients who were in severe pain but who were terminally ill, but incompetent to decide on treatment withdrawal, should wherever possible be kept alive.

⁹⁵ *ibid.* p.224.

⁹⁶ *ibid.* p.229.

⁹⁷ *ibid.* p.231.

Nagel: Mortal Questions.

Nagel's treatment of the proposition '*Death is an evil*' in Mortal Questions is not dissimilar from the earlier discussion in The View from Nowhere; though more rigorous and focused, it is none the less equally unsatisfying.⁹⁸ He first considers why death is an evil, then turns to address some of the logical problems associated with his suggested solution, before finally dealing with the problem of whether it is meaningless to speak of death being evil in view of its biological inevitability.

In order to simplify the problem when discussing '*Death is an evil*' Nagel only considers the individual's attitude to his own death, not the suffering it may cause to others. He does not believe in any after-death existence so the evil of death must be accounted for, not in terms of its positive features, but in terms of what it deprives us of *i.e.* life. Nagel draws further support for suggesting that the core meaning of '*Death is an evil*' is to be found not through a contemplation of death but through an analysis of life, by observing:

- * that in judging that '*life is a good*', it is not the *state* of life that makes it a good but what that state 'contains'. Equally⁹⁹ the assertion that '*death is an evil*' is not because of any properties of the *state* of death but because of the absence of goods, and the absence of life which is their precondition.
- * that life, '*like most goods*', follows the principle that '*more is better*'.¹⁰⁰ In contrast to suggest that, of death, '*more is worse*'¹⁰¹ is meaningless.

The first of these observations implies that 'good' does not attach to 'mere organic survival' as:

*"... almost everyone would be indifferent (other things being equal) between immediate death and immediate coma followed by death twenty years later without reawakening."*¹⁰²

So life is a good, Nagel argues, not because of life, *qua* life, but '*life as possibility*' to permit the experiencing of the 'goods'¹⁰³ of life. The 'good of life' is not, however, to be identified with the possession of the 'goods of life' because these 'goods of life'- though normally thought of as conferring benefits - may cause misery, thus raising the question as to whether there may be a net balance of evil in a life and thereby threatening the universality of the proposition '*Life is a good*'. Nagel resolves this problem by arguing that experience itself '*is emphatically positive*' and thus, though undergoing terrible experiences, it is still '*a good*' to be alive.

Nagel's conclusion at this point is that '*Death is an evil*' because of '*the desirability of what it removes*'¹⁰⁴ which is not life, as such, but the possibility of experience. Nagel then turns to examine some problems associated with his proposed solution. He identifies three such problems:

- (i) Since death (as distinct from dying) is not unpleasant, how can it be accounted as bad for someone?

⁹⁸ Nagel's test for a proposed solution to a philosophical problem, actually being a solution is:

"... if a neat solution to a problem does not remove the conviction that the problem is still there ... then something is wrong with the argument and more work need to be done." (Nagel, Mortal Questions p.x)

Nagel appears to believe that the problems of life (and death!) are resolvable through argument and analysis; presumably, (and *apropos* Diogenes' argument mentioned in Section 1) he can satisfy his hunger by rubbing his books!

⁹⁹ The structure of Nagel's argument is by no means clear at this point; the argument appears to be that '*Death is an evil*' is not an independent ethical judgement but a *derived* proposition, logically equivalent to '*Life is a good*'; in short, '*Death is an evil*' '*≡ (df.) 'Life is a good*'

¹⁰⁰ His acceptance of this principle - thought not acknowledged to be so by Nagel - is *determinative* of death being an evil. See also:

"If death is an evil at all, it cannot be because of its positive features, but only because of what it deprives us of."

(*ibid.* p.1)

¹⁰¹ *e.g.* Shakespeare has received a greater portion of death than Proust because he is dead longer. *ibid.* p.3

¹⁰² *ibid.* p.2.

¹⁰³ Perception, desire *etc.*

- (ii) There is no subject to whom the misfortune can be assigned.
- (iii) There is an unaccounted for, asymmetry¹⁰⁵ between attitudes to posthumous and prenatal existence.

Nagel's account of death has problems of such a magnitude that to inquire into the difficulties posed by the asymmetry between attitudes to pre-birth and to post-death is not only an indulgence but a presumption; they will not be discussed further. Nagel attempts to resolve the other difficulties by insisting that the judgement of good or evil must not be restricted to immediate circumstances but must be judged *relationally*, i.e. in relation to the history and alternative possible developments of the individual concerned. Nagel takes the example of an intelligent and successful person who suffered severe brain damage in an accident; nonetheless he is now happy in his present, but simple, circumstances; can we say that the accident was for *him* an evil, and if so why? Nagel's solution is that the accident was an evil because it deprived him of what he *could* be, it is an evil *in relation* to his possible life. Nagel concludes that we are justified in calling death an evil in relation to the possibilities which might have been had death not existed; furthermore, the evil does not need a 'current owner' to be so described.

Nagel finally turns to consider the objection that it is meaningless to speak of death being evil in view of its biological inevitability:

*"Blindness or near-blindness is not a misfortune for the mole nor would it be for man, if that were the natural condition of the human race."*¹⁰⁶

Nagel attempt to counter the objection by saying :

*"A man's sense of his own experience ... does not embody this idea of a natural limit. His existence defines for him an essentially open ended possible future ... Viewed in this way, death, no matter how inevitable, is an abrupt cancellation of indefinitely extensive possible goods."*¹⁰⁷

To pursue Nagel's analogy, imagine an Adrian Mole born with a talent far outstripping his fellow moles. He takes to writing and in one of his novels, by a huge leap of the imagination, he succeeds in conveying the idea of farsightedness. This idea fascinates his fellow moles and they deeply desire such a gift. Is there lack of farsightedness to them *now* a misfortune and their near-blindness *now* an evil simply because they now desire it?

The banality of Nagel's reasoning is also made clear by imaging that one is sitting at a sumptuous banquet, gorging on the finest of foods which are presented course upon course in seemingly never-ending variety, *must* one conclude that the fact that a banquet has an end, is evil?

Summary of Nagel's Arguments

There are two limbs to Nagel's argument that '*Death is an evil*' :

- (i) That in establishing '*Life is a good*', he determines '*Death is an evil*'.

This is an error that Nagel shares with Foot. That it *is* an error can be seen by noting that one can simultaneously assert that '*Life is a good*' and that '*Death is not an evil*' without breaching any rule of logic. Unlike Foot, Nagel at least recognises this and offers the

¹⁰⁴ *ibid.* p.4.

¹⁰⁵ No one finds it disturbing to contemplate the eternity before his own birth and to complain about the 'lack of goods' in that state. In The View from Nowhere (*op.cit.* p.228) Nagel mentions that Lucretius found in this asymmetry an argument against regarding of death as an evil; however, it does not convince Nagel.

¹⁰⁶ *ibid.* p.9.

principle that, of a 'good', one can say '*more is better*' which - if true - would be logically sufficient, in conjunction with '*Life is a good*', to establish '*Death is an evil*'.

But the principle is not true. Pleasure is indeed a good, but one can have a surfeit of pleasure which quickly turns to pain.¹⁰⁸ Thus, *at best* Nagel establishes that '*Life is a good*' unconditionally; but to do this he has had to assert that *all* experience - even that of the terminally ill man wracked by pain - is a good.

- (ii) That because death offends our deepest desires it must be an evil.

The barrenness of this argument can be readily seen by slightly transposing it. Consider a youth who wanted to be the greatest philosopher who ever lived. Middle age brings him up against the hard realisation that this is not to be. He has two options. He can try to accept the reality of the situation and acknowledge that his talents are quite limited, or he can insist that his not being acknowledged as the greatest philosopher the world has ever known is an evil. The second path is hardly to be commended.¹⁰⁹

Mothersill: Death¹¹⁰

Mary Mothersill's argument is a three-pronged attack on Nagel's analysis of the evil of death.

Mothersill first considers Nagel's assertion that '*death is a misfortune for the one who dies*' and seeks to disentangle its sense. In furtherance of this she attempts to use the tools of formal logic. Because Nagel's formulation of his argument was, at best, tentative and not expressed with a precision sufficient to even contemplate it's being formalised, Mothersill's response is inappropriate and unhelpful.

Mothersill then turns to Nagel's question "*Is it a bad thing to die?*" Nagel had radically distinguished between the propositions "*I am going to die*" and "*They are going to die*" and concluded that they belonged to irreconcilable perspectives: from the objective perspective we could readily accept the death of another, judging even that it was a good thing; from the subjective viewpoint, however, our own death is unacceptable, an unparalleled disaster. Because these viewpoints are so disparate, Mothersill concludes that, not only can there be no general answer to Nagel's question, but "... *there can be no general question: 'whether it is a bad thing to die.'*" To Mothersill, the very posing of the question is but an interesting psychological aberration.¹¹¹ However, she does accept that some individuals, through confronting their own death, transcend this '*conjunction of callousness and self-pity*'¹¹² and are able to extend deep compassion to others who are dying. They have already faced their own death and, having recognised the truth of Donne's "*Ask not for whom the bell tolls, it tolls for thee*", can speak from within that wisdom.

¹⁰⁷ *ibid.* p.9 -10.

¹⁰⁸ A comment by Alan Watts (which was mentioned earlier in Chapter 3, Section 2 when discussing pain judgements) may clarify this:

"What we feel is to an enormous and unsuspected degree dependent on what we think, and the basic contrasts of thought ordinarily strike us as the basic contrasts of the natural world. We therefore take it for granted that we FEEL an immense difference between pleasure and pain. But it is obvious in some of the milder forms of these sensations that the pleasure or the pain lies not so much in the feeling itself as in the context. There is no appreciable physiological difference between shudders of delight and shudders of fear ... but the context of the feeling changes its interpretation, depending on whether the circumstances which arouse it are for us or against us."

[Alan Watts, *Nature, Man and Woman*, p.86]

¹⁰⁹ A similar point can be made in relation to those dissatisfied with their bodies which, they believe, offend in some way against their ideal of beauty; *must* one agree that, to them, their bodies are an evil? Is not the ancient wisdom which urges them to learn to accept and love that which you cannot change, to be preferred?

¹¹⁰ Mary Mothersill. '*Death*' included in Rachels (ed.), *Moral Problems*. (editions prior to 3rd).

¹¹¹ *ibid.* p.377; see also:

"Of course, Nagel's question - 'Is it a bad thing to die?' - is itself rather mystifying. Nagel says it is a question that 'arises.' Does it? ... What I think has happened is that Nagel has tried to transform a peculiar and interesting psychological phenomenon into a disputed point of theory." (*ibid.* p.375)

Mothersill's redirection of the discussion is useful as it suggests that the question "*Is it a bad thing to die?*", rather than being posed in the expectation of a factual answer, is really an injunction to come to terms with one's own mortality.¹¹³

Mothersill's third point of criticism relates to the inference that Nagel draws from the existence of a 'fear of death', and this will be considered in the next section. She concludes her article by giving her own thoughts on whether '*Death is an evil*': death is not subjectively inconceivable and the ability to face death with equanimity is a trait '*useful to oneself and others*';¹¹⁴ she allows that in certain circumstance '*it may be a good thing to die*'.¹¹⁵

Conclusions

Nagel's argument that '*Death is an evil*' reduces either to the assertion that experience is *unconditionally* a good (which is difficult, if not impossible, to sustain) or to the assertion that death is an evil because we have the desire for immortality. Spinoza, who also believed that the good *is* that which is desired, tempered this definition with the realisation that, in order to live a harmonious life, desires must be tempered to accord with reality. Considering for a moment, the equation:

$$\text{'the good'} \equiv (\text{df.}) \text{'that which is desired'}^{116}$$

Spinoza does not consider that his insights apply to the left hand side of the equation - which would have the result that he was offering intellectual arguments for a redefinition of '*the good*' to coincide with '*that which is desired and is attainable*'.¹¹⁷ rather his insights are directed at the right hand side of the equation and are in the nature firstly, of a recognition that desires are of their nature limitless and unbounded and (because of this) secondly, of an injunction that they must, for our own sakes, be restrained *at least* to the extent that the impossible is not desired. The achievement of whatever freedom there is lies in a fettering of desire because desires are the creators of the '*human bondage*' of which Spinoza speaks. It is important to recognise that Spinoza offers a programme to be *lived* and not just a rational argument to be *apprehended*.

Conclusion₉₋₅ : Arguments, such as Nagel's, that '*Death is an evil*' because we desire immortality gives precedence to desire over reality; as such they are hardly to be commended on rational grounds.

Subsection 5: The Fear of Death

The concepts of '*fear*' and '*death*' are connected in traditional philosophical discourse in two ways:

- (i) in the assertion that the fear of death is irrational.
- (ii) in the assertion that the very existence of the fear of death implies that '*Death is an evil*'

¹¹² *ibid.* p.376.

¹¹³ In Section 2 of this chapter it will be argued that the acceptance of the proposition '*Death is an evil*' bespeaks a '*denial of death*', a refusal to fully accept - both intellectually and emotionally - one's own mortality, thus implying a similar injunction; see also Conclusion₉₋₂ : The predicates 'good' or 'evil' cannot meaningfully be applied to 'death' without further qualification. The assertion that '*Death is an evil*' (simpliciter) implies a denial of death in that it implies a refusal to accept human mortality.

¹¹⁴ *ibid.* p.379 and which she attributes to Hume.

¹¹⁵ *ibid.* p.383.

¹¹⁶ i.e. that they are equal by definition.

¹¹⁷ This was the argument proposed in Subsection 1.

The fear of death is irrational

The argument that the fear of death is irrational is exemplified in the following excerpts from classical literature:

Epicurus: "That most frightful of evils death is nothing to us, seeing that when we exist death is not present, and when death is present we do not exist." ¹¹⁸

Lucretius: "So, if we are to experience sadness and pain in the future our true selves must exist at that time for such thing to befall us. Death, however, rules this quite out and prevents there from being ever the person again who can feel this complex of suffering. Therefore we know for sure that death can bring us no terrors, ..." ¹¹⁹

Bacon: "Men fear death, as children fear to go in the dark ... [but] there is no passion in the mind of man, so weak, but it mates, and masters the fear of death; and therefore death is no such terrible enemy, ..." ¹²⁰

Mothersill considers the argument of Epicurus - and other similar arguments - to be nothing other than a rhetorical device to console the minds of those who, not only anxious about death, were also overtroubled by the fear of an afterlife. She suggests that to regard it as logical argument - as Nagel did - is a mistake because: "*It is a textbook example of the Fallacy of Equivocation.*" ¹²¹

It is certainly true that some fears can be dispelled by the giving of information; for example, in explaining to one that a blemish which he fears is cancerous, is merely benign, his immediate fear of dying of cancer is dissipated. However, this dispelling of fear by information or argument is as immediate as is a lighted torch in expelling the dark; it does not occur by act of will. Consequently the argument that, in face of certain information, a fear is '*irrational*' is as beside the point as is the argument to a hungry teenager that they cannot be hungry because they have just eaten: the child is hungry and his hunger will not be fed by information. The conclusion to be drawn from the continuance of the fear is that the information or argument, is not apposite to the fear, not that the fear is somehow '*irrational*'. The arguments on the irrationality of fear presuppose that fear can be removed by act of will and that a rational argument to the effect that the fear is inappropriate is the sole precondition for this act of will - but fear is *not* removable by act of will.

The arguments that the fear of death is irrational, face a much more powerful challenge from a distinction made by the Existentialists, than from formal logical analysis. Heidegger's distinction between '*anxiety*' ¹²² and '*fear*' - anxiety connoting a fear without a specific object - allows the '*fear of death*' to be seen as but the mask for the anxiety or ontological insecurity which is the lot of all humans in the face of existence. If '*fear of death*' is really '*anxiety in the face of being*' then appeals to rationality and proportionality are obviously vacuous.

¹¹⁸ Lloyd *op.cit.* p.117.

¹¹⁹ Warner *op.cit.* p.164.

¹²⁰ Francis Bacon, Essays: '*Of Death*'

¹²¹ Rachels, Moral Problems, p.379:

"Either, the conclusion 'Death is nothing to us ... repeats the premise 'When we are, death is not come ...', in which case there is no inference, or else the conclusion 'Death is nothing, i.e. a matter of indifference to us' is a nonsequitor."

¹²² See also Kierkegaard's concept of '*dread*':

"One almost never sees the concept dread dealt with in psychology ... it is different from fear and similar concepts which refer to something definite, whereas dread is the reality of freedom as possibility anterior to possibility. One does not therefore find dread in the beast, ..."

[Søren Kierkegaard. The Concept of Dread quoted in Kaufmann *op.cit.* p.101]

Conclusion ₉₋₆ : Arguments that the fear of death is 'irrational' presume that, for a fear to exist, it must have rational grounds and that, once the 'irrationality' of the grounds are demonstrated, the fear can be vanquished by an act of will. Fear is not removable by an act of will and the distinction made by the Existentialists between 'anxiety' and 'fear' show that questions of rationality are inappropriate in discussing the fear of death.

The existence of the fear of death implies that 'Death is an evil'

The principal underlying this implication is that

*'It is a sufficient condition for something to be an evil to X, that it be feared by X.'*¹²³

Thus, for example, punishment is an evil to the criminal because it is feared by him. Can we say that *all* events which are feared are evil? Getting old (disassociated from all ideas of death) is feared, it is an evil?¹²⁴ From such a perspective the rites of passage of many societies would be judged to be evil because they are greatly feared by those who must undergo them; the fact that, in retrospect, these rites are considered to have been beneficial appears to be of no relevance to the conclusion.¹²⁵

To equate evil with that which is presently feared removes the possibility of finding a secure stable foundation on which to build ethical values; furthermore, in recognising that fear can be a chimera which quickly vanishes of its own accord, and that that which is feared can - once it has occurred - be seen to have been of benefit,¹²⁶ it is clear that fear is not a reliable indicator of the presence of evil. To overcome the problem of fear without harm, it is possible to amend the principle:

'It is a sufficient condition for something to be an evil to X, that it is feared by X and that it may probably harm X'.

¹²³ This is similar to the earlier argument that that which is desired is a good. William James' aphorism that '*fear is fear of the universe*' [quoted in Ernest Becker (1973) at p.145] would, if true, elegantly and effectively dispose of this argument.

¹²⁴ Kübler-Ross (1975) p.27 mentions the Trukese Indians who believe:

"... *life ends when you are forty; death begins when you are forty.*"

¹²⁵ The relationship between 'fear' and 'harm' can be made clearer: fear exists because of a challenge to the *existing* ego; it is nothing but the apprehension felt at the prospect of a change adjudged to be threatening. However, the ego in order to mature must change to accommodate the wider world; to attempt to refuse change would be the road to psychosis; one consequence of this is that events which threaten the ego at one stage - and cause fear - are seen at a later stage - and by a more mature ego - to have been beneficial; the events themselves having been the cause of the maturing of the ego. This would imply that any direct correlation of 'fear' and 'evil' is simplistic.

The relationship between fear and evil is explored in Buddhism and in the philosophy of Spinoza. The Buddhist belief is that 'fear' and 'ego' are mutually independent ideas and that with maturity towards 'egolessness' fear will necessarily disappear. Spinoza's philosophy implies that, when all is judged from the perspective of the universe as a whole, neither 'threat' nor 'evil' nor 'fear' nor 'harm' can exist as these are, at best, relations between parts of the universe, originating when one part presumes to a preeminence or to an unchanging status; they cannot be meaningfully asserted of the whole. Taoist philosophy expresses a similar attitude:

"The profound and intelligent man, identifying himself with change itself, would be quiet at any occasion and follow any course. He is at one with evolution; he is everywhere. To him there is neither gain nor loss, neither death nor life. ... Whenever there is attachment, there is bondage."

[Fung Yu-Lan. *Chuang-Tzu: A Taoist Classic*. p. 62.] The similarity to the philosophy of Spinoza is clear.

¹²⁶ cf. Kierkegaard's attitude to despair (elaborated in his *The Sickness unto Death*):

"... despair is that sickness of which it is true that it is the greatest bad fortune never to have had it; ... " [ibid. p.56]

"The relation between ignorance and despair is like that of ignorance to dread ... the dread in a spiritless person is recognisable precisely in his spiritless sense of security. ... Despair is itself a negativity, ignorance of it a new negativity." [ibid. p.74]

"A human being is a synthesis of the infinite and the finite ... Looked at in this way a human being is not yet a self. ... That is why there can be two forms of authentic despair. If the human were self-established, there would only be a question of one form: not wanting to be itself, wanting to be rid of itself." [ibid. p.43]

Though such a usage of the terms 'good' and 'evil', where their meaning is strictly circumscribed by narrow self interest, is counter to traditional ethical understanding, it is certainly logically possible. Indeed, Spinoza used the terms in just such a sense, Lloyd comments:

*"Self-preservation becomes for Spinoza the foundation and end of virtue. The continuation of existence ... becomes ... the good itself. The dichotomy between self-seeking and altruism here falls away. Self-seeking - traditionally opposed to rational virtue - now becomes its foundation."*¹²⁷

However, to Spinoza, the judging of 'good' and 'evil' in terms of narrow self interest was a provisional position. The practice of philosophy, he suggested, leads one to conceive of the interconnectedness of all, and to understand that the only tenable perspective from which to act in seeking a harmonious life was not that of a narrow self interest but that of the universe *sub specie aeternitatis*. Thus, in accepting 'self interest' as the basis for ethics, one was lead away from construing this self interest in a narrow individualistic fashion - simply because to act in such a fashion was destructive of one's inner harmony - and towards a more all embracing interpretation.¹²⁸ Using Nagel's terminology, Spinoza's argument is that the subjective perspective can only find its full expression within the objective framework. Attempts to insist on the primacy of the subjective perspective - being nothing but presumption doomed to failure - are ultimately destructive of self interest.

Conclusion 9 - 7 : *Arguments which seek to establish deduce the evil of some particular occurrence from the fact that it is feared, trivialise the concept of evil.*

Section 2: Manifestations of the denial of death.

In Section 1 it was argued that the proposition '*Death is an evil*' is, if unqualified, untrue; the goal of this Section is to establish the same conclusion though working this time from a psychological, rather than philosophical, direction. It is argued that to assert '*Death is an evil*' is to be involved in - what Ernest Becker terms - the '*denial of death*' and that such a denial is no less injurious to the human spirit than the denial of sexuality. This implies that there is not only a philosophical necessity, but a *psychological necessity*, to reject the proposition '*Death is an evil*'.

Medical attitudes to death are of particular relevance in the making of 'end-of-life' decisions, indeed they are often determinative of such decisions. Because physicians are more intimately connected with matters of life and death than members of any other profession, it seems strange to suggest that death denial might be prevalent in clinical medicine; yet Elisabeth Kübler-Ross and Daniel Callahan¹²⁹ have persuasively argued that the 'denial of death' is not only prevalent but a well nigh universal phenomenon of clinical medicine. J. D. Morgan who is an academic and medical doctor, suggests as a possible reason, the hubris often found amongst medical clinicians which, he argues, is not unconnected with certain religious attitudes:

¹²⁷ Lloyd *op.cit.* p.9.

¹²⁸ Eastern religions consider the path to truly ethical action as being found, not through acts *against* self interest - the common Western view - but rather through attempts to enlarge the concept of self. Once the 'self' is sufficiently all-embracing (so that the actor sees himself in all others) there is no need for ethical rules: to act out of an enlightened self-interest or compassion, is sufficient. This may help explain the Buddhist emphasis (also found in philosophy of Schopenhauer) on developing compassion rather than on following rules of 'right' and 'wrong' conduct.

¹²⁹ Kübler-Ross and Callahan's views are discussed in detail in this Section.

*"Medicine and religion have much in common. Both address the fears of humanity and the meaning of events surrounding life and death. Religion has responded to these needs by constructing theologies; medicine, by providing a scientific theory of health and sickness. Labelling a biological state as a disease is akin to declaring that there is an evil that ought to be eliminated. The rescue fantasy, that one can 'snatch the patient away from the jaws of death', is an important part of medical culture and the popular folklore about physicians. As Becker has pointed out, all power is ultimately viewed as power over death; thus the conceptions of the physician's powers flow from the view that medicine is a priesthood with power over evil. Cardiopulmonary resuscitation is an example of the rescue fantasy becoming a reality."*¹³⁰

It is clear that the medical attitude to death as portrayed by Morgan finds its intellectual underpinning in the proposition '*Death is an evil*', precisely the same proposition that, as we have seen,¹³¹ underlies the Christian attitude to death. Because of this coincidence, the medical attitude appears to have a familiarity and naturalness which successfully masks the poverty of the intellectual foundations on which it rests. Morgan also suggests that the contemporary view of death in the West is that every death is *contingent*, a matter of chance, and that, in principle, there is no reason why any particular injury or disease cannot be overcome. An extreme example of such an attitude is found in the World Health Organisation's refusal to admit '*death by old age*' as a category in its medical statistical analysis into the causes of death.¹³² These attitudes are not confined to a medical elite but are common throughout society; Ernest Becker - the most influential writer on this subject¹³³ - has called this cluster of attitudes¹³⁴ the '*denial of death*'.

To simplify presentation of theories concerning the denial of death, I will first consider the 'denial of death' as a phenomenon found in society as a whole [in Subsection 1]; and then the denial of death as manifested in clinical medicine [in Subsection 2]. The concept of 'a good death' will arise naturally from attempts to incorporate the inevitability of death into clinical medicine.

Subsection 1: What is the 'denial of death'?

Freud recognised that any explanation of the human condition must take account of both sexuality and death as these are the very poles around which the constellation of life revolves. As a consequence of Freud's work it has now become a commonplace to talk of the repression, or denial, of sexuality. Furthermore it is possible to examine both the *manifestation* of a denial of sexuality - as in the refusal to acknowledge female sexual desire in Victorian society - and the *consequences* of such denial - as in the inappropriate 'resolution' of some social problems.¹³⁵ However, Freud's insights into the importance of death have not received the same attention, particularly from lay audiences.

¹³⁰ J. D. Morgan, Attitudes Toward Death. [Internet source: <http://www.wwdc.com/death/attitudes.html>.]

Morgan continues:

"Cardiopulmonary resuscitation was developed for a select group of patients with temporary cardiac arrhythmias who would die without resuscitation. The procedure became standard practice and now the presumption is that no one should be allowed to die in a hospital without an attempt at resuscitation even though less than 20 percent survive."

¹³¹ Section 1, Subsection 2.

¹³² Mentioned in a Sunday Times Editorial (22-3-98).

¹³³ In speaking of Becker, Kübler-Ross [1975, p.143] says:

"Ernest Becker, the author of 'The Denial of Death' died a few weeks after I was privileged to review his manuscript. He finished a true masterpiece a few weeks before he died."

¹³⁴ i.e. that '*Death is an evil*' and that '*Death is contingent*'.

¹³⁵ e.g. the response to pregnancy outside marriage ranged from forced adoption to - for a second 'offence' - incarceration in a mental hospital.

Jung, even more so than Freud, recognised the most profound consideration that must be paid to the *'irresistible approach of King Death'*:

*'As a physician I am convinced that it is hygienic to discover in death a goal towards which one can strive; and that the shrinking away from it is something unhealthy and abnormal which robs the second part of life of its purpose.'*¹³⁶

Anthony Clare goes even further and suggests that death, rather than sex, is the fundamental concept of modern psychology:

*"Sex and death are seen in many cultures as rites of passage of equal importance; psychology is conventionally associated in the public mind with an openness, even a preoccupation, concerning sex whereas in truth the whole of modern psychology could be said to arise from thoughts about death."*¹³⁷

Clare notes that this is the reverse of current lay perceptions where not only is 'sex' given a preeminent position as an explanatory concept for analysing modern society but discussion of 'death' is considered to be either an embarrassment or morbidly unhealthy.¹³⁸ Such attitudes are not universal; other cultures (such as Buddhist and monastic Christian) hold the belief that it is through the perpetual awareness of death - not death in some abstract sense but *our own individual* death - that life finds its true value; such cultures believe that such an awareness fosters a respect for the fragility of life and its transience, and turns the focus of life towards living the present moment to the full.

If, as is suggested, the role of death as an explicatory concept is unacknowledged in our culture, then we are no less involved in a denial of death than was Victorian society in a denial of sexuality.¹³⁹ Recognising that the Victorian denial of sexuality led to the inappropriate treatment of certain problems, we may well ask what are the inappropriate patterns of behaviour which now occur because of *our* 'denial of death'; the area of *'treatment withdrawal resulting in death'* is an obvious candidate for exploration. In attempting to answer this question the views of Becker and Kübler-Ross are of considerable assistance; however, because both Becker and Kübler-Ross explain the denial of death by situating it within a wider theoretical framework, it is convenient to consider their views separately.

Becker and the denial of death

Ernest Becker argues that death is a symbol for the entire spectrum of adult anxiety and that our unwillingness to fully accept our mortality is the fundamental problem of human psychology.¹⁴⁰

Becker, in the preface to the work for which he is most famous, wrote:

¹³⁶ Quoted in Joseph Campbell *The Masks of God: Volume 1, Primitive Mythology*, p.123-31.

¹³⁷ Anthony Clare, *'Death and Dying'* in Colm Keane (ed.) *Death and Dying* p.15.

¹³⁸ Clare, *op. cit.* p.20:

"Ours is a culture that has been accused of being evasive in the face of death. We use euphemisms for death itself ... The real loss of innocence is not a child's discovery of sex but of death, of his or her own mortality."

see also his comments in The Irish Times [1.7.1998]:

"... exploration or analysis of death ... was not morbid but was the very essence of life ... to see and face death and to go on living was to live enriched."

¹³⁹ It is indeed ironic that, although discussion of sexuality was a taboo amongst Victorians, discussion of death was not. Callahan refers to an article by Geoffrey Gorer entitled *'The pornography of death'* (1955) which called attention to the peculiar way in which Victorian sexual constraints were gradually overthrown but those same constraints were subsequently used to suppress the public expression of death.

[Daniel Callahan. *The Troubled Dream of Life: Living with Mortality*, p.30.]

¹⁴⁰ Daniel Liechty. *Transference and Transcendence: Ernest Becker's Contribution to Psychotherapy*, p.103.

*"... the idea of death, the fear of it, haunts the human animal like nothing else; it is a mainspring of human activity - activity designed to largely avoid the fatality of death, to overcome it by denying in some way that it is the final destiny for man."*¹⁴¹

Becker does not mean by this that we are directly motivated by the fear of death and that in consequence we consciously adopt stratagems to avoid facing this fear; quite the contrary, he believes that the fear of death is so shattering to human pretensions that it cannot be acknowledged; his argument is that the postulation of such an unacknowledged fear makes many human actions wonderfully clear. This is precisely the approach adopted by Freud who did not suggest that the Victorians wilfully denied the sexual content of certain experiences, but rather that the hypothesis of sexual repression was a powerful unifying explanatory mechanism for aspects of Victorian society which were otherwise left without adequate explanation. It is Becker's thesis that awareness of death, the anxiety that this provokes and the strategies that people devise to deal with the anxiety are at the very core of why we act the way we do.¹⁴²

Becker sees the fear of death as being closely connected to man's unwillingness to accept his 'creatureliness' :

*"... his abject finitude, his physicalness, the likely unreality of his hopes and dreams."*¹⁴³

He sees the beginnings of this in the child's awareness that it cannot have complete control over its body. Liechty describes the child's situation:

*"In the course of the oedipal transition, the child comes to see the body as an object to be controlled in the interests of symbolic modes of self-esteem maintenance. ... But [the body] also represents the major and primary threat to the child's sense of ego mastery. ... [leading to] The self scolding of a child for temporarily losing control of the body ... The child is horrified by its own animal condition and in scolding this animal part ... regains the sense that the symbolic self, the 'true me', will have mastery over the animal."*¹⁴⁴

Becker - in portraying the mental torture of man unable to accept the 'grotesque contradiction' between his view of himself as a spiritual being and the hard fact of his animality - humorously quotes a poem by Swift about a young man and his beloved who was named Caelia:

*"Nor wonder how I lost my Wits;
Oh! Caelia, Caelia, Caelia shits!"*¹⁴⁵

To Becker, the refusal of man to accept his basic animal condition - and the mortality that is the necessary corollary of such an acceptance - is, rather than sexuality, the primary repression. The death denial - like Victorian sexual repression - is an ineffective strategy in that the unacknowledged problem does not disappear but reappears in another guise (as has been well documented in cases of repression of sexuality). This immediately raises the question: What are the manifestations of 'denial of death' ?

¹⁴¹ Ernest Becker. *The Denial of Death* (1973) p. ix.

¹⁴² Liechty, *op.cit.* p.102.

¹⁴³ Becker (1973) p.33. Cartesian dualism is a paradigm of man's refusal to accept his 'creatureliness'.

¹⁴⁴ Liechty p.56-7. Becker notes (*op.cit.* p.37) that "... 'paradoxically' 'children toilet train themselves'."

¹⁴⁵ Becker [1973, p.33]; this finds an echo in Montaigne who, in speaking of royalty, observed that 'even on this highest throne they are seated on their arses.'

The most concrete manifestation of the denial of death is either '*frenetic activity*'¹⁴⁶ - actually a physical flight from death - or the insistence that one be '*in control*' of one's life. Becker also suggests that the answer lies in - what he terms - '*causa sui projects*': those strategies which man uses to deny his mortality by seeking an identification with something - such as nation, religion, work or children - which will permit a continuation of some replica of himself. Liechty calls these '*immortality strategies*'¹⁴⁷ and suggested that Becker viewed '*such immortality striving as the very source of human evil*'¹⁴⁸ although Liechty himself took a less extreme position. *What then is to be done?*

The most obvious response is to recognise that it is not death, but the denial of death, that is an evil.¹⁴⁹ On a more personal level, Becker argues for the necessity for 'self mourning' and for resigning oneself to one's creatureliness;¹⁵⁰ Liechty - drawing on the work of Kübler-Ross - urges that one should '*make awareness of death an ally in life*';¹⁵¹ he quotes Becker as stating:

*"The incorporation of death into life enriches life; it enables individuals to extricate themselves from smothering trivialities, to live more purposefully and more authentically."*¹⁵²

This is a perspective which finds support from psychologists such as Stanislav Grof:

*"Once people confront death and the impermanence of everything on an experiential level they frequently start seeing all of their present life strategies as being erroneous ... The experiential encounter with death often amounts to a true existential crisis that forces people to re-examine the meaning of their lives and the values they live by."*¹⁵³

Kübler-Ross and the denial of death

Elisabeth Kübler-Ross is widely known for her pioneering work with the dying. She attempted to give a direct voice¹⁵⁴ to the terminally ill, one which was not mediated through the medical profession. Her aim was to subvert the conventional wisdom as to the needs of the dying - which defined these needs solely in terms of medical treatment - and to discover, through countless interviews with the terminally ill, what they *themselves* saw as their requirements. She has urged through her teaching and writings over many years, that in the medical treatment of those who are terminally ill, *their* voice must be listened to and *their* interests must be centre stage and that the interests of the medical professionals - which exist despite their protestations of disinterest - must not be allowed to predominate.

Kübler-Ross's writings¹⁵⁵ can best be analysed as addressing two concerns:

- (i) the meaning of 'a good death', and how to best help the individual dying patient achieve it;

¹⁴⁶ *ibid.* p.23; Heidegger also considers that one of the manifestations of 'inauthenticity' is '*frenetic busyness*' [Steiner *op.cit.* p.99]. Kierkegaard's perspective is similar, he notes, wittily:

"The biggest danger, that of losing oneself, can pass off in the world as if it were nothing; every other loss, an arm a leg, five dollars, a wife, etc. is bound to be noticed." [The Sickness unto Death p.62]

¹⁴⁷ Liechty *op.cit.* p.63.

He continues (p.76):

"... human beings spend most of their psychic energy in the creation of symbols of immortality that allow, at least momentarily, suppression from consciousness the fact of their mortal, animal nature."

¹⁴⁸ Liechty *op.cit.* p.173.

¹⁴⁹ Although Kübler-Ross believes that it is therapeutically unwise and basically unkind to force a patient to give up this denial when it is truly needed.

¹⁵⁰ Becker (1973) p.217.

¹⁵¹ Liechty *op.cit.* p.165.

¹⁵² *ibid.* p.166.

¹⁵³ Quoted in Fritjof Capra, *Uncommon Wisdom*, p.109.

¹⁵⁴ [1975, p.xv] "*For many years I continued to ask terminal patients to be our teachers.*"

- (ii) current medical practices in relation to terminally ill patients and how these not only hinder, but often prevent a dying patient achieving 'a good death'.

The '*denial of death*' is central to both of these questions and it is the first of the four stages of the schema, used by Kübler-Ross, to describe the individual patient's ability to cope with their impending death.¹⁵⁶ The stages, according to Kübler-Ross, are:

Denial The patient considers that their impending death is unreal and impossible. Such a denial may be more apparent than real in that the patient may not deny their impending death to themselves but to those around them, such as family and carers, who need the denial in order to remain present;¹⁵⁷ the patient's apparent denial being in reality a fear of being abandoned in the face of death. However, Kübler-Ross believes that at least partial denial is used by all patients at some stage where it may act as a useful - and hopefully temporary - buffer in dealing with that which is too threatening.¹⁵⁸ She considers attempts to 'forcibly' subvert such a denial as unjustifiable.

Anger The patient rages at their impending death and its perceived unfairness. Such an attitude is exemplified in Dylan Thomas' poem written on the death of his father:

*"Rage, rage at the dying of the light,
Go not gently into that good night."*

Bargaining The patient accepts that they will die but attempts to postpone it until some project - such as a family wedding, birth of a child or piece of work - is completed.¹⁵⁹

Acceptance Some patients consider their impending death as a defeat, a battle lost. For them the best that can be hoped for is acceptance, in its negative sense, as *resignation*. However, others can see death, not an alien intruder, but as part of life's natural cycle and they can achieve a *positive acceptance*. It is, however, a mistake to assume such a positive acceptance to be a happy stage, as it is almost devoid of emotion and feeling.¹⁶⁰

The focus of Kübler-Ross's writings is on how best to bring a dying patient to a full acceptance of their dying. She sees this as an essential constituent of what I have called 'a good death'.¹⁶¹

Kübler-Ross sees the medical attitude to death - based she argues on a denial of death - as one of the main obstacles to a patient who is dying in a hospital environment, achieving 'a good death'.

We next consider Kübler-Ross's views on death and its supposed evil.

Kübler-Ross: Is death to be considered an evil?

Kübler-Ross begins '*Death - The Final Stage of Growth*' by saying:

¹⁵⁵ The writings that have been consulted are, primarily, *On Death and Dying* (1970) and *Death: The Final Stage of Growth* (1975).

¹⁵⁶ The schema should be considered as indicating a direction rather than a progression; the stages are not as steps on a ladder but often coexist. The schema is not restricted to death but also encompasses events such as divorce and retirement where essentially the same steps will be traversed; Kübler-Ross expresses this by saying:

"... *dying is something we human beings do continuously, not just at the end of our physical lives on this earth.*" [(1975) at p. 145]

¹⁵⁷ e.g. People who respond to the patient's attempts to broach the question of death with total avoidance or false optimism or discouraging comments such as: "*Don't be morbid*" or "*Don't dwell on it*".

¹⁵⁸ (1970) p.35; she quotes one of La Rochefoucauld's maxims: "*We cannot look at the sun all the time, we cannot face death all the time.*"

¹⁵⁹ She notes that none of the patients who did, in fact, live until their goal was accomplished, '*have kept their promise.*'

[Kübler-Ross (1970) p.73]

¹⁶⁰ *ibid.* p. 99.

¹⁶¹ Her views on this will be considered further in Section 3 of this chapter which deals with the concept of 'a good death'.

*"Death is a subject that is evaded, ignored, and denied by our youth-worshipping, progress-oriented society. It is almost as if we have taken on death as just another disease to be conquered. ... Death is as much a part of human existence, of human growth and development, as being born. ... Death is not an enemy to be conquered or a prison to be escaped. It is an integral part of our lives¹⁶² that gives meaning to human existence. ... Whatever the things that would make your life more personally meaningful before you die - do them now, because your are going to die."*¹⁶³

Death, she argues, has in our modern society become a dreaded and unspeakable issue to be avoided by every means possible; all the more so because - despite our technological advances - it reminds us of our human vulnerability. This is especially so for those who put a high value on being 'in control' of their lives and who are deeply offended by the thought that they, too, are subject to the forces of death¹⁶⁴ but who, if they can no longer deny death, attempt to master it.¹⁶⁵

To Kübler-Ross, the denial of death is pervasive in modern Western society as is the view that death is an evil. It has been argued earlier¹⁶⁶ that the assertion that death was an evil logically implied a denial of death. Kübler-Ross argues¹⁶⁷ the converse: that our denial of death, i.e. the belief in the contingency of our own death, means that in our unconscious mind we believe that we can only be *killed* - our dying of natural causes or old age being inconceivable to us - so that we associate death with a bad act and thus, an evil. Kübler-Ross argues that death - far from being an evil - is a positive good; speaking of the bereaved, she says that most of them have found that the year following the death of a loved one has been an opportunity for growth; of her own life, she says:

*"... these experiences with the reality of death have enriched my life more than any other experiences I have had. Facing death means facing the ultimate question of the meaning of life."*¹⁶⁸

To Kübler-Ross, death is a highly creative force from which the highest spiritual values of life can originate.¹⁶⁹ It does not have to be a catastrophic destructive thing, indeed it can be viewed as one of the most constructive, positive and creative elements of life.

It is interesting to compare the insights on death and dying of a practitioner - such as Kübler-Ross - with some of her contemporaries who approach similar questions from a more philosophical direction: for example, it is quite astounding to see how closely her views correspond with those of the existentialists;¹⁷⁰ the following passage, for example, could be a direct quotation from either Heidegger or Jaspers:

"Death is the key to the door of life. ... It is the denial of death that is partially responsible for people living empty, purposeless lives; ... For only when we understand the real meaning of death to human existence will we have the courage to become what we are destined to be. ... You must give up 'their' approval whoever they are, and look to yourself for evaluation of

¹⁶² She begins the last - as she does each - chapter of *On Death and Dying* with some lines by Rabindranath Tagore. *'Death belongs to life as birth does.*

The walk is in the raising of the foot as in the laying of it down'.

¹⁶³ Kübler-Ross (1975) p. x-xi.

¹⁶⁴ *ibid.* p. 5.

¹⁶⁵ Kübler-Ross (1970) p.11.

¹⁶⁶ in Section 1.

¹⁶⁷ Kübler-Ross (1970) p. 2.

¹⁶⁸ Kübler-Ross (1975) p.126, where she also spoke of her experiences in Nazi Germany.

¹⁶⁹ *ibid.* p.1

¹⁷⁰ Discussed in Section 1, Subsection 3.

success and failure, in terms of your own level of aspiration that is consistent with your values. Nothing is simpler and nothing is more difficult.”¹⁷¹

It is no less astounding to see how little these insights have in common with Nagel's arguments given earlier.¹⁷²

Conclusion 9-8 : *The proposition ‘Death is an evil’ considered simply as a proposition of psychology, i.e. as a maxim for living, should be rejected; it is the denial of death, rather than death, that is an evil.*

Subsection 2: Medical manifestations of the ‘denial of death’

We will first consider Kübler-Ross's pioneering contribution to this debate and then the contributions of more recent commentators.

Kübler-Ross

Although, when first attempting to commence her project, Kübler-Ross had considerable support from hospital administrators, she faced considerable opposition from the medical staff who:

“... reacted with great resistance, at times overt hostility, to our seminar.”¹⁷³

In contrast, her patients responded with enthusiasm. She found doctors to be very defensive when discussing death¹⁷⁴ and unwilling to consent to their patients being interviewed; these refusals were ostensibly to protect their patients but, as Kübler-Ross comments:

“... doctors who need denial themselves will find it in their patients ...”¹⁷⁵

She found that:

“Approximately nine out of ten physicians reacted with discomfort, annoyance, or overt or covert hostility when approached for their permission to talk to their patients.”¹⁷⁶

Early in her work she observed “... the desperate need of the hospital staff to deny the existence of terminally ill patients on their ward.”¹⁷⁷ Some of the nurses referred to their colleagues - who had attended Kübler-Ross's seminars - as ‘vultures’;¹⁷⁸ only 8% of nurses felt that dying patients needed their care;¹⁷⁹ most responded to their dying patients “... with a sense of anger, as if these patients committed an angry act against them by dying in their presence.”¹⁸⁰

¹⁷¹ Kübler-Ross (1975) pp 164-5 [emphasis in the original]; compare with the passage from Jaspers quoted earlier (in Section 1 Subsection 3):

“... dead-ends but frontiers where being-in-itself is to be encountered. Death, for example, so long as I am forgetting it or fleeing from it or merely taking note of it as the inevitable end, is just an empirical fact about an empirical object in the world of being-there; it is not constitutive of my life, and in so far as it is not I am not living at the level of being-oneself.” (H.J. Blackham, *Six Existential Thinkers*, p.52)

and (Steiner, *Heidegger*, p.94):

“Inauthentic Dasein lives not as itself but as ‘they’ live. ... It ‘is lived’ in a hollow scaffolding of imposed, anonymous values. In inauthentic existence we are constantly afraid (of other men’s opinions, of what ‘they’ will decide for us, of not coming up to the standards of material or psychological success ...). Fear ... of this order is part of the banal, prefabricated flux of collective sentiment. Angst is radically different. ... Angst is a mark of authenticity, of the repudiation of ‘theyness’.”

The similarity is eloquent testimony to the practical value of Continental philosophy.

¹⁷² Section 1, Subsection 4.

¹⁷³ Kübler-Ross (1970) p.218.

¹⁷⁴ [Kübler-Ross (1975) p xix]:

“Our main problem was with the physicians.”

¹⁷⁵ Kübler-Ross (1970) p.28; see also p.29:

“The need for denial is in direct proportion with the doctor’s need for denial.”

¹⁷⁶ *ibid.* p.220.

¹⁷⁷ *ibid.* p.222.

¹⁷⁸ *ibid.* p.223.

¹⁷⁹ *ibid.* p.224.

¹⁸⁰ *ibid.*

The patients, in contrast:

"... responded favourably and overwhelmingly positively to our visits. Less than 2% of questioned patients flatly refused to attend the seminar, ..." ¹⁸¹

Kübler-Ross's does not present a systematic theory as to the reasons for the reactions of the medical carers which have just been described, though she does consider that death denial on the part of the *carers*, plays a central role. This denial of death is best considered in terms of its manifestations, the primary one being an overestimation¹⁸² of the power of clinical medicine so that death is considered to be a contingent, rather than a necessary, eventuality. A corollary of this attitude is that when death does occur, it is considered to be a failure either on the part of the medical carers, or of medicine itself. Such a framework explains the '*rescue fantasy*'¹⁸³ and the frantic medical activity¹⁸⁴ which often occurs when death is seen to come close.¹⁸⁵ Kübler-Ross asks:

"Is this approach our own way to cope with and repress the anxieties that a terminally or critically ill patient evokes in us? ... [because they] remind us once more of our lack of omnipotence, our own limitations and fallibility and, last but not least perhaps, our own mortality?" ¹⁸⁶

Such a framework also explains the responses of nurses when faced with an unavoidable death:

"They sensed their own impotence in the face of death and when they became aware of the doctor's similar feelings it angered them out of proportion." ¹⁸⁷

It also explains the avoidance and neglect of such patients by the medical staff under the excuse that '*nothing can be done*'. This belief that '*nothing can be done*' to help a dying patient is reinforced by the ideology that underlies modern medicine - *i.e.* that of a discipline defined by its '*curative*' rather than its '*caring*' role.¹⁸⁸ The regarding of medicine as a curative discipline is intimately connected with its being identified as a scientific discipline. Because science is regarded as the locus of power and prestige in modern society; the regarding of clinical medicine as primarily a scientific discipline actively encourages the overestimation of the power of physicians and also exacerbates those clinical attitudes to patients which have just been discussed because the patient,

¹⁸¹ *ibid.* p.229.

¹⁸² The existence of such a hubris amongst physicians is discussed by Hans Mauksch in his essay entitled '*The Organisational Context of Dying*' which is included in Kübler-Ross (1975); and by Jacob Needleman in an essay entitled '*The Two Sciences of Medicine*' included in his *The Indestructible Question*.

¹⁸³ Kübler-Ross (1970) p.148.

¹⁸⁴ Such activism is indicative of death denial *cf.* James B. McCarthy, *Death Anxiety: the Loss of Self* (p.11):
"Perhaps the most widely used security operation that holds the fear of death at bay is the 'manic defence', a concept illuminated by Donald Winnicott and derived from the early work of Melanie Klein. ... Winnicott explains that a great variety of activities can provide reassurance against death. ... Being 'too busy to think'... The need to be constantly occupied, the inability to tolerate aloneness with oneself, the rush to fill leisure time with social activity ... are illustrative of the manic defence against depression and fear of death."

(Compare also with Becker's view mentioned in Subsection 1).

¹⁸⁵ It is also seen in the tendency to speak of death in military terms; one of the most incongruous examples is in the phrase '*no heroic measures*' when used in relation to the withdrawal of medical treatment thus permitting a person to die; if heroism is to be decreed surely it is to those who, in the face of the current ideology of aggressive medical interventionism, allow a person to die peacefully. On this theme Kübler-Ross notes (in a quotation which I cannot, at present, trace):

"While medicine considers its hi-tech interventions 'heroic measures', the real truth is that just being there for the patient is the real measure of heroism."

¹⁸⁶ Kübler-Ross (1970) p.8.

¹⁸⁷ *ibid.* p.223.

¹⁸⁸ As will be argued later in this Subsection the distinction between regarding clinical medicine as a scientific discipline and as a caring discipline is of crucial importance to the discussion of death denial.

who is seen by the carer 'as a person', appears, to the scientist, 'as an object'.¹⁸⁹ Kübler-Ross described such attitudes:

*"Slowly but surely he is beginning to be treated like a thing. He is no longer a person. Decisions are made often without taking his opinion. If he tries to rebel he will be sedated."*¹⁹⁰

*"The dying patient is not yet seen as a person and thus cannot be communicated with as such."*¹⁹¹

Conclusion 9-9 : In clinical medicine, 'death denial' is manifested in:

- * a refusal to fully acknowledge the inevitability of death..
- * inappropriate medical activity in the face of death.
- * the belief that when death occurs it is due to a failure of medicine.
- * the belief that 'nothing can be done' to help a dying patient.
- * a refusal to talk to patients about their dying.

Kübler-Ross's recommendations

Because Kübler-Ross regards the denial of death as the central problem connected with the medical management of death, it is no surprise that she sees the solution as lying in more education and better communication: education in death and dying¹⁹² for the medical carers and better communication especially between doctors and their patients:

*"The fact that we don't use denial, that we are willing to use the words death and dying, is perhaps the most welcomed communication for many of our patients."*¹⁹³

*"If this book serves no other purpose but to sensitise ... to the implicit communications of dying patients, then it has fulfilled its task."*¹⁹⁴

She speaks of one of her patients who:

*"... was sad that he was forced to struggle for life when he was ready to prepare himself to die. It is this discrepancy between the patient's wish and readiness and the expectation of those in his environment which causes the greatest grief and turmoil in our patients."*¹⁹⁵

Communication is the only solution in such cases, and the obligation to communicate with patients is - as is argued in Chapter 10 - nothing other than a primary constituent of the obligation to treat the patient as a person.

Conclusion 9-10 : Kübler-Ross's principle recommendations involve:

- (i) the necessity of combating 'death denial' - which she regards as endemic amongst medical professionals, and

¹⁸⁹ Hans Mauksch in his essay 'The Organisational Context of Dying' [included in Kübler-Ross (1975) p.23] refers to Erving Goffman's concept of the 'stripping process' whereby total institutions - such as hospitals, especially mental hospitals, convents and the military - strip the individual of his autonomy and identity, ostensibly for the greater efficiency of the institution. In a hospital this is accomplished by subtle expressions of power e.g. by patients being kept waiting, by the use of plastic name tags, by obligatory hospital clothes; the result is that the 'personhood' of the patient is diminished and the objectification of the patient increased.

¹⁹⁰ Kübler-Ross (1970) p.8.

¹⁹¹ Kübler-Ross (1975) p. 25.

¹⁹² [Kübler-Ross (1970) p. vii]:

"Medicine should not confine itself to the prevention of death any more than family planning should confine itself to the prevention of birth."

¹⁹³ Kübler-Ross (1970) p.233.

¹⁹⁴ *ibid.* p.126.

¹⁹⁵ *ibid.* p.78.

- (ii) the primacy of the obligation on medical professionals, to communicate with their patients.

More recent commentators

Kübler-Ross's main work was done in the 1970's and the themes that she identified have in the intervening years been explored by many others of whom Daniel Callahan is particularly notable for the incisiveness of his analysis. The themes identified by Kübler-Ross were:

- * the pervasiveness of death denial amongst medical carers, and
- * the ambiguous nature of the role of medicine: *Is the role of medicine primarily a caring one, or is it essentially curative, life preserving, and 'scientific'?*

Though recent developments, commentaries and studies in these areas are interconnected, it is convenient to consider both them, and the work of Callahan, separately.

The pervasiveness of death denial amongst medical carers

The recommendations of a recent report issued by the US Institute of Medicine¹⁹⁶ give few grounds for believing that there have been radical changes in recent years in either medical attitudes to death or in the aggressive medical interventions which are a consequence of these attitudes. The report notes that the education and training of physicians “... fails to provide them with the knowledge, skills, and attitudes required to care well for the dying patient;”¹⁹⁷ and does not equip them to “... understand and manage their own emotional reactions to death and dying.”¹⁹⁸ The recommendation that:

*“Textbooks ... need revision to reflect the reality that people die ...”*¹⁹⁹

is startling in its implications and makes abundantly clear the magnitude of the task required. These deficiencies in medical education are further highlighted by a recent statistic that, of 126 medical schools in the US, only 5 have an obligatory course on death and dying.²⁰⁰

The Institute of Medicine's report believes that the denial of death is not confined to medical professionals but is widespread throughout society:

*“... this nation has not yet discovered how to talk realistically about the end of life, nor has it learned to value the period of dying ...”*²⁰¹

The continued prevalence of death denial in medicine is conceded in a recent research project under the auspices of 'The Hastings Center'; this project proceeded on the premise that:

*“... modern medicine is, at its core, ambivalent and even schizoid on the problem of death, uncertain whether to accept death as a necessary part of life and medicine, or to see death always as the enemy, to be vanquished.”*²⁰²

¹⁹⁶ Institute of Medicine Approaching Death: Improving care at the End of Life.

¹⁹⁷ *ibid.* p.265.

¹⁹⁸ *ibid.*

¹⁹⁹ [*ibid.* p.269]:

“Textbooks and other material likewise need revision to reflect the reality that people die and that dying patients are not people for whom ‘nothing can be done.’”

Callahan recounts a telling anecdote:

“‘Death’, Dr Otto Guttentag told me well over two decades ago, ‘has no place in modern medicine. Only pathologists take death seriously.’ I thought at first he was simply making a joke. He was not. Death is for the most part absent in modern textbooks of medicine ...” [The Troubled Dream of Life p. 73]

²⁰⁰ Esther B. Fein, ‘Failure to Discuss Dying Adds to Pain of Patient and Family’, New York Times on the Web March 5, 1997. [Internet source: <http://nytsyn.com/newsservice/index.html>]

²⁰¹ Institute of Medicine, Approaching Death, pp. 265-271.

However, the denial of death is not solely an American phenomenon: a recent BMA report notes:

*"...the unrealistic expectations in society about the extent to which it is possible to postpone death such that death is sometimes seen not as a natural, inevitable event but as a failure of medicine. Societal perceptions need to shift away from the view that life can be prolonged indefinitely back towards a realistic acceptance of the inevitability of death."*²⁰³

Conclusion ⁹⁻¹¹ : Recent reports from the US Institute of Medicine (1997) and the BMA (1999) indicate that 'death denial' is a widespread phenomenon of modern life; the US report found considerable evidence of its prevalence in clinical medicine.

The role of medicine: to cure or to care?

The Institute of Medicine's report concluded that there are very serious problems in 'end-of-life' medical care and identified two areas of particular concern:

- (i) the management of pain (and, in particular, the ungrounded fears of opiate addiction), and
- (ii) the widespread belief that dying people are patients for whom '*nothing can be done*'.²⁰⁴

The report is scathing in its criticism of clinical practice in relation to pain management:

*"Indeed, in this committee's view, if physician and hospital performance in infection control were as poor as it is, for example, in pain management, the ensuing national outcry would create an immediate demand for responses ..."*²⁰⁵

It is no less forgiving in its criticism of over-intrusive medical intervention:

- * *"... too many people suffer needlessly at the end of life both from errors of omission - when care givers fail to provide palliative and supportive care known to be effective - and from errors of commission - when caregivers do what is known to be ineffective and even harmful."*²⁰⁶
- * *"Medical culture still tolerates and even rewards the misapplication of life-sustaining technologies while slighting the prevention and relief of suffering."*²⁰⁷
- * *"... the aggressive use of ineffectual and intrusive interventions may prolong and disfigure the period of dying."*²⁰⁸

²⁰² The Hastings Center Report 1.7 Research, Clinical Practice, and the Care of the Dying. [Internet source: http://www.cpn.org/sections/affiliates/hastings_center.html]

The project is under the direction of Daniel Callahan and is described as:

"This project proceeds on a somewhat different track from those which have marked the termination of care debate in this country. Its premise is that modern medicine is, at its core, ambivalent and even schizoid on the problem of death, uncertain whether to accept death as a necessary part of life and medicine, or to see death always as the enemy, to be vanquished. Where clinical medicine, at least of the sensitive kind, works hard to find a place for death in the humane care of patients, research medicine still has death as its declared enemy. For researchers, there are no acceptable causes of death. The net result is that medicine is fundamentally torn, unable to decide whether death should be accepted, as clinicians well understand, or rejected, as researchers seem to imply in their agenda of eliminating the causes of death. The aim of the project is to see if medicine can find a better way of conceptualizing its stance toward death, with the hope that the schism within medicine on this crucial subject can be healed."

²⁰³ BMA (1999a) 1.4.1.

The report also notes that:

"Many nurses have reported concern about what they perceive as 'moral distancing' on the part of some doctors. They consider that those who make the decision generally delegate its implementation to nurses, who can feel unhappy if they have not been able to contribute in any way to that decision." [BMA (1999a)3C.18.2]

²⁰⁴ Institute of Medicine Approaching Death at p.269.

²⁰⁵ *op.cit.* p.263-4.

²⁰⁶ *ibid.* p.264.

²⁰⁷ *ibid.*

²⁰⁸ *ibid.*

This last conclusion is eloquently supported by a research study (which the report quotes) showing that of a group of patients reviewed, nearly half received mechanical ventilation during the last 3 days of life.²⁰⁹

Conclusion 9 - 12 : *The Institute of Medicine's 1997 report clearly shows that, of the alternative philosophies of medicine i.e. 'curative' or 'caring', it is the curative that, at least in the US, is in the ascendant.*

Many writers on this subject have pointed out that medicine has its historical origins in 'caring' rather than 'curing' and that the latter that should always be to the fore. William Ruddick,²¹⁰ for example, quotes the Prayer of Maimonides '*never to forget that the patient is a fellow creature in pain, not a mere vessel of disease.*'²¹¹ Leo Alexander notes:

*"The original concept of medicine and nursing was not based on any rational or feasible likelihood that they could actually cure and restore but rather on an essentially maternal or religious idea ... motivated by the compassion in alleviating suffering."*²¹²

Alexander has written on how the medical ideology which was prevalent in Germany in the 1930's actively assisted the Nazi's in their implementation of the so-called '*euthanasia programmes*'. This ideology was one where the ideals of compassionate caring were being supplanted by those of scientific medicine with its emphasis on cure and rehabilitation:

*"However, with this increased efficiency based on scientific development went a subtle change in attitude. Physicians have become dangerously close to being mere technicians of rehabilitation."*²¹³

He also saw this trend developing in the US.²¹⁴ This trend, he argues, results in those less likely to be rehabilitated:

*"... being looked down upon with increasing definiteness as unwanted ballast. A certain amount of rather open contempt for those people who cannot be rehabilitated with present knowledge has developed. This is probably due to a good deal of unconscious hostility, because these people for whom there seem to be no effective remedies have become a threat to newly acquired delusions of omnipotence."*²¹⁵

Alexander insists that the so called '*euthanasia programmes*' of Nazi Germany were not solely the responsibility of the Nazi state²¹⁶ but to a considerable extent predated Nazism.²¹⁷ Furthermore, they drew considerable support from the medical ideology then becoming prevalent in Germany, an ideology which defined medicine in terms of its curative role. This is an invaluable insight because,

²⁰⁹ *ibid.* p.134.

²¹⁰ William Ruddick 'Do doctors undertreat pain?' *Bioethics*, (p 3). Ruddick has written about the tendency amongst physicians to '*psychologically forget the patient's pain*' and to see it only as a useful indicator of disease. Ruddick's article was discussed in Chapter 3, Section 5.

²¹¹ *op.cit.* p.1.

²¹² Leo Alexander. '*Medical science under dictatorship*' *New England Journal of Medicine* at p.45.

²¹³ *ibid.*

²¹⁴ The fact that the hospice movement with its emphasis on caring rather than curing, developed *outside* the traditional medical structure is also indicative of how modern medicine defines itself in terms of 'curing' rather than 'caring'.

²¹⁵ Alexander *op.cit.* p.45.

²¹⁶ Alexander argues that such programmes were widely discussed in medical circles before the Nazi's took charge in Germany:

"Sterilization and euthanasia of persons with chronic mental illnesses was discussed at a meeting of Bavarian psychiatrists in 1931. By 1936 extermination of the socially unfit was so openly accepted that its practice was mentioned incidentally in an article in an official German medical journal." [*op.cit.* p.39]

²¹⁷ This topic is considered in more detail both in the next chapter and in an appendix on the development of euthanasia in pre-war Germany (Appendix E).

without it, it has been all too easy to assign full responsibility for such programmes to Nazism,²¹⁸ thus permitting the comforting - but unjustifiable - belief that, in the absence of Nazism, such practices could not recur. Alexander's argument that there are pressures, independent of Nazism and implicit in certain medical ideologies, which tend to foster such practices suggest a re-examination of the reasons currently offered for the withdrawal of life-sustaining treatment particularly in the area of disability. Two recent examples from the medical literature are instructive:

- * The criterion of '*clinical advantage*' has been used in deciding whether or not to administer treatment. The Bland case interpreted this criterion to mean '*recovery*'. Andrews criticises this and comments:

*"This has serious implications for many other disabled people. ... There is, therefore, no clinical advantage in much of the rehabilitation for patients with disabling disorders since there is no recovery."*²¹⁹

- * Gillon is scathing of the efforts of those, such as Andrews's, who classify as successes those patients who:

*"... recovered sufficient consciousness to smile at cartoons, to show pleasure when his wife was present, and to show distress when she was absent."*²²⁰

He argues that even if funds were unlimited it is not incontestable that such treatment should continue; but he continues '*resources are severely limited*'.²²¹ Such attitudes to disability are not wholly removed from those portrayed by Alexander.

The issue of treatment withdrawal on the grounds of disability will be further considered in Chapter 11 in discussing the conceptual framework used in making 'end-of-life' decisions for Down Syndrome infants, and in Appendix E.

Conclusion⁹⁻¹³ : *A medical ideology which defines the medicine's role as being fundamentally curative and which minimises its caring role, tends to foster death denial.*

Callahan²²²

Daniel Callahan's book The Troubled Dream of Life is:

- * *firstly*, a critique of current medical attitudes and practices in relation to death and dying,
- * *secondly*, an analysis of the beliefs which, either explicitly or implicitly, underpin such attitudes,
- * *thirdly* a way out of (what Callahan sees as) the present impasse.

I will consider these aspects separately.

²¹⁸ For example, the well respected BBC series The Nazis: a Warning from History in its discussion of child euthanasia implied that such programmes *originated* with the Nazis; it made no mention of the fact that such programmes had been widely discussed in academic circles as far back as 1920 (see the discussion of the proposals by Binding and Hoche in Appendix E).

[The Nazis: a Warning from History: Part 2 (shown on BBC2 29-7-00)]

²¹⁹ Andrews (1993a) p.1601.

²²⁰ Gillon (1993) p.1603.

²²¹ *ibid.* p.1603.

Alexander's riposte (*op.cit.* p.45) to the scarce resources argument is apposite:

"There has never in history been a shortage of money for the development and manufacture of weapons of war; there is and should be none now"

²²² I came across Daniel Callahan's book -The Troubled Dream of Life: In search of a Peaceful Death - by chance, when the main ideas of this thesis, and particularly of this chapter, had begun to take shape. It was a time when my confidence in my approach was at a low ebb and it was most encouraging to find many of the ideas that I wished to elaborate, being shared by such an eminent and experienced commentator and being espoused with such eloquence and conviction. To him, I wish to express my deep gratitude.

In describing death in a modern medical setting Callahan contrasts, what he calls, the 'tame death' of our forefathers - where death though perhaps no more welcome was more tolerable and familiar - with the 'wild death' of modern times.²²³ This 'wild death' is characterised by a 'medical brinkmanship' where, although there is a recognition that a person can be harmed by the overuse of medical technology, the intent is to go as close as is possible to this line;²²⁴ the presumption being that treatment must be given if it preserves life even if doing so enhances the likelihood that a later death will be worse than the one averted.²²⁵

Callahan suggests that in modern Western society, it is remarkably difficult to talk about death and its meaning.²²⁶ Discussions about dying quickly become debates about law, not about death itself. Whereas an earlier generation sought (by, for example, the use of funeral parlours) to put death out of sight; modern society - in its attempt to restrict discussion of death to issues of rights and choices - is guilty of an even greater evasion.²²⁷ He sees the concept of 'control' - in the sense of being 'in control' of one's life - as being central to any discussion and interpretation of the role of death in modern society:

*"Everyone will want some degree of control. ... My target has been the mistaken belief that a necessary condition of our self-worth is our control of our lives. ... Choice - and the control over life and death that is its necessary condition - has come to be understood as the final meaning of human existence: the capacity to make of ourselves what we want to be. ... To make our sense of wellbeing and dignity dependant on a capacity to control and manipulate our circumstances is already to have set ourselves up for a fall. ... It is precisely the brute force, the external and unavoidable nature of illness and death that makes them so intolerable."*²²⁸

The euthanasia movement seeks to persuade us that we can die as we choose and in that they peddle an illusion.²²⁹ Callaghan argues that to seek to come to terms with our own death through the medium of legal rights - so that having consulted a lawyer and armed with suitable advance directives we can then believe ourselves adequately prepared for death - is an act of the greatest folly.²³⁰ Such attempts ensure that the inevitable loss of control experienced in dying is perceived as 'an intolerable insult to a patient's sense of dignity';²³¹ they are, ultimately, destructive of a peaceful death.

²²³ Callahan [op.cit. p.28] where he notes the insistence of many moderns "... that death must have been worse in earlier times." His response is that then people typically died of infectious diseases and that the long and lingering death of modern times was uncommon.

²²⁴ op.cit. p.41.

²²⁵ ibid. p.70.

²²⁶ ibid. p.13.

²²⁷ ibid. p.35.

²²⁸ "... we have discovered in the language of choice and rights still another kind of evasion ... we choose 'choice' about death, rather than death itself, as the new, supposedly liberating focus."

²²⁹ ibid. p.153-4.

²³⁰ ibid. p.92.

²³¹ Callahan does not deny the limited usefulness of such as living wills; however when used as a strategy for dealing with death they become implements of death denial. He believes the attempt to exert control over one's living and dying has having an almost 'driven quality' [op.cit. p.16] and that the preoccupation with control has become both subtly demeaning and socially troubling. [op.cit. p.17].

Callahan states [op.cit. p.155]:

"Should I want some control over my life and death? Of course. Should I think that I am somehow less of a person when I cannot have that control? No. Should I have a right to specify conditions for the medical management of my dying? Yes. But if I am thereby led to make myself someone who cannot endure the thought of not having control over death itself, I will have done myself great harm."

²³¹ ibid. p.101.

To Callahan, the great lesson taught us by death is that we cannot be totally 'in control'; to presume so is an act of hubris - a setting of the stage for the inevitable nemesis. However, to come to terms with the medical and ethical issues associated with death it is necessary to leave the periphery and head straight to the heart of the matter - *death*. Callahan, speaking of Becker and Aries, says "*Correctly and with profundity, they said that death itself is the issue.*"²³²

As a first step in the task of confronting death it is necessary to reassess our relationship to nature. The distinctions and differences between man and nature have been stressed both in religion (especially by Christianity with its doctrine of the soul) and in philosophy (especially by Cartesianism and Existentialism). This one-sidedness has fostered the modern belief that man is a self-created creature somehow outside of nature and exempt from its laws. To Callahan, man is ineluctably embedded in nature and subject to its laws; one such law is that all that lives, dies,

*"To think that we can bend nature wholly to our will ... is nothing less than foolish. In the fact of human mortality, nature retains its own imperial independence."*²³³

A recognition of the mortality of man is crucial to any reassessment of the problems associated with death.²³⁴ Such a proposition has the appearance of a vacuous truism yet so many of the practices of modern medicine are explicable only in terms of its denial:

*"Medicine, I believe, has implicitly defined its central purpose as an all-out fight against death. ... It has declared war on death, ... [it] has come ... to look upon death as a correctable biological deficiency."*²³⁵

Certainly the biological necessity of death is understood but the cause of every death is taken to be contingent because:

*"... in principle and in medical theory there is no reason why any particular disease cannot be overcome."*²³⁶

The belief is, because the diseases which cause death can be cured one by one, that death itself can be dismantled (since death is caused by disease).²³⁷ Medicine thus confuses its power to alter disease with its power to banish mortality.²³⁸ Callahan notes the:

*"... subtle, tacit distinction that runs through scientific medicine, that illness, and the diseases that cause it, can be distinguished from ageing, mortality and death. Death can only be brought back within medicine by a repudiation of the mythical line between illness and death."*²³⁹

Attitudes such as Callahan depicts are exemplified by the refusal of the WHO to consider that old age could possibly be a cause of death.²⁴⁰ In a memorable phrase Callahan describes life and

²³² *ibid.* p.34.

²³³ *ibid.* p.122.

²³⁴ *ibid.* p.123-4.

"Our first task at present is to recapture our mortality, to give it once again a meaningful relation in our lives. Death must be brought back to the surface, given its rightful place ... The fact of its inevitable triumph - its ultimate necessity - must be built into the very definition of medicine ... the way of wisdom for the Greeks was the acceptance of necessity ..."

²³⁵ *ibid.* pp. 74, 57-58.

²³⁶ *ibid.* p.74 [emphasis in original].

²³⁷ *ibid.* p.157.

²³⁸ *ibid.* p.59.

²³⁹ *ibid.* p.198.

²⁴⁰ referred to earlier (Introduction to Section 2).

death as a 'zero-sum game, the causes of death can only be moved around',²⁴¹ to presume that they can be eliminated, is folly.

Callahan's proposals

Callahan's main proposal is that the goals set by medicine for itself should not *just* relate to life, its enhancement and extension²⁴² but should, in a full acceptance of the inevitability of death, also recognise that the achievement of a 'peaceful death' is an objective worthy of its efforts:

*"The goal of a peaceful death should be as much a part of medicine as that of the promotion of good health. That means that medicine must abandon the modern cultic myth that in the cure of disease lies the cure of death."*²⁴³

This aspect of Callahan's analysis will be considered in the Section 3 which deals with 'a good death'; two other aspects - his treatment of the question '*Death is an evil*', and his discussion on *suffering and loss of dignity* - will be discussed here; the latter aspect is best considered in terms of the distinction between '*being*' and '*doing*' which, though not used by Callahan, is helpful.²⁴⁴

Death is an evil

Though Callahan acknowledges the centrality of the proposition '*Death is an evil*', his analysis lacks the rigour²⁴⁵ and clarity shown in the rest of his discussion. Much like Philippa Foot, he - by choosing categories more abstract than is required for his analysis - impales himself on the horns of a (self-imposed) dilemma: for example, in considering 'life is a good' he takes life in the abstract, i.e. unrelated to death, as the primary idea thus obliging him to treat '*Life is a good*' as synonymous with '*Death is an evil*'; in consequence, he is forced into precisely the same difficulties as was Foot.²⁴⁶ This is all the more inexcusable in that, in doing so, he is ignoring his very own strictures not to treat death as contingent. Had he followed his own advice and considered death as a necessary part of life - *there is no life that does not end in death* - it would have been clear that to ask 'life a good' and 'death an evil' (simpliciter) is as meaningful as to attempt to cleave to the concept '*left*' without immediately recognising that the concept of '*right*' is its necessary companion.²⁴⁷ Despite these criticisms Callahan does arrive at the conclusion:

*"... our moral judgement should focus on the timing and circumstances of death, which we can to some extent manage and control, not on the existence of death, which we cannot."*²⁴⁸

In the end he does break free of the stranglehold imposed on his analysis by his acceptance of the duality '*life is a good / death is an evil*'; and he finds a new way to view death which he calls the '*inside*' view:

²⁴¹ *op.cit.* p.198.

²⁴² e.g. Callahan (*op.cit.* p.211) sees the US health care system as embodying the view that:

"... physicians owe it to their patients to provide the most aggressive life-extending treatment, regardless of cost."

²⁴³ *ibid.* p.229.

²⁴⁴ It has been mentioned earlier (Chapter 1, Section 3); it will be discussed again in discussing personhood (Chapter 10).

²⁴⁵ Such as when (*ibid.* p.165) he asserts that:

"Only if we understand life to be a good and death to be an evil can it make sense to us to speak of some deaths as more tolerable than others."

²⁴⁶ See the earlier discussion of Foot's argument in section 1 subsection 3 and in Appendix D.

²⁴⁷ In an attempt to clarify my suggestion that the problem lies in the level of abstraction, consider the examples of 'a book' or 'a journey'. Both of these are, of their nature, limited - in the sense that a book, to be a book, must have an end and, equally so, a journey. To ask whether it is a 'good' for a book, or a journey, to have an end is obvious nonsense. The nonsense can be concealed however by considering a higher level of abstraction. The concept *book_U* (or equally *journey_U*) - i.e. an *unlimited* 'book', one not necessarily limited by an end - and the abstract concept of '*End*' can apparently permit the question of whether '*Is it a 'good' for a book_U to have an End?*' to be posed. This is precisely what is occurring when the questions '*Is life a good?*' or '*Is death an evil?*' are asked.

"There is a way of interpreting life that can give an integral place to death. I will call it the 'continuous', or 'inside', view, to distinguish it from the 'fragmented' or 'outside', view. It begins with a different kind of question. We should not ask whether death is an evil (for this already fragments death), but whether a life course that includes death at its end is an evil. And the answer ... is: not necessarily ... life and death are inextricably intertwined, and that much of the value of life comes because of this relationship, not despite it. In this view, life itself requires, for its meaning and piquancy, death as its necessary complement. Life cannot be life as we understand it without death's being integral to it. ... One reason for accepting it, perhaps unpleasantly realistic, is this: that is the way things are, and you had better accept it."²⁴⁹

'Being' v 'Doing'

In using this polarity I am attempting to bring into focus a view of man and of his place in the world that is so prevalent in the West that the possibility of any alternative view is often not recognised. In the West, man is primarily conceived as one who acts on his environment; his definition - to himself and to others - is in terms of the changes that he has wrought on the world; a life lived without the possibility of making such changes would be widely considered as being a useless life.²⁵⁰

Westerners who visit the East often comment on the 'passivity', or 'fatalism', of those peoples; by this is meant that, in the face of circumstances deemed to be unsatisfactory, two responses are possible:

- * one can attempt to change the circumstances or
- * one can attempt to accommodate oneself to the circumstances - to change one's inner attitude so that one can accept the existing circumstances.

Eastern responses to problems are sometimes 'inner directed' so that by meditative, or other such spiritual practices, it becomes possible to live in harmony with, what was previously considered to be, an intolerable situation. To the Westerner such responses are categorised as passive and fatalistic; his response, in contrast, is 'outer directed' or 'active' - a solution being seen in attempting to find harmony by changing the outer environment.

However, it is in facing that which cannot be changed - our mortality being the supreme example - that the typical 'outer directed' response *accentuates* the original disharmony. It is in facing death that the hitherto successful strategy of 'activism' becomes a frantic activity,²⁵¹ a panic in the face of the impending 'loss of control'. This is the perspective from which Callahan's thoughts on 'suffering' and 'loss of dignity' are best understood.

Callahan distinguishes between 'pain' and 'suffering'; 'suffering' relates to a person's psychological or spiritual state²⁵² and occurs at some impending destruction of the person²⁵³ or their self-image. Suffering is the response to threats to the ego, pain being the response of the body.

²⁴⁸ *ibid.* p.178.

²⁴⁹ *ibid.* pp 168-170.

²⁵⁰ To such as Owen Flanagan (in his *Consciousness Reconsidered*) a life lived without the possibility of 'life-plans' would put the very existence of personhood in doubt.

²⁵¹ see Kübler-Ross's observations earlier in this section at Subsection 1; see also Heidegger's view that 'frenetic busyness' 'lust for novelty' and 'self-scattering' are the marks of an inauthentic life lived in a denial of death. [Steiner *op.cit.* p.79, 99; and the discussion on Heidegger in Section 1, Subsection 3.]

²⁵² Callahan *op.cit.* p.95.

²⁵³ *ibid.* p.133. In this context the term 'person' is best understood as the social being rather than the physical being; cf. Chapter 10.

Often the only path available to deal with suffering is through a changing of the attitude²⁵⁴ adopted towards that which appears to be threatening. As a preliminary to such a change it is often necessary to adopt a stance more akin to 'being' than to 'doing':

*"Facing up to terror is something we do entirely with and within ourselves ... It is the mastery of self,"²⁵⁵ not of the outside world, that brings the deepest satisfaction, and in the end it is the only mastery that is proof against what the world brings."*²⁵⁶

Callahan sees the solution to the perceived loss of dignity (often spoken of in relation to dying) as flowing from the same source:

*"One has no more right to dignity - and hence to dignity in death - than one has to beauty or courage or wisdom, desirable though these may be. However much we work to control the circumstances of our dying, its essence is loss of ultimate control, the final disenfranchisement of the controlling self. Our dignity will stem from the way we come to understand and master that loss, not from the loss itself."*²⁵⁷

The distinction between the attitudes 'being' and 'doing' (and the different values which society associated with them) is of considerable importance when discussing 'end-of-life' decisions. The all-too-common assumption that *only* active responses are of worth and that only those who consistently manifest such responses, have value, needs to be critically examined; otherwise it becomes all too easy in looking at, for example, inactive old people in a nursing home, to judge that such lives are useless and without value. Furthermore, if the 'being' response is undervalued and if there is nothing that we can actually do for a dying person then - as Kübler-Ross has well documented - it becomes all too easy to leave them to face their dying alone. In such circumstances it requires a degree of courage to face and acknowledge one's impotence and to remain and simply be with another in their suffering:

*"Then we discover something at once humbling and appalling. We can be with another in his suffering, and we can try to share it, but we cannot relieve it."*²⁵⁸

The inability to sit with such feelings of impotence is, perhaps, the cause of many of the inappropriate medical interventions that occur in end of 'end-of-life' situations.²⁵⁹ Furthermore, it is at the root of the conflict in medicine between the activism of those who adhere to a 'scientific medicine' - who believe medicine to be solely a rehabilitative discipline - and those who, like Callahan, see caring - which may often be just a 'being with' - as the most basic value in medicine.²⁶⁰

²⁵⁴ *ibid.* p.128. Callahan refers to Viktor Frankl as saying that the last of the human freedoms is to choose one's *attitude*; see also p.142.

²⁵⁵ Callahan makes a distinction between 'self-mastery' and 'self-control'.

²⁵⁶ *ibid.* p.131.

²⁵⁷ *ibid.* p.147.

²⁵⁸ Callahan *op.cit.* p.141; see also p.144:

"I want only to work against the assumption that we cannot possibly do well by others unless we can relieve their suffering, that we must relieve one another's suffering." [emphasis in original]

²⁵⁹ Kübler-Ross (1970 p.105) has spoken of the importance of recognising that some patients in their dying want no outside interference, just silent understanding:

"When our patients reached the stage of acceptance and final decathexis, interference from outside was regarded as the greatest turmoil and prevented several patients from dying in peace and dignity." [*ibid.* p.237]

²⁶⁰ Sherwin B. Nuland in an essay 'The Doctor's Role in Death' [included in Spiro, Curnen, Wandel (eds.) *Facing Death* which is a series of essays, by physicians from the Yale Medical School, on attitudes to death] describes the development of his own attitudes to the role of medicine:

"By the time I was senior in medical school, I was no longer someone who thought that the greatest good I could achieve was the relief of human suffering. Instead I had begun to believe that the greatest good I could achieve was the solution to The Riddle of disease". [*op.cit.* p.39]

*"It should be understood that caring is the most basic value in medicine ... the same cannot be said of cure, which is not always needed."*²⁶¹

Conclusion_{9 - 14} : Callahan in *The Troubled Dream of Life* concludes that death denial pervades Western society and its medicine. He recommends that:

- * *medicine must fully acknowledge that death is intrinsic to the human condition.*
- * *the presumption that it is possible, either on an individual or social level, to be in control of nature - and in particular of death - must be jettisoned.*
- * *the caring aspect of medicine - and in particular the goal of a peaceful death - must be reintegrated into, and given an honoured role in, medical practice.*

Section 3: The moral obligations implied in stating a death is 'a good death'.

In Section 1 of this chapter it was argued that the proposition '*Death is an evil*' could not be justified on *logical* grounds; in Section 2 it was contended that it could not be justified on *psychological*²⁶² grounds. Thus, the proposition '*Death is an evil*' (simpliciter) is not sustainable. From this it follows that *some* deaths are a 'good'.

Conclusion_{9 - 15} : *As the proposition 'Death is an evil' (simpliciter) cannot be justified on either logical or psychological grounds, it is not sustainable. It follows that some deaths are a 'good'.*

What characterises such deaths?

One possible avenue of investigation is to pose the question²⁶³ 'How would you wish to die?' A person who fully (*i.e.* not just intellectually but also emotionally) accepts their mortality, will not respond to such a question by refusing to contemplate such an eventuality - for such evasion would be a denial of death - but will have certain preferences. Some deaths will be desired and these could be termed '*good deaths*' - for example death '*without pain*', or '*not alone*', or '*at peace with myself*'. There will be others that would be regarded with loathing and these could be termed '*bad deaths*' - for example death '*by violence*', or '*prolonged painful death*', or '*death where one was treated as an object*'. However, before pursuing this analysis a possible ambiguity first needs to be resolved.

A possible ambiguity

It may be that the term '*good*' when used in the context of 'a good death' is not being used in its ethical sense but in a vernacular or aesthetic sense. It seems best to (at least temporarily) distinguish between two senses of the term '*good*' (an aesthetic sense and a moral sense) and to

"As physicians, we abandon our patients too frequently, and almost universally. I attribute this failure again to our fascination with The Riddle of disease. It is the riddle of diagnosis and therapy that captivates us. When we realise that there is no longer anything we can do, the very stimulus that has made us excellent doctors in an intensive care unit is lost: we lose interest in our patients as individuals because we have lost our interest in their now insoluble Riddle. We must reorient ourselves to an image of us not only as enemies of disease but also as people who stand by the values that brought most of us into medicine - the values that inform us that our primary mission is to relieve human suffering." [op.cit. p.42]

²⁶¹ Callahan op.cit. p.209.

²⁶² In the sense of it not providing a viable belief system from which to live one's life. These are distinct grounds. It was John Dewey, I believe, who suggested that it was not the *truth* of a belief that was of importance, but whether the belief permitted us to live life well.

²⁶³ This way of tackling the problem of defining 'a good death' was suggested by a comment in Callahan's book where he spoke of '*just listening to people talk about the death they would like*'. [op.cit. p.195]

correspondingly distinguish between two senses of the term 'a good death': the moral sense denoted by '*Good_MDeath*', and the vernacular sense denoted by '*Good_VDeath*'. Our first task is to consider the import, if any, of this distinction.

Imagine a mountaineer whose greatest love was to climb and who had spent his life scaling the highest mountains in the world. In attempting one such mountain - which he had always found particularly challenging - his rope gave way, he fell and was instantly killed. Colleagues could, perhaps, call such a death 'a good death' in the sense of it being a fitting or apt or appropriate end to a career spent climbing. Would their use of the term be in the sense of a '*Good_MDeath*', or in that of a '*Good_VDeath*'?

Ethical propositions are often characterised as being '*ought-type*' statements (in contrast to, for example, scientific propositions which are '*is-type*' statements in that they describe an existing situation and connote no sense of obligation). Applying this to our example would suggest that (because in saying that the climbers death was 'a good death' there is no connotation of 'oughtness') the sense is that of '*Good_VDeath*'. But is this a premature conclusion? Is the calling of such a death a '*Good_VDeath*', devoid of ethical significance?

If it transpired that the climbing partner had cut the rope, thus causing the death, the phrase 'a good death' would seem highly inappropriate; however, if it then became apparent that the climber had been suffering from a terminal illness, had not long to live, had wanted to die whilst climbing and had asked his partner to help him die on the mountain and the rope had been cut in response to this, the balance again changes and the phrase may again become appropriate. Such considerations show that the phrase '*Good_VDeath*' is not independent of ethical considerations. The problem then is to determine the nature of this dependence.

One method of resolving this difficulty is by using the concept of '*aptness*'. It was mentioned earlier²⁶⁴ that both uses of the term '*good*' could perhaps be subsumed under the one concept of '*aptness*' or '*fitness for purpose*' or '*appropriateness*', and that this appears to have been the practice in Greek philosophy. However, to say of a response that it was '*appropriate*' requires an examination of more than just the circumstances which were responded to, it also requires consideration of the '*responder*'. Certain responses to circumstances may be appropriate responses for one person to make but not for another: to chastise a misbehaving child may be an appropriate response from a parent but not so from a stranger. Thus, in considering whether a response is apt, not only the circumstances but also the status of the responder must be taken into account - a complication that is often neglected in considering whether an action is ethically a '*good*'. Thus, to say of the death of the mountaineer that it was a '*good*' means that considering all the circumstances it was an apt end to the climbers life - but apt in the sense of apt for 'the gods' to decree, not for man; ('the gods' knowing that this man must die and aware of all the possibilities, may decree that his death on the mountain is the most fitting end). However, for any 'mere' human to lay claim to such knowledge and thus appropriate the role of 'the gods', would render his involvement in the death of the climber inappropriate; this is most especially so if such action was done without the knowledge and consent of the one for whom it was supposedly performed.

A second method of resolving the difficulties is to use the device adopted by Philippa Foot in her discussion of euthanasia;²⁶⁵ Foot, in discussing whether an action was, or was not, a '*good*',

²⁶⁴ It was mentioned at the beginning of this chapter that the Greek term '*arete*' - often translated as virtue and which appears to us to be an ethical term - was used by the Greeks to refer to the ability to respond *appropriately* to the existing circumstances.

²⁶⁵ Discussed earlier in Section 1, Subsection 2; and in Appendix D.

separated the 'goodness' of the action from the 'oughtness' of the action. A (contemplated) action could be considered a good if, in so far as it affected X, it was being done 'for the sake of' X. Such (contemplated) actions were a good because they sprang from the virtue of Charity. The judgement that a (contemplated) action was a 'good', although a necessary condition was, however, not a sufficient condition for its being performed; for not only had the (contemplated) action to be in accord with Charity, it must also accord with Justice. Foot's principle is that '*Where Charity and Justice conflict, Justice must prevail*'. The principle of 'Justice' that Foot has in mind, is the right to non-interference - 'to be let alone' - so that no person should be subjected to interference against his will even if this be done with the 'best' of motives. To return to our mountaineering example, although the knowledge of a fellow climber that his companion was suffering from a terminal illness, and that dying on the mountain would be 'a good death' for him, he is prohibited by the virtue of Justice from attempting to achieve this unless done at the request of his fellow climber. However, even if his friend requests help in dying - thus removing the objections flowing from considerations of Justice - Foot is of the view that the wider interest of society may still prohibit such actions.

To summarise: to Foot, a (contemplated) action is a good if it flows from the virtue of Charity, it should not, however, be performed unless it satisfies the requirements of Justice; this however may not be a sufficient condition as it may also be required that the action be not detrimental to the interests of the wider society.²⁶⁶

Returning to the distinction made earlier between a 'Good_V Death' and a 'Good_M Death', the import of the distinction seems to lie in the fact that in discussing a 'Good_V Death' the unqualified sense of 'oughtness' - usually implicit when something is described as being a 'good' - is not present. Once it is accepted, in stating 'a good death' is a 'good', that the 'ought' implications are strictly circumscribed, then the distinction between a 'Good_V Death' and a 'Good_M Death' can be dropped.

Conclusion 9 - 16 : *In stating that 'a good death' is a good, the obligations imposed on third parties must be strictly circumscribed.*

'A good death' is not 'a least worse death'

Margaret Pabst Battin has used the concept of '*The Least Worse Death*'²⁶⁷ in her analysis of 'end-of-life' decisions:

*"The crucial point is that certain conditions will produce a death that is more comfortable, more decent, more predictable, and more permitting of conscious and peaceful experience than others. Some are better, if the patient has to die at all, and some are worse. ... What the patient who rejects active euthanasia or assisted suicide may realistically hope for is this: the least worse death among those that could naturally occur."*²⁶⁸

The phrase '*the least worse death*' - as is emphasised in the phrase '*if the patient has to die at all*' - is irretrievably embedded within the framework of death denial, of believing that death is contingent and that it is an evil. The use of such a phrase, whilst it may arrest the greatest

²⁶⁶ It is possible to include this last condition under the ambit of Justice if Justice is considered to have two aspects: an individual aspect 'Justice_i' and a social aspect 'Justice_s'; this is discussed further in Chapters 10 and 11. I wish to thank Dr. Dolores Dooley for this suggestion.

²⁶⁷ Margaret Pabst Battin, *The Least Worse Death*.

²⁶⁸ Battin *op.cit.* p.36 [emphasis added]

excesses of interventionist medicine, still validates the philosophical principles which underlie such procedures and thus reinforces the denial of death.

The connotations of suggesting to medical professionals that they help a patient achieve 'a good death' are quite different to those implicit in helping a patient achieve a 'the least worse death'. The former implies some positive obligations on carers, the latter suggests a duty of non-intervention: imagine a recently bereaved family discussing the death of a beloved with the deceased's medical carers; for the family to congratulate the carers for helping their relative achieve 'a good death' though, perhaps, not common would be unremarkable; however, for them to congratulate the carers for their loved one's '*least worse death*' would surely be bizarre; this clearly shows the magnitude of the difference between the connotations of the different terms. Callahan is also of the opinion that a 'lesser evil' standard is not appropriate.²⁶⁹

In stating that 'a good death' is a 'good', what obligations are implied?²⁷⁰

General considerations

In saying such a death is a 'good', obligations might arise in two ways;

- * in relation to occasioning²⁷¹ the death itself, and
- * in relation to occasioning the 'goodness' of the death.

In relation to occasioning the death itself

A consideration of the question '*How would you wish to die?*' makes clear that to be killed in the face of one's direct protestations could never be considered to be 'a good death', whereas to be killed at one's request might well be so considered. This might suggest that if the death - as distinct from the nature of the death - was being occasioned, that consent was a requirement; however, there are circumstances - such as irreversible coma or PVS - where many might consider that even to be killed without one's consent was a 'good'. As is evident from the continuing debate on assisted suicide and euthanasia the question is contentious, however, some assistance can be derived from a consideration of the requirements of Justice which are considered below and (in more detail) in Chapter 11.

However, one conclusion can be unequivocally stated:

- * To occasion the death of another in the face of their objections could not be considered to be 'a good death'

In relation to occasioning the 'goodness' of the death

In recognising that an intervention in a person's dying which was contrary to their wishes would be destructive of the goodness of the death, it is clear that the primary obligation is to attempt to communicate with the patient in an effort to determine their wishes. Kübler-Ross has suggested that the obligation on the carers to communicate with the dying patient is perhaps the greatest

²⁶⁹ Callahan *op.cit.* p.180:

"But is a 'lesser evil' standard strong enough? I think not."

²⁷⁰ To answer this question fully it is first necessary to clarify the concept of 'personhood' and, in particular, the necessary conditions for its ascription (this is done in Chapter 10); this gives us the tools to enable a more rigorous discussion of the nature and limitations of the obligations imposed on medical carers to help a patient achieve 'a good death' (this discussion is the focus of Chapter 11).

The discussion which follows sets out the views of Kübler-Ross and Callahan on the obligations imposed on medical carers in relation to 'a good death' and seeks to draw some broad conclusions; it is best considered as being preliminary to the discussion in Chapter 11.

obligation at this time - the important thing being simply to ask the dying person "*What do you want?*"²⁷² She has described²⁷³ the typical medical practice in relation to a severely ill patient as beginning by considering him as a '*person with no right to an opinion*'²⁷⁴ and progressing to treating him as an object.²⁷⁵ This permits the conclusion:

- * The primary obligation on the medical carers of a patient who has entered onto the threshold of death is to attempt to communicate with the patient.

Obligations flowing from Justice

The obligation to communicate flows not only from the obligation to ensure 'a good death', it is also a direct consequence of the requirements of Justice. Foot considers that the requirements of Justice can, in the present context, be crystallised in '*the duty of non-interference*'. Justice could thus be infringed either by interfering to cause the death of a person unless at the request of that person, or by interfering with the death of a dying person in a manner contrary to their wishes; the first, obviously, being the more serious infringement. In considering a medical intervention, the primary duty on carers - as seen from the perspective of Justice - would be to attempt to communicate with the patient so as to establish their wishes, the secondary obligation would be to desist from such a proposed intervention if it were contrary to the patient's expressed wishes. This permits the conclusion:

- * Medical carers should desist from a proposed intervention if contrary to the patient's expressed wishes.

The last three conclusions can be amalgamated:

Conclusion 9 - 17 : *The primary obligation on the carers of a patient who has entered onto the threshold of death is to attempt to communicate with the patient. Medical carers should desist from a proposed intervention if contrary to the patient's wishes and, in particular, the occasioning of the death of a patient in the face of his objections could not be 'a good death'.*

What if communication is not possible?

What of those patients with whom it is not possible to communicate so that it is not possible to ascertain whether they wish to be helped to die, or, if dying, how they should be assisted?²⁷⁶

There are two situations to be considered:

- firstly*, where it is believed that communication, although not possible at present, can be re-established; and
- secondly*, where it is believed that the loss of the ability to communicate is permanent.

In the first case the requirement is that all effort should be directed towards re-establishing communication and that such attempts should only be stopped if they appeared to be destructive of a peaceful death. The questions to be asked are '*If this immanent death be prevented:*

²⁷¹ I use the word 'occasioned' rather than 'caused' as the later suggests, in certain contexts, a degree of opprobrium; a (justifiable) withdrawal of treatment which foreseeably leads to death would 'occasion' that death.

²⁷² Kübler-Ross (1975) p. 36.

²⁷³ as mentioned earlier in Section 2.

²⁷⁴ Kübler-Ross (1970) p.7

²⁷⁵ [Kübler-Ross (1970) p.8]:

"Slowly but surely he is beginning to be treated like a thing. He is no longer a person. Decisions are made often without taking his opinion. If he tries to rebel he will be sedated"

(i) *Is it likely that communication can be re-established?* and

(ii) *Is it likely that a later death will be a better death?*

In such cases much depends on the individual circumstances and, in particular, on whether the patient was aware that death was immanent and has settled his affairs or whether 'unfinished business' remains. Such cases raise their own complication and, as they are not within the ambit of this thesis, they will not be considered further. The second type of case will be considered in the Chapter 11.²⁷⁷

The conclusion to be drawn is that:

Conclusion ⁹⁻¹⁸ : *In considering whether a prospective death is 'a good death' for a patient who has entered onto the threshold of death (i.e. one for whom death is an immanent possibility) it is important to distinguish between those patients who have the present ability to communicate, those with whom communication may be established and those who have permanently lost the ability to communicate.*

Callahan's position

As has been discussed,²⁷⁸ Callahan believes that in discussing death, dying and the appropriateness of medical intervention, the most crucial step is the acceptance of the inevitability of death. Once this is recognised then any medical decision to intervene to postpone death *must* weight the possibility that the later death may be worse than the one avoided. To Callahan:

"Death is acceptable ... when it comes at a point in life when

(i) further efforts to defer dying are likely to deform the process of dying, or when

*(ii) there is a good fit between the biological inevitability of death in general and the particular timing and circumstances of that death in the life of the individual."*²⁷⁹

A death in such circumstances is not only morally acceptable but is a moral good.²⁸⁰

Callahan argues that:

*"It is a moral evil to distort death negligently by human intervention just as it is a moral evil wilfully to allow death to occur when the timing²⁸¹ and circumstances are wrong."*²⁸²

Furthermore, it is imperative that:

*"... once a potentially fatal illness appears, it be considered seriously as the candidate for the cause of death, if other conditions of the timing and circumstance of death are acceptable."*²⁸³

²⁷⁶ These categories are distinct: a PVS patient, for example, is not dying yet it can be contemplated that they might wish to die; though see Callahan's criticism (below) of the phrase 'is dying'. Perhaps, both cases can be subsumed under the phrase 'entered onto the threshold of death' - i.e. where death is an immanent possibility.

²⁷⁷ There the argument will be developed that, in accordance with the necessary condition for personhood to be established in Chapter 10, a permanent loss of the ability to communicate entails a loss of personhood. This loss of personhood in turn entails that the requirements of Justice - in the sense of the obligation of non-interference - lapse. In such situations the requirements of Charity are gainsaid only by the interests of the wider society, if at all.

²⁷⁸ Section 2, Subsection 2.

²⁷⁹ *ibid.* p.180.

He believes that death can be deformed in three ways;

- by 'deforming the process of dying itself' - as in technological brinkmanship which can 'both save life and ruin dying' as when it results in extended loss of consciousness;

- by 'deforming the dying self' - as with obsessions with loss of control or loss of image.

- by 'deforming the community of living' as when community life is distorted thorough the denial of death or through doctrines that certain lives are not worth living. [Callahan *op.cit.* p.192]

²⁸⁰ *ibid.* p.200:

"I call such a death a 'moral good' because it allows us to achieve important personal as well as social ends."

²⁸¹ i.e. they are premature and untimely.

²⁸² *ibid.* p.185.

Callahan suggests two additional tests to determine whether a death is opportune:

- * The 'historical mourning test' - 'Would such a death have been greatly mourned a generation ago as unfair?'²⁸⁴ and
- * The 'treatment invention test' - 'If such a treatment had not yet been invented would we wish for it?'²⁸⁵

For example, in relation to PVS patients, the 'historical mourning test' would pose the question as to whether, a generation ago the death of such a patient would have been considered as unfair. The 'treatment invention test' would pose the question as to whether, in the absence of such as ANH, we would have hoped for its invention for use with PVS patients.

Callahan believes that the 'location of the gate between life and death' is becoming increasingly more indeterminate so that now it is:

"... increasingly useless to base decisions concerning whether to terminate treatment on some medical determination that the patient 'is dying'.²⁸⁶ ... The old question was: when is a patient dying, and thus a candidate for the abatement of lifesaving treatment? The new question should be: at what point, or within what range, should lifesaving treatment be abated to enhance the likelihood of 'a good death'?"²⁸⁷

Callahan's emphasis would be on the moral obligation on carers,²⁸⁸ if the timing and circumstances are opportune, to ensure the best death possible for their patient. The conclusion to be drawn is that:

Conclusion⁹⁻¹⁹: *The acceptance of human mortality implies that medical carers must, in treating a patient who has entered onto the threshold of death, consider whether - in postponing the particular death - a 'better death' is more likely. The particular circumstances of the patient and their family are of crucial importance to any such evaluation. If it is deemed that a better death is unlikely then the immanent death (termed 'a good death') is a positive good in the sense that there is a moral obligation²⁸⁹ on the medical carers to attempt to achieve that death for their patient and to do so in a manner that is in as harmonious as is possible with the patient's interests. 'A good death' is to be distinguished from a 'a least worse death' which connotes no such positive moral obligations.*

²⁸³ *ibid.* p.199.

²⁸⁴ *ibid.* p.183.

²⁸⁵ *ibid.* p.184.

²⁸⁶ I have earlier used the phrase 'entered on the threshold of death' - i.e. that death is 'on the agenda', a possibility - in place of the phrase 'dying'; I believe that this meets Callahan's objections.

²⁸⁷ *ibid.* p.44-46.

²⁸⁸ The BMA, for example, have stated:

"... there are strong arguments for complying with reasonable requests from competent patients for treatment to be continued for a limited period to allow them to achieve a particular goal or to sort out their affairs. What is 'reasonable' will need to be judged on an individual basis, taking account of factors such as the patient's ability to achieve the goal, the time it would take to do so and the potential opportunity costs for other patients who may be denied treatment as a consequence of respecting the patient's wishes." [BMA (1999a) 2.11.1]

²⁸⁹ By using the concept of 'personhood' (which is discussed in Chapter 10) a more detailed examination of the nature of these obligations is possible; this is carried out in Chapter 11.

Some further characteristics of 'a good death'

I believe that to attempt to *define* 'a good death' - in the sense of attempting a comprehensive list of necessary and sufficient conditions - would be counterproductive. Although it - like the concepts of 'a happy childhood' or 'a good birth' - escapes any attempt at exhaustive definition some general characteristics can be enumerated and some of the threads that might help to create that tapestry that is a good death will be suggested in what follows.

Kübler-Ross, as has been mentioned, is highly critical of inappropriate 'life sustaining' medical intervention:

*"This man was ready to separate himself from this world. ... many such patients have been given an additional 'lease on life'. I have heard more curses than words of appreciation for the gained time, and I repeat my conviction that a patient has a right to die in peace and dignity. He should not be used to fulfil our own needs when his own wishes are in opposition to ours."*²⁹⁰

Kübler-Ross believes that the greatest effort should be directed towards keeping open the possibility of communication with the dying person:

*"All too often families ... and even medical staff assume that all a dying person wants is to be comfortable. ... We are terribly anxious about pain and seek the latest medications, most of which deaden the mind as well as the body. I am not prepared to say that this is all wrong. But I do believe that we have our priorities confused. Someone's life is about to end. Surely, there are important things for that person to say and do before he dies!"*²⁹¹

In order to clarify the issues involved, the two extremes of 'conscious dying' and 'sedated dying' can be contrasted. Kübler-Ross would err in favour of the conscious dying because it would allow matters of 'unfinished business'²⁹² to be resolved for both the patient themselves²⁹³ and for the patient's family. Erring on the side of 'sedated dying' may indeed be just a further manifestation of death denial on behalf of *the carers*, in that they themselves can be shielded from the more distressing aspects of death and dying. A move towards 'sedated dying' may be the unintended consequences of the recommendations made by the Institute of Medicine, discussed earlier,²⁹⁴ and the judgement of the US Supreme Court against the right to assisted suicide and in favour of extended palliative care.²⁹⁵

Callahan also favours 'conscious dying' over 'sedated dying'; in discussing his concept of a 'peaceful death'²⁹⁶ he says:

²⁹⁰ Kübler-Ross(1970) p.156, [emphasis added].

²⁹¹ Kübler-Ross (1975) p. 36.

²⁹² The phrase 'unfinished business' refers to any issues that have not been fully dealt with in our lives and for which we feel the need for resolution. Kübler-Ross has commented [Kübler-Ross (1970 p.241)]:

"We are always amazed how one session can relieve a patient of a tremendous burden and wonder why it is so difficult for staff and family to elicit their needs, since it often requires nothing but an open question."

²⁹³ as, for Roman Catholics, in confession.

²⁹⁴ Section 2, Subsection 2.

²⁹⁵ The New England Journal of Medicine in its 'Sounding Board' of October 23, 1997, Vol. 337, No. 17, says

"By authoritatively pronouncing that terminal sedation intended for symptomatic relief is not assisted suicide, the Court has licensed an aggressive practice of palliative care."

²⁹⁶ Speaking in the first person, Callahan defines a 'peaceful death' by the following criteria:

I want to find meaning in my death or at least be reconciled to it;

I hope to be treated with respect and sympathy;

I would like my death to matter to others;

I do not want to die abandoned;

I do not want to be an undue burden on others;

I want to live in a society that does not shun death;

*"What must a peaceful death encompass? There is need to fashion a notion of the self that has, in some sustaining way, come to accept death, a self that understands that control over fate will pass from its hands, that this is precisely what biological death means and must mean. It should also be a death marked by consciousness, by a self awareness that one is dying, that the end has come - but, even more pointedly, a death marked by self-possession, by a sense that one is ending one's days awake, alert, and physically independent, not as a machine-sustained body or a body that has long ago lost its mind and self-awareness."*²⁹⁷

Callahan's view is that the achievement of a peaceful death should not be a goal sought only when nothing more can be done, but should be central to the mission of medicine.²⁹⁸

Conclusion 9 - 20 : *'a good death' - as in a leavetaking - should as far as is possible be marked by a conscious awareness of parting; for this reason excessive sedation (which is often administered for reasons of death denial on the part of family or medical carers) should be avoided.*

Kübler-Ross has spoken about some people having a *wiffulness* about their deaths in that they showed a remarkable power of personal choice in their dying; they intuitively sensed:

*"... that meaningful life was drawing to a close and [were] able to enter the final phase easily and naturally."*²⁹⁹

Kübler-Ross was discussing American Indians; the same *wiffulness* and composure in the face of death is also a mark of the Japanese Zen Buddhist, seen particularly in the tradition of writing death poems³⁰⁰ shortly before the moment of death. It is also found in Hindu culture: Werner Menski comments on traditions of death in Hinduism:

*"Yet again, the individual conscience of the terminally ill individual allows for radical solutions. The Hindu concepts of 'a good death' and 'a willed death' are relevant here. In the former, a person prepares for death, having finished all earthly business. In 'a willed death' people who are old and weak, but not terminally ill, may virtually wait till death arrives, refusing to take any food or drink."*³⁰¹

This is of particular interest in relation to 'end-of-life' decisions for PVS patients in that withdrawal of food (in the form of ANH) - though often categorised disparagingly as starvation and thus carrying the implication that it is an evil - is yet the preferred method of those who 'will' their own deaths; these are said to die with such a composure that the conclusion might be drawn that deaths by food withdrawal is not necessarily destructive of 'a good death'.

*I want to be conscious;
I want my death to be quick and not drawn out;
I hope that I can bear pain well if it is unavoidable.*

[*op.cit.* p.195]

²⁹⁷ Callahan *op.cit.* p.54.

²⁹⁸ *ibid.* p.185.

²⁹⁹ Kübler-Ross (1975) p. 36.

³⁰⁰ A few days before his death Kozan Ichikyo called his pupils together, ordered them to bury him without ceremony and forbade them to hold services in his memory. He wrote the following poem on the morning of his death, laid down his brush and died sitting upright:

*"Empty-handed I entered the world
Barefoot I leave it.
My coming, my going -
Two simple happenings
That got entangled."*

from Yoel Hoffman (ed.) Japanese Death Poems. [Quoted in the Internet magazine *Salon*, in an issue devoted to death and dying. Internet source: <http://www.salon.com/weekly/intro960805.html>]

³⁰¹ Included in Morgan, Peggy & Lawton, Clive (eds.) Ethical Issues in Six Religious Traditions at p.33.

Conclusion 9-21 : *Death by withdrawal of food - and a fortiori withdrawal of ANH - is not necessarily destructive of 'a good death'.*

A contrary view is that the practice of withdrawal of ANH from sedated patients, or the use of 'double effect' drugs, is inhuman and could not constitute 'a good death'. It is often suggested that the killing of such patients might, in certain circumstances, be both more honest³⁰² and more humane.

More honest, in that reliance is not placed on doctrines of indirect effect which many consider to be intellectually dishonest.³⁰³

More humane, in that the action of 'double effect' drugs³⁰⁴ is unpredictable. Dr. Bert Keizer³⁰⁵ considers that morphine - when used as a 'double effect' drug - is barbaric; he states that such procedures are banned in Holland because they are slow and uncertain.³⁰⁶ Professor O'Shea, a neuroscientist, in discussing the painful death of his 11 year old daughter from an inoperable brain tumour, testified to a similar effect: his daughter had been given a 'double-effect' drug which, he had been told, was likely to stop her breathing; the hope was that she might die gently and without stress yet:

"It took nearly 24 hours for Linda to succumb. During that time she was going through complete arrests of breathing for several minutes, then the nervous system would kick in and she would start breathing again. It was extremely distressing: she died several times ... "

A mother, whose 4 year old son's feeding tube was removed, states that his death:

"... was a long drawn out process in our home that took 17 days."

These testimonies show the importance, when discussing 'a good death', of considering the effect of a death of a patient *on their family* - the more harrowing and distressing the less 'good' the death.³⁰⁷ The necessity of considering the effect on the family is all the greater when considering patients who are believed to have permanently lost consciousness as there the greater quantum of the good in 'a good death' will come, not from the patient, but from the family and the wider society. However, many would argue that there are no circumstances where a direct killing could be considered to be either 'a good death' or a 'good'. Yet to harbour only feelings of compassion towards another and to do them an evil would also seem to be contradictory; unless, of course, there was an infringement of the obligations of Justice. It will be argued in Chapter 11 that, in relation to PVS patients, the obligations of Justice, as to non-interference, are in abeyance; this will leave open the possibility that to kill such patients, if motivated solely by compassion, might not be an evil and might in the circumstances constitute 'a good death'. This does not imply that such killing should be legalised.

Conclusion 9-22 : *It is possible that, in certain cases - such as when requested to do so by a patient or in cases where the ability to communicate is irretrievably lost - a killing*

³⁰² Quill, Dresser and Brock 'The Rule of Double Effect - A Critique of Its Role In End-of-Life Decision Making' New England Journal of Medicine 337, 24, (1997) are critical of the doctrine and of attempts to use it to justify the practice of 'terminal sedation'.

³⁰³ See the earlier discussion in Chapter 6, Section 3, Subsection 1(ii).

³⁰⁴ i.e. drugs the use of which use can be justified under the doctrine of double effect in that they are painkillers but which can also foreseeably result in death.

³⁰⁵ Keizer has written (in his Dancing with Mr. D) on the practice of euthanasia in the Netherlands.

³⁰⁶ This, and the following testimonies, was reported in an article in the Sunday Times of 27.7.1997.

³⁰⁷ One of Callahan's criteria for a 'peaceful death' was that it did not deform or distort the dying process; he listed three ways in which this might happen, the third being 'the deforming of the community of the living'.

might be constitutive of 'a good death'. However, there may be important social reasons why such a killing should be prohibited.

Section 4: Conclusions

In Section 1 of this chapter, it was established that the proposition 'Death is an evil' could not, if unqualified, be justified on logical grounds; in Section 2, it was established that it could not be justified on psychological grounds; hence, the proposition 'Death is an evil' (simpliciter) is not sustainable. Consequently there are *some* deaths that may be spoken of as being 'good deaths'. Whilst recognising that such deaths cannot be precisely defined, Section 3 sought to outline their broad characteristics.

The greatest hindrance to a good death is caused by the denial of death; such denial is prevalent throughout society but is particularly acute in clinical medicine. The primary manifestation of death denial is the belief that death is contingent and that it is possible to be '*in control*' of one's death; the view that the primary role of medicine lies in the cure of disease rather than in the care of patients exacerbates the worst effects of death denial.

The resolution of the problem of death denial lies through a full acceptance of human mortality, through a recognition that death is intrinsic to the human condition and that medicine cannot attempt to control death but can, at most, influence the circumstances or the timing of an individual death. This limited control should only be exercised in the knowledge that (in the light of all the circumstances of the particular case) if the 'present' death is, in fact, postponed a 'better death' is more likely. If it is deemed that a 'better death' is unlikely then the immanent death is a positive good³⁰⁸ in the sense that there is a moral obligation³⁰⁹ on the medical carers to attempt to achieve that death for their patient and to do so in a manner that is in as harmonious as is possible with the patient's interests. 'A good death' is to be distinguished from a 'a least worse death' which connotes no such positive moral obligations.

In considering whether a perspective death is 'a good death' for a patient who has entered onto the threshold of death,³¹⁰ it is important to distinguish between:

- (i) those patients who have the present ability to communicate;
- (ii) those with whom communication may be established; and
- (iii) those who have permanently lost the ability to communicate.

In the first two cases the primary obligation on the patient's carers is to attempt to communicate with the patient and, having succeeded, to accede as far as is possible to the patient's wishes; medical interventions contrary to the patient's wishes are incompatible with 'a good death'. It is important that, where possible, dying be a conscious experience as only in such circumstances can 'unfinished business' - which if it exists is destructive of 'a good death' - be resolved; for this reason excessive sedation should be avoided.

In cases where the patient is deemed to have permanently lost the ability to communicate it is important to recognise that it is not only the patient's interests that must be considered in classifying an immanent death as being 'a good death', the interests of the patient's family and carers are also of importance: for a death to be 'a good death' it must cause minimal damage to the surviving community. In certain circumstances it is possible that a killing or that a withdrawal of food or of

³⁰⁸ then termed '*a good death*'.

³⁰⁹ The nature of this obligation is discussed more fully in Chapter 11.

³¹⁰ *i.e.* one for whom death is an immanent possibility.

ANH may be constitutive of 'a good death'; however, there may be important social reasons why such procedures should be prohibited; these issues are discussed in greater detail in Chapter 11.

The conclusions which were established in this chapter are:

Conclusion₉₋₁ : *The belief in the contingency of X and that the occurrence of X is, to some extent, dependent on human agency are preconditions for asserting either 'X is good' or 'X is evil'.*

Conclusion₉₋₂ : *The predicates 'good' or 'evil' cannot meaningfully be applied to 'death' without further qualification. The assertion that 'Death is an evil' (simpliciter) implies a denial of death in that it implies a refusal to accept human mortality.*

Conclusion₉₋₃ : *Christianity considers 'death' to be a punishment inflicted on man and as not intrinsic to the human condition; it - unlike many Eastern religions - subscribes to the proposition 'Death is an evil'.*

Conclusion₉₋₄ : *The arguments against the proposition 'Death is an evil' (simpliciter) are varied:*

- (i) that, in times of suffering, death can be a friend. (Foot, Scruton)*
- (ii) that human mortality is a fact of the universe and, as such, must be accepted. (Plato, Spinoza)*
- (iii) that the gateway to an 'authentic' life which embodies individual moral responsibility, lies in the willing acceptance of our individual mortality; it is incompatible with the denial of death implicit in the proposition 'Death is an evil'. (Jaspers, Heidegger, Derrida)*
- (iv) that the gifts of creativity and spirituality flow from, and are sustained by, a full intellectual and emotional acceptance of our individual mortality. (Becker, Koestler)*

Conclusion₉₋₅ : *Arguments, such as Nagel's, that 'Death is an evil' because we desire immortality gives precedence to desire over reality; as such they are hardly to be commended on rational grounds.*

Conclusion₉₋₆ : *Arguments that the fear of death is 'irrational' presume that, for a fear to exist, it must have rational grounds and that, once the 'irrationality' of the grounds are demonstrated, the fear can be vanquished by an act of will. Fear is not removable by an act of will and the distinction made by the Existentialists between 'anxiety' and 'fear' show that questions of rationality are inappropriate in discussing the fear of death.*

Conclusion₉₋₇ : *Arguments which seek to establish deduce the evil of some particular occurrence from the fact that it is feared, trivialise the concept of evil.*

Conclusion₉₋₈ : *The proposition 'Death is an evil' considered simply as a proposition of psychology, i.e. as a maxim for living, should be rejected; it is the denial of death, rather than death, that is an evil.*

Conclusion 9 - 9 : *In clinical medicine, 'death denial' is manifested in:*

- * *a refusal to fully acknowledge the inevitability of death..*
- * *inappropriate medical activity in the face of death.*
- * *the belief that when death occurs it is due to a failure of medicine.*
- * *the belief that 'nothing can be done' to help a dying patient.*
- * *a refusal to talk to patients about their dying.*

Conclusion 9 - 10 : *Kübler-Ross's principle recommendations involve:*

- (i) *the necessity of combating 'death denial' - which she regards as endemic amongst medical professionals, and*
- (ii) *the primacy of the obligation on medical professionals, to communicate with their patients.*

Conclusion 9 - 11 : *Recent reports from the US Institute of Medicine (1997) and the BMA (1999) indicate that 'death denial' is a widespread phenomenon of modern life; the US report found considerable evidence of it's prevalence in clinical medicine.*

Conclusion 9 - 12 : *The Institute of Medicine's 1997 report clearly shows that, of the alternative philosophies of medicine i.e. 'curative' or 'caring', it is the curative that, at least in the US, is in the ascendant.*

Conclusion 9 - 13 : *A medical ideology which defines the medicine's role as being fundamentally curative and which minimises its caring role, tends to foster death denial.*

Conclusion 9 - 14 : *Callahan in The Troubled Dream of Life concludes that death denial pervades Western society and its medicine. He recommends that:*

- * *medicine must fully acknowledge that death is intrinsic to the human condition.*
- * *the presumption that it is possible, either on an individual or social level, to be in control of nature - and in particular of death - must be jettisoned.*
- * *the caring aspect of medicine - and in particular the goal of a peaceful death - must be reintegrated into, and given an honoured role in, medical practice.*

Conclusion 9 - 15 : *As the proposition 'Death is an evil' (simpliciter) cannot be justified on either logical or psychological grounds, it is not sustainable. It follows that some deaths are a 'good'.*

Conclusion 9 - 16 : *In stating that 'a good death' is a good, the obligations imposed on third parties must be strictly circumscribed.*

Conclusion 9 - 17 : *The primary obligation on the carers of a patient who has entered onto the threshold of death is to attempt to communicate with the patient. Medical carers should desist from a proposed intervention if contrary to the patient's wishes and, in particular, the occasioning of the death of a patient in the face of his objections could not be 'a good death'.*

Conclusion _{9 - 18} : *In considering whether a prospective death is 'a good death' for a patient who has entered onto the threshold of death (i.e. one for whom death is an immanent possibility) it is important to distinguish between those patients who have the present ability to communicate, those with whom communication may be established and those who have permanently lost the ability to communicate.*

Conclusion _{9 - 19} : *The acceptance of human mortality implies that medical carers must, in treating a patient who has entered onto the threshold of death, consider whether - in postponing the particular death - a 'better death' is more likely. The particular circumstances of the patient and their family are of crucial importance to any such evaluation. If it is deemed that a better death is unlikely then the immanent death (termed 'a good death') is a positive good in the sense that there is a moral obligation on the medical carers to attempt to achieve that death for their patient and to do so in a manner that is in as harmonious as is possible with the patient's interests. 'A good death' is to be distinguished from a 'a least worse death' which connotes no such positive moral obligations.*

Conclusion _{9 - 20} : *'A good death' - as in a leavetaking - should as far as is possible be marked by a conscious awareness of parting; for this reason excessive sedation (which is often administered for reasons of death denial on the part of family or medical carers) should be avoided.*

Conclusion _{9 - 21} : *Death by withdrawal of food - and a fortiori withdrawal of ANH - is not necessarily destructive of 'a good death'.*

Conclusion _{9 - 22} : *It is possible that, in certain cases - such as when requested to do so by a patient or in cases where the ability to communicate is irretrievably lost - a killing might be constitutive of 'a good death'. However, there may be important social reasons why such a killing should be prohibited.*

Chapter 10: A necessary condition for personhood

Introduction

Philippa Foot in discussing¹ the question of whether an action is a 'good' - and whether, in consequence, it 'ought' to be performed - finds it useful to distinguish between the 'goodness' of the action and the 'oughtness' of the action; her analysis relates these to the, logically more basic, concepts - or virtues - of 'Justice' and 'Charity'.²

Foot suggests that a contemplated action can be considered to be 'a good' if - in so far as it affects X - it is being done 'for the sake of' X. Such actions, done 'for the sake of' another, spring from the virtue of Charity. Thus, 'good actions' are synonymous with 'charitable actions'.

But ought one perform such good actions? Here the situation becomes a little more complex. The judgement that a (contemplated) action is a 'good', although a necessary condition, is not a sufficient condition for advocating its performance because, Foot argues, it may still conflict with Justice. Foot's first principle is that for an action to be one which ought to be performed not only must it be in accord with Charity - and thus be a good action - but it must also accord with Justice. But what of actions which are in accord with one but not the other virtue? Foot's second principle helps resolve this dilemma. This principle is that, if the demands of Justice and Charity conflict, Justice must reign supreme; to assert otherwise would be to render Justice as null. Foot considers that the requirements of Justice can be crystallised³ into the 'right to non-interference' or 'the right to be let alone'.⁴ From this discussion it is possible to draw the conclusion that no person should be subjected to interference against his will even if this be done from the most altruistic of motives.

The term 'person'

The word 'person' has crept, as it were by stealth, into the last proposition. It is in fact *crucial* to its truth; by this I mean that if the term 'person' were replaced by, for example, the term 'human' the proposition would no longer be true. To see that this is so it is first necessary to analyse the concept of 'person' and this is, essentially, the task of this chapter. Earlier in the thesis⁵ the term 'Object of Intrinsic Moral Worth' ('OMW') was coined and it is useful in attempting to delineate the

¹ In her essay 'Euthanasia' included in Philippa Foot, *Virtues and Vices*, pp 33-62; this essay is summarised in Appendix D.

² Foot's use of the virtues of 'Justice' and 'Charity' to enable a distinction to be drawn between the 'goodness' and the 'oughtness' of an action has been adopted in this thesis and is fundamental to the arguments set out in this, and the succeeding, Chapter.

³ In a context similar to the present.

⁴ The fundamental nature of this 'right to be let alone' finds an echo in Joel Feinberg's discussion of 'rights':
"This reformulation of the harm principle gets us nowhere, however, until we have an account of which interests a person has a right not to have invaded by another. And the notion of right is notoriously obscure and ambiguous. Speaking generally, a right is a valid claim which an individual can make in either or both of two directions. On the one hand, some of a person's rights are claims he can make against specific individuals for assistance ... or against all other individuals - the 'world at large' - to noninterference in his private affairs. On the other hand, an individual citizen can also make claims against the state, not only for specific services ... but also claims to the legal enforcement of valid claims he has against other private citizens."

[Joel Feinberg, *The Moral Limits of the Criminal Law*: Vol. 1: 'Harm to Others' p.109 (emphasis in the original)].
Feinberg, neither in his volume on 'Harm to Others' nor in his 'Harm to Self' - Volumes 1 and 3 respectively of *The Moral Limits of the Criminal Law* - discusses the concepts of 'person' or 'personhood'. His discussion of 'rights' - considered in the abstract - is surprisingly limited; he does, however, quote with approval Bentham's adage:

"Right ... is the child of the law: from real laws come real rights; ... Natural rights is simple nonsense: natural and imprescriptible rights, rhetorical nonsense - nonsense upon stilts."

(*op cit.* p.254).

See also the judgement of Denham J. in the Ward case, (quoting Hamilton P. in *Kennedy v Ireland*):

"The right to privacy is not an issue, the issue is the extent of that right or the extent of the right 'to be let alone'."
(In the Matter of a Ward of Court [1995] 2 ILRM 401 at p. 460).

ambit of the term 'person'. It will be argued that 'person' stands in the same relation to Justice as 'OMW' stands to Charity, each describing the type of objects, effects on which are considered relevant when proposed actions are being scrutinised from the perspective of the corresponding virtue. In order to explain this more fully, let us first recap on the meaning of the term 'OMW'. So that the subsequent discussion in this chapter has a point of focus, the question (which was implicitly posed by Foot) should be born in mind: *'Why - arguing from a philosophical, as distinct from a religious, perspective - is it permissible to put an animal out of its pain but not so a human?'* The goal of this chapter is to first clarify, and then answer, this question.

'Objects of Intrinsic Moral Worth'

Ethical theories are often described as being concerned with the listing of certain prescriptive rules of behaviour - usually described as 'good' actions - and the justification for such rules. However, they also have in common the fact that in discussing the morality of a proposed action they will not be interested in *all* the effects of such an action but only those which affect a small class of objects. Thus, to take an extreme example, in discussing the bludgeoning to death of a man with a rock, the possible damage to the rock will be considered to be of no relevance to the morality of the action; in contrast, the damage to the man is considered to be of supreme relevance. It is convenient to introduce a term to distinguish between those objects, injury to which will be the concern of a particular ethical theory and those objects injury to which it will regard as of no consequence. I have used the term '*Object of Intrinsic⁶ Moral Worth*' ('OMW' - for short) for this purpose.

Various ethical theories define their '*Objects of Intrinsic Moral Worth*' in their various ways. Thus, in Cartesianism or in mediaeval Christianity, animals had, of themselves, no moral status, *i.e.* to injure an animal was *in itself* neither good nor evil. In such a system humans were the only 'OMW's'.⁷ More recent ethical theories have sought to describe the injury of, or at least the cruelty to, animals as 'evil'; some have sought justification for this assertion in the 'fact' that such animals are conscious. In such theories 'OMW's' are defined as those objects possessing consciousness; and one corollary of this is that in such theories, humans who have permanently lost consciousness have *of themselves* no *locus standi* in moral discussions. Other ethical theories - for example, some Buddhist and early Celtic ethical traditions - have considered *all* objects to be 'OMW's'; adherents being urged not to inflict intentional damage on any object whether it be animate or inanimate.⁸

Where can these 'OMW's' be situated in Foot's analysis? It is clear that in any particular ethical theory, 'OMW's' constitute the domain within which the virtue of Charity is operative. These are the very objects capable of 'receiving' Charity; effects on anything lying outside this domain are

⁵ In Chapter 1, Section 2.

⁶ The inclusion of the term '*intrinsic*' is to emphasise that the damage is considered objectionable in its own right and not, for example, because the object has some connection to some other 'OMW' and acquires value because of this connection, as occurs, for example, when an object is owned by some human.

⁷ In such a system, the terms '*persons*' and '*Objects of Intrinsic Moral Worth*' are equivalent, though it could be argued that, for example, children and the insane are 'OMW's' but not '*persons*'.

⁸ To many people, such ethical theories have a surrealistic aura; this is, perhaps, because these theories - and especially Buddhism - seek to justify their ethical stance not by examining the supposed effects of an action on the *object* of the action but by the effects on the *subject* of the action. For example, the injunction that one should not seek revenge on another is not primarily because of that other, but because the yielding to the urge to revenge is detrimental to one's own future peace of mind. This is, perhaps, an oversimplification as one of the aims of Buddhism is to breach any rigid distinction between subject and object; in practical terms this implies an obligation to see oneself in the circumstances out of which some other acted and thus allow a compassion to arise rendering even the injunction to forgive unnecessary. It will be assumed in the remainder of this Chapter that the criterion for classifying an object as an '*Object of Intrinsic Moral Worth*', is '*possession of consciousness*'.

irrelevant when analysing actions from the perspective of Charity. Thus, those who believe that 'consciousness' is the appropriate criterion for adjudging 'OMW' could be charitable to a conscious animal but could no more be charitable to a supposedly permanently unconscious PVS patient⁹ than to an inanimate object.

What, however, is the domain within which Justice operates? Is it the same as the domain of Charity? Justice is without doubt concerned with 'rights' but to whom can rights be ascribed? Let us consider, for example, the case where '*possession of consciousness*' is regarded as the appropriate criterion for adjudging 'OMW'. Such ethicists regard a conscious animal as worthy of moral consideration and they would consider themselves under a moral obligation to ease the lot of an animal in pain; such obligations would, as we have seen, be grounded in Charity as being done '*for the sake of*' the animal. Would the ethicists consider that they were under any obligations to an animal which were grounded in Justice as distinct from Charity?

An immediate and unavoidable difficulty is presented in that such ethical theorists often present their arguments as being in favour of so-called '*animal rights*'. Such a terminology is, I suggest, inappropriate and adds further confusion to an already difficult area.¹⁰ The existence of such rights implies that obligations to animals flowed from the virtue of Justice; it would imply, for example, the right of the animal to non-interference¹¹ (and the obligation on humans to respect this right) in cases where the animal was seriously injured and assistance was being contemplated *solely* for the sake of the animal. The inappropriateness of this suggests that so-called 'animal rights' flow, not from Justice, but from Charity and are, not rights, but *obligations* on humans to provide appropriate benevolent care.¹² The appropriate claim then is not that '*Animals have rights*' but that '*Animals are Objects of Intrinsic Moral Worth*' and that '*Persons have obligations to animals*'.

This example, despite the terminological difficulties, makes clear that though the domains of Justice and of Charity may overlap, they are not necessarily equivalent. A term is required which

⁹ Considered for his own sake and not for the sake of his family.

¹⁰ Consider the following excerpt:

"We should accord legal personhood to chimps and bonobos, giving them the 'dignity rights' of bodily integrity and liberty. The argument is twofold: legal and scientific. ... On the legal side, Wise conducts a fairly brutal assault on the common law that enshrines the human animal division. Common law, he says, 'values the past for merely having been'. It preserves old misconceptions such as the pre-Darwinian, anthropocentric view of nature. ... The scientific argument is that chimps and bonobos are so close to us intellectually that it is absurd to deny them personhood."

[From a review by Bryan Appleyard (Sunday Times magazine 14-5-00) of *Rattling the Cage: Towards Legal Rights for Animals* by Steven M. Wise; Wise teaches animal-rights law at Harvard.]

¹¹ The right of X 'to be let alone' is best considered as being composed of two components:

(i) the right of X to be free from interference whose motivation is not *solely* to benefit him. ('*non-beneficial*' interference)
(ii) the right of X to be free from interference which is motivated *solely* to benefit him. ('*beneficial*' interference)

In so far as the obligations flowing from Charity are - in cases of an intervention which affect X - to intervene if and only if such is '*for the sake of X*', it follows that 'non-beneficial' interventions are prohibited under the virtue of Charity as well as Justice.

In summary, the right of X to be let alone from 'non-beneficial' interference flows from Charity and Justice; the right of X to be let alone from 'beneficial' interference flows from Justice.

Thus, in relation to animals: humans are not (under Charity) entitled to intervene in the life of an animal if the intervention is not for his sake; this implies a restricted '*right*' 'to be let alone' - though flowing from Charity and not Justice; if however, a right flowing from Justice is also present then the right flowing from Justice takes precedence. For example, in the case of a lion attacking a person whereas the lion has the '*right*' 'to be let alone' unless the intervention is motivated by concern for his welfare this '*right*' (grounded as it is in Charity) must yield to the right of the person to his life (which is grounded in Justice). [I have used the term '*right*' in relation to animals as signifying not a right owned by animals but an obligation on persons - persons being the only ones who can 'own' rights or obligations. Restricting the word 'right' to apply only to persons results in considerable awkwardness when speaking of the obligations owed by persons to animals as there is no corresponding 'right' involved; one solution to this terminological problem would be to speak of '*Justice Rights*' - *Rights_J* - and '*Charity Rights*' - *Rights_C*; both of which generate obligations and such that:

(i) *Obligations* and *Rights_J* can be ascribed to an individual if and only if that individual is a 'person';

(ii) *Rights_C* can be ascribed to '*Objects of Intrinsic Moral Worth*'.

(iii) In case of conflict, *Rights_J* take precedence over *Rights_C*.

This terminological problem should not mask the underlying analysis; to this end I have chosen to restrict the term '*right*' to '*rights_J*' for the remainder of the discussion.]

¹² This also explains why killing an animal in pain may be the appropriate response - since it satisfies an obligation flowing from Charity unfettered by requirements of Justice - whereas such a response to a *person* in pain would be inappropriate contravening as it does the requirements of Justice.

can stand in the same relationship to Justice as 'OMW' stands in relation to Charity: 'person' is such a term.¹³ This term describes the objects which must be considered when the repercussions of a proposed course of action are being examined from the perspective of Justice. They are, and only they are, the bearers of 'rights' (and 'obligations') and they share the attribute of 'personhood'.¹⁴

A number of conclusions can be drawn from this discussion:

Conclusion 10-1 : *Rights (and obligations) can be ascribed to an individual if, and only if, that individual is a person.*¹⁵

Conclusion 10-2 : *Obligations may exist towards individuals who are not persons; such obligations arise from Charity. The class of individuals to whom persons have obligations that flow from Charity are called 'Objects of Intrinsic Moral Worth' ('OMW's'). The possession of consciousness is the usual criterion for classifying an individual as an 'OMW'.*

Conclusion 10-3 : *Obligations flowing from Justice - of which the most important is the right 'to be let alone' - take precedence over the obligations flowing from Charity.*

Conclusion 10-4 : *The right to be let alone can be analysed into:*

(i) *the right to be free from 'non-beneficial' interference; this right¹⁶ flows from both Charity and Justice.*

(ii) *the right to be free from 'beneficial' interference; this right flows from Justice.*

The aims of the current chapter vis-a-vis the wider argument of this thesis.

Let us next consider the relevance of these conclusions to the general topic of this thesis which is the making of 'end-of-life' decisions for PVS patient; doing so will also help clarify the propositions that must be established in this chapter if the general argument put forward in this thesis is to succeed.

It has been argued in an earlier chapter,¹⁷ that PVS patients should be treated as *if* they possess consciousness. It has also been argued that an appropriate definition for PVS patients is

¹³ The use of the *existing* term 'person' as a synonym for 'bearer of rights' will be justified in the course of this Introduction.

¹⁴ The difficulty occasioned by not having a concept such as 'OMW' and thus being forced to rely solely on the concept of right, is shown in the following excerpt from the President's Commission:

"Someone who has died cannot be said to have 'rights' in the usual sense; ... To be sure, Karen Quinlan was not 'dead' in most of the increasingly multiple senses of that term, but the task of giving content to the notion that she had rights, in the face of the recognition that she could make no decisions about how to exercise any such rights, remains a difficult one."

(President's Commission for the Study of Ethical Problems in Medicine p.182, footnote; quoting Laurence Tribe American Constitutional Law at p.936)

This quotation also exemplifies a further confusion: because rights cannot exist without correlative obligations, it is often suggested that only those who have responsibilities can possess rights, this is a nonsequitor. Certainly a right cannot be said to exist if there is not correlative responsibility to respect that right, but it does not follow that rights and responsibilities must coexist in the same person - that the owner of rights is also subject to responsibilities; thus though a comatose child cannot be said to have responsibilities, this does not preclude their having rights. A similar argument applies to the suggestion that because rights can only exist if there is an ability to enforce those rights, a person's incapacity to enforce rights implies the loss of those rights. In particular, a PVS patient does not suffer a diminution of their rights (if, in fact, they possess any rights) either because they are themselves incapable of enforcing their rights or because their responsibilities are in abeyance.

¹⁵ It is convenient for ease of exposition, to place this conclusion at this point in the Introduction; arguments in its favour are considered later in this Introduction.

¹⁶ In so far as it flows from Charity it is best considered not as a *right* but as an *obligation* on persons; though see footnote *supra* on the possibility of using the terminology 'Justice Rights' - *Rights_J* - and 'Charity Rights' - *Rights_C*.

¹⁷ Conclusion 5-5: *All patients diagnosed as PVS, should be treated as if they are conscious and can experience pain.*

permanent loss of the ability to communicate.¹⁸ Hence, if possession of consciousness is accepted as the criterion for being an 'OMW', it follows that PVS patients are owed the obligations that flow from Charity.

The aim of the present chapter is to establish the following propositions:

(T): *"It is a¹⁹ necessary condition for the ascription of personhood to an individual that communication, to some minimal standard, be possible with that individual."*²⁰

Once this is established then, provided it is accepted that:

(U): *"Personhood' is a necessary and sufficient condition for the ascription of rights."*²¹

the conclusion:

(V): *"Rights cannot be ascribed to an individual who is permanently unable to communicate."*

immediately follows.

From (T) it follows that PVS patients have lost their personhood; from (V) it follows that PVS patients are not owed obligations flowing from Justice but only from Charity.²² The implications that flow from this will be examined in Chapter 11.

In summary, the remainder of this chapter is concerned solely with establishing the following propositions:

(T): *"It is a necessary condition for the ascription of personhood to an individual that communication, to some minimal standard, be possible with that individual."*

(U): *"Personhood' is a necessary and sufficient condition for the ascription of rights."*

The Initial Strategy

Given an agreed definition of 'personhood', the method required to establish (T) is clear, although difficulties may present in its execution; it is simply to show that the definition of 'personhood' implies an ability to communicate; once this is established, then (T) directly follows. The method to establish (U) is equally obvious; it is to show that the definition of personhood was logically equivalent to (U). Unfortunately, since no universally accepted definition of personhood exists, an alternative strategy must be found.

¹⁸ Conclusion 4.17: *The persistent vegetative state is characterised by seeming wakefulness in the absence of an ability to communicate.*

¹⁹ Neither 'necessary', nor 'necessary and sufficient', nor 'sufficient' conditions need be unique; thus N₁ and N₂ may be necessary conditions for Y, yet N₁ and N₂ may not be equivalent. For example, to arrive in the USA it is a necessary, but not sufficient, condition that one leaves Ireland; it is also a necessary, but not sufficient, condition that one leaves Europe, yet leaving Ireland and leaving Europe are obviously not equivalent.

²⁰ The standard or level of communication required is discussed in Section 4; in so far as the condition sought to be established is a *necessary* condition, questions as to the *level* of communication are not as crucial as they would be if *sufficient* conditions were under discussion.

²¹ *i.e. that 'personhood' = (df.) 'bearer of rights'*

²² This also justifies the assertion made earlier that the term 'person' - as distinct from 'human' - is crucial to the validity of the proportion:

"No person should be subjected to interference against his will even if this be done from the most altruistic of motives."

(V) also implies that all decisions in relation to the care of PVS patients (even one resulting in their death) should be taken on a 'best interests' basis (assuming, of course, that PVS patients have lost their personhood); it is of interest that this is *precisely* the decision arrived at in the Ward and Bland cases but argued from different premises.

The attribution of personhood to an individual (or even attenuated personhood - see discussion in Section 5) implies that there are limits to the type of decisions affecting that individual that can be taken on a 'best interests' basis; for example, a decision to embark on a course of action which resulted in the death of a *person* could not be justified without the consent of that person.

Alternative Strategies

The first step towards an alternative strategy is found in noting that - for the purposes of establishing the conclusions of this thesis - a definition of 'personhood' is, strictly speaking, not required. This is because the term 'personhood' is used, in this and the following chapter, not in isolation but only as a middle term of, what is essentially, a syllogism:

(T): *"The ability to communicate is a necessary condition for the ascription of personhood to an individual."*

(U): *"It is a necessary and sufficient condition for the ascription of 'rights' to an individual that that individual possesses 'personhood'."*

(V): *"Rights cannot be ascribed to an individual who is permanently unable to communicate."*

The term 'personhood' functions only as a 'placeholder' and provided that the term is used with a consistency of meaning, its explicit definition is not required. It is the conclusion (V) - rather than (T) or (U) - which is of importance to the development of the argument. This latter point might suggest that it is possible to dispense completely with the term '*personhood*' and attempt to establish the proposition (V) directly, *i.e.* that a permanent inability to communicate implies a loss of rights.

Establishing (V) directly

A difficulty immediately arises in that it is not intuitively obvious why being the '*bearer of rights*' should be logically connected to possessing the '*ability to communicate*'. It is possible to construct an argument on the basis that the obligations of Charity to an individual should be gainsaid by those of Justice *only* if that individual wished otherwise and so expressed his wishes. This argument essentially reduces to the point that the right to refuse beneficial²³ interventions makes sense only if there is an existing ability to accept them; this implies an ability to communicate. It is only the ability to communicate that could make patent how an action - which on its face was charitable and done 'for the sake of' another - in fact, involved a deep trespass to the dignity of that other. However, these ideas seem too tenuous a foundation on which to seek to establish so far-reaching a proposition as (V).²⁴

It seems then that, in seeking to establish (V), the three concepts '*personhood*', '*ability to communicate*' and '*bearer of rights*', and their possible interrelationships, are at the heart of our discussion; the concept of '*personhood*' being useful in that it functions as a 'bridge' between the other concepts and allows the conclusion (V) to be established as a consequence of two simpler conclusions (T) and (U).

The possible interrelationships between the three concepts can be represented in a diagram and table which may help clarify the issues involved. (In Diagram 10-1 and Table 10-1 '*P*' represents '*personhood*'; '*C*' - '*ability to communicate*' and '*R*' - '*bearer of rights*'.)

²³ *vide* discussion earlier in this Introduction where it was argued that non-beneficial interventions were prohibited by Charity.

²⁴ The argument has, however, the advantage of showing *exactly* the level of communication required: sufficient to give consent (or refusal) to a charitable intervention.

Diagram 10-1: A diagrammatic representation of the relationships between the concepts '*personhood*', '*ability to communicate*' and '*bearer of rights*'.

The possible relationships between *C*, *P* and *R* are set out in the following table:

$C \rightarrow R$	<i>X has the 'ability to communicate' implies that X is a 'bearer of rights'.</i>
$R \rightarrow C$	<i>X is the 'bearer of rights' implies that X has the 'ability to communicate'.</i>
$P \rightarrow C$	<i>X possesses 'personhood' implies that X has the 'ability to communicate'.</i>
$C \rightarrow P$	<i>X has the 'ability to communicate' implies that X possesses 'personhood'.</i>
$P \rightarrow R$	<i>X possesses 'personhood' implies that X is a 'bearer of rights'.</i>
$R \rightarrow P$	<i>X is a 'bearer of rights' implies that X possesses 'personhood'.</i>

Table 10-1: The possible relationships between the concepts '*personhood*', '*ability to communicate*' and '*bearer of rights*'.

The proposition (T) can be expressed symbolically as ' $P \rightarrow C$ '.

The conclusion that is sought to be established is (V), which, expressed symbolically, is:

'not-C \rightarrow not-R'.²⁵

This is logically equivalent to ' $R \rightarrow C$ '

This conclusion will follow from (T) provided ' $R \rightarrow P$ ' is established.

In summary, the argument, expressed symbolically, is: ' $R \rightarrow P$ and $P \rightarrow C$, implies $R \rightarrow C$ '

Thus, in addition to (T) we need to establish a proposition (U') which states symbolically that $R \rightarrow P$.

In words it states:

(U'): "*The possession of 'personhood' is a necessary condition for the ascription of rights.*"

this is less onerous to establish than is the original proposition (U).

Hence, it is possible to refine the chapter aims given earlier; to establish (V) it is only necessary to establish (T) and (U') [rather than (T) and (U)].

²⁵ i.e. inability to communicate entails loss of rights.

The problem of defining personhood revisited

The recognition, as stated earlier, that no universally accepted definition of personhood exists suggested that attempts to prove (T) and (U) through an analysis of the definition of personhood were doomed to failure. This conclusion may have been premature. The assertion that no universally accepted definition exists follows from the recognition that many definitions of 'personhood' have been proffered in recent times and these definitions are not logically equivalent. Because the competing definitions are not logically equivalent, there is a penumbra to the term 'personhood' which is uncertain; however, the definitions may well share a common core where the meaning of the term 'personhood' is beyond dispute.²⁶

A distinction - introduced by Mill - between the 'connotation' and the 'denotation' of a term is of assistance. In considering the various definitions of 'personhood' it will be seen that difficulties relate not to the connotation of the term but to its denotation. This is best explained by means of an example: in the continuing debates about the morality of abortion the statement '*The foetus is a person*' is often encountered. This proposition is advocated by those opposed to abortion and denied with equal vehemence by those supporting a right to abortion. What is of interest in the present context is that both sides agree that if the proposition were conceded, certain conclusions would follow, namely that the foetus is the bearer of rights including the 'right to life'; where the sides disagree is in whether the concept 'person' encompasses a foetus. Thus, the connotation of the term 'person' is non-contentious - it is to be a 'bearer of rights'; disagreement is restricted to the denotation of the term 'person' - does it include a foetus?

Similarly, the various definitions encountered in Appendix F will be found to focus on the possible denotations of the term 'person' whilst its connotation - as a 'bearer of rights' - is uncontroversial. Returning to consideration of (T) and (U), it is clear that (T) relates to the denotation of the term 'person' whilst (U)²⁷ relates to its connotation and is, in consequence, unproblematic.²⁸ The problem is essentially the establishment of (T).

A short digression is useful at this stage to examine why, in discussions of the concepts of 'person' and 'personhood', questions of definition have exercised a particular dominance; especially because it allows further strategies towards establishing (T) to emerge.

The search for a definition of personhood - a chimera?

There is a well-established philosophical tradition of searching for the strict definitions of certain terms which underlie particular philosophical problems in the hope that once such definitions can be established, the associated philosophical problems can be easily resolved. Wittgenstein considered such projects to be chimeras, born of a deep misunderstanding of the nature of language; they originated in attempts to transpose a method from the scientific field - where it has been highly successful - to the realm of philosophical inquiry where it is wholly inappropriate.²⁹ It is

²⁶ It may well be that (T) and (U) do not impinge on the area of vagueness but belong to the kernel common to all definitions and may be established from their analysis. This strategy is pursued in Appendix F which, in fact, considers 11 different modern definitions of personhood and arrives at the conclusion:

Conclusion F - 1: *Definitions of personhood given by 11 modern philosophers are considered in Appendix F. All of these definitions imply (T); however, in two cases - Tooley and Harris - it is necessary to rely on Wittgenstein's 'Private Language Argument'. A corollary is that Harris and Tooley accept (T) for the ascription of personhood but not for its removal; all others accept (T) as a criterion both for the ascription, and removal, of personhood. All of the definitions, with the exception of Harris's, assume (U).*

²⁷ and (U).

²⁸ This is a belated justification of Conclusion 10 - 1 given earlier in this Chapter.

²⁹ Passmore notes:

'inappropriate' because the words which are central to most philosophic problems³⁰ are usually words which are in everyday use: 'handyman words with a variety of jobs', 'open-ended' words whose boundary of definition is necessarily vague³¹ quite unlike the technical terms of a scientific discourse. Wittgenstein suggested a refocusing of philosophical effort away from the search for definition and towards an examination of how words were actually used.³² In applying his admonitions to the current discussion, it is clear that the term 'personhood' is not a term of art, nor a technical term open to definition by *fiat*. Attempts to treat it as such result in individuals not normally spoken of as 'persons', being ascribed 'personhood' and conversely; such developments rather than helping to resolve philosophical problems can only exacerbate them. Thus, before any attempts at definition or discussion of the term 'personhood', the usages of the term 'person' - particularly borderline usages as, for example, in the term '*non-person*' - must first be examined. The concept of 'personhood' must be used in such a way that it is *at least consistent* with such usages of the term 'person'. This linguistic exploration of the term 'person' offers an additional strategy in the furtherance of our aims and is briefly sketched in [Section 2](#).

Linguistic investigation as a strategy

A further reason for scepticism towards attempts at resolving philosophical problems by means of a search for precise definitions is that - particularly in ethical matters - such attempts can serve as a subterfuge in that if ethical problems are portrayed as simply matters of easily resolvable linguistic convention,³³ ethical choices can masquerade as simply linguistic choices. This difficulty can also arise if what are essentially ethical questions are considered to be resolvable *solely* by an examination of linguistic usage. It is important that this issue be directly addressed and the correct role for a linguistic investigation be clarified. Thus, assuming that an examination of linguistic usage is unequivocally supportive of (T) - in the sense that linguistic usage is not inconsistent with (T) - what conclusion should be drawn?

The appropriate conclusion is that traditionally there has been an acceptance of (T) and, as such, the linguistic investigation is persuasive, but not conclusive, evidence for (T). An analogy may help clarify this distinction: suppose a discussion centred on whether women should be accorded equal rights with men in the workplace, a linguistic examination - which contrasted the usages of the terms 'man' and 'woman' in the context of their work and its value - might well conclude that man's work was consistently given a higher value than was women's. The question as to whether this should continue to be so is a quite separate issue and should not be confused

"Philosophers, Wittgenstein came to think, had made the mistake of trying to model their activities on those of scientists - as indeed, the very phrase 'logical atomism' [in Russell's philosophy] suggests; that is why they tried to lay down strict definitions and to discover true, if unusually abstract, universal propositions."

[John Passmore, *A Hundred Years of Philosophy*, p.425]

³⁰ Many words, e.g. the terms '*force*' and '*energy*', are used in both non-scientific and scientific discourses. Their use in non-scientific discussion - e.g. '*He is a forceful and energetic speaker*' - is so different to their use in science - e.g. '*F=ma*' and '*E = ½ mv² + mgh*' - that they are best considered as completely different terms; there being no necessity to use distinct words as the context makes clear which use is intended thus precluding any ambiguity.

³¹ Such '*vagueness*' or '*openendedness*' or '*fuzziness*' should not be thought of as defects but rather as the qualities which give to language its rich texture; the suggestiveness of poetry, for example, would not be possible in the absence of such qualities.

³² see also Strawson who comments:

"... the wish to understand is less likely to be served by the search for a single strict statement of the necessary and sufficient conditions of its application than by seeing its applications - in Wittgenstein's simile - as forming a family, the members of which may, perhaps, be grouped around a central paradigm case and linked with the latter by various direct or indirect links of logical connection and analogy."

P. F. Strawson, *Individuals*, p. xv.

³³ Dolores Dooley Clarke and Desmond M Clarke '*Analysis: An introduction to Ethical Concepts*' *Journal of Medical Ethics*, at p.186; where they state:

with how these matters were traditionally resolved. An examination of the first question requires the adoption of the perspective of the social reformer, the second, that of the social anthropologist. These perspectives are being separated in this chapter so that only in Section 5 - 'Conclusions' - will consideration be given to whether rights *should* be restricted to those with whom communication either already exists or can be established at some future time. The earlier sections will consider only whether it is possible to justify (T) and (U') from within schema which have traditionally found an acceptance either in the philosophical community (Section 1, 3 and Appendix F) or within the wider society as shown by linguistic usage (Section 2).

John Locke

The philosopher to first raise the problem of personhood in its modern form³⁴ was John Locke whose discussion of the nature of definition is also singularly insightful. These aspects of Locke's philosophy give a convenient framework within which to begin a discussion of personhood and the problems of its definition and they will be sketched in Section 1. This section will also investigate whether (T) and (U') would find support from within Locke's philosophy.

Wittgenstein's 'Private Language Argument' as a strategy

The last - and by far the most powerful - strategy for establishing (T) comes from the realisation that refutations of (T) are irretrievably embedded in Cartesian philosophy. This emerges when certain anti-Cartesian aspects of Wittgenstein's philosophy, relating to the self and language, are contrasted with their Cartesian counterparts. The clearest entry into this discussion is through the acknowledgement that, in setting out the broad ambit of the term 'personhood', two distinct approaches are possible:³⁵

- (i) The first - the '*atomistic*' approach - seeks to determine the personhood of an individual by considering his characteristics *without reference to his social environment* and, for example, seeks to characterise a person in terms of his cognitive skills or brain development or, from a religious perspective, possession of a 'soul'.
- (ii) The second - the '*social*' approach - regards personhood as essentially a concept born out of social interaction and no more applicable to an isolated individual than is the concept of 'sociability'.³⁶

"... where moral dilemmas coincide with disagreement about the correct use of inexact concepts the apparent ease with which these dilemmas might be resolved, by definition, is an illusion."

³⁴ Roger Scruton, *Modern Philosophy*, p.304.

³⁵ A. H. Maslow in *The Farther Reaches of Human Nature* raises an interesting point on the limitations of the atomistic way of thinking when he suggests (*ibid.* p 72) that whilst the atomistic way of thinking was of use in certain areas of science, such as physics, where all variables but one could be held constant and the effects of changing this one variable then studied, it is '*now dead in the general philosophy of science*' and useless in the study of the living world where it cannot encompass "... systemic and organismic changes ... in which any single stimulus is conceived to change the whole organism, which then, as a changed organism, emits behaviour changed in *all* departments of life."

Ernest Gellner in his *Language and Solitude* adopts a similar standpoint, his opening paragraph being a succinct and eloquent exposition:

"There are two fundamental theories of knowledge. These two theories stand in stark contrast to each other. They are profoundly opposed. They represent two poles of looking, not merely at knowledge, but at human life. Aligned with these two polar views of knowledge, there are also related, and similarly contrasted, theories of society, of man, of everything. This chasm cuts right across our total social landscape." [op.cit. p.3]

He then describes these two approaches:

"There is, first of all, what one might call the individualistic/atomistic conception of knowledge. Knowledge, on this view, is something practised or achieved above all by *individuals* alone ... In principle, the acquisition of knowledge is something open to Robinson Crusoe, and perhaps to him especially. ... Deeply contrasted with the atomic theory of knowledge, there is what one might call the organic vision. First of all, this vision repudiates the individualism of its rival. No man, least of all when he endeavours to know and understand the world, is an island unto himself." [op.cit. p.3-6].

³⁶ The concept of '*nearness*' - as when one says that A is *near* B - is obviously a relational concept; that is, it requires more than one 'argument' before it can be meaningfully asserted - no meaning can be given to the proposition '*A is near*';

The first approach regards the individual as logically prior to society whilst in the second, the individual is a product of society; the first approach draws its succour from Cartesian philosophy, the second from contemporary philosophy.³⁷ In an earlier chapter³⁸ it was mentioned that the perspectives of Cartesian philosophy permeate much of Western intellectual culture,³⁹ one example of such is the widespread assumption that 'personhood' can be ascribed to an isolated individual. Though this assumption drew its original sustenance from the Judeo-Christian tradition of the soul, its modern expression originates in Cartesian philosophy - Descartes being in some respects a secular apologist for Christian beliefs. From a Christian perspective, it is clear that to possess a 'soul' does not require any prior participation in society or possession of language or ability to communicate with others; a 'soul' being a gift from God, not from society; furthermore, the fact that an individual possesses a 'soul' is that which creates the obligation on others to value, or respect, that individual; yet this is precisely the connotation of the concept of 'personhood'. Hence, the equation of 'personhood' and 'possession of a soul' easily follows as does the corollary that personhood is an 'atomistic' property.

These same conclusions are equally valid within Cartesian philosophy. To Descartes, the starting point of his philosophy - the setting to the '*cogito*' argument - was that of an isolated, questioning, individual. Descartes presupposed nothing - no society, no social community, no governments or nationality, no culture, no history, nothing, just a thinking thing; on this basis he began his project and set out to construct his philosophy. Descartes' method was that of universal doubt but his isolated individual was unable to doubt his very own existence as a thinking thing and this gave him the secure foundation from which he could begin to repossess the world. Thus, to Descartes man could rise to his full stature as a self-reflective, rational, questioning being, independent of society.

mathematically speaking, this is expressed by saying that 'nearness' is a relation between two variables A and B and cannot be asserted of a single variable. In contrast, the proposition '*X is a person*' appears to depend on only a single variable, i.e. to determine its truthfulness we need only look at X; this is a mistaken view as the following analogy will make clear: the statement '*X is heavy*' also appears to depend only on the properties of X; however, X can only have 'weight' if some other object exists which provides a gravitational force; it could not be asserted of an isolated X, that '*X is heavy*'. Thus, despite appearing to depend only on a single variable X, the statement '*X is heavy*' requires the existence of some other unspecified object Y such that X and Y are related gravitationally. Similarly, '*X is a person*' - though it appears to depend only on the characteristics of X - in fact requires the existence of some other unspecified Y where X and Y are in relation, (the relationship which will be argued for in this Chapter is that of being in communication).

³⁷ The second approach is evocative of a much wider discussion current amongst scientists, particularly biologists, and philosophers on so-called '*emergent properties*' - these are properties which appear in a system once a particular level of complexity has been achieved, they are not explicable in terms of the properties of the individual units of that system considered as isolated entities. '*Consciousness*', for example, is considered by some to be such an emergent property as it is not explicable in terms of the chemical structure of the individual molecules which compose the individual body but is rather a property of the body considered as a whole (similarly with the concept of '*free will*', though Roger Penrose has attempted to link this to quantum mechanical effects at the level of the individual atom). To say, then, that 'personhood' cannot be ascribed to an isolated individual and can only be defined in terms of a society composed of such individuals, could also be described by saying that personhood was such an emergent property.

³⁸ In Chapter 1, Section 4.

³⁹ A development which does not meet with universal regard; Jaspers, for example, states:

"Descartes' perverted conception of science and philosophy made his influence disastrous."

[Karl Jaspers *Way to Wisdom* at p.185]

Hacker states:

"... Cartesians ... subtly and progressively twisted our concept of person, human being, mind, thought, body, behaviour, action and will out of all recognition. ... The Cartesian myth, like all great myths, is insidious. It can assume many guises, and even those who think of themselves as liberated from Cartesianism adopt crucial elements of the tale. A striking feature of contemporary philosophers, psychologists and neurophysiologists is that whilst rejecting mind/body dualism, they accept the fundamental conceptual structure of the Cartesian picture."

[P. M. S. Hacker *Wittgenstein* p.5, 15]

Capra makes a similar criticism of Freud suggesting that Freud's Cartesian orientation - that is a focusing on the single object rather than the group and then defining the group in terms of the single objects - severely limited his theoretical insights. He quotes Ronald Laing as saying:

"Freud had no constructs for any system consisting of more than one person ... he had no idea of how two of these mental apparatuses, each with his own constellation of internal objects can relate to each other. For Freud, they interacted simply mechanically, like two billiard balls. He had no concept of experience shared by human beings."

[Fritjof Capra *Uncommon Wisdom* at p118, 130]

However, Wittgenstein in his *'Private Language Argument'* ⁴⁰ ('PLA', for short) found the Achilles heel of the Cartesian project: the supposition that an individual could have a 'private language' - that is, that he could begin this process of questioning and doubting without the necessity of assuming a prior social environment within which those very tools that are necessary to begin the process of doubting and questioning, would have been generated. Wittgenstein's 'PLA' denies the possibility that such a private language can exist; it implies that an individual, isolated from all contact with his fellow man, can never develop language. To Wittgenstein, language is *essentially* a social activity; the existence of language depends on social rules and social interaction. From this it follows that an isolated individual cannot have a *'reflexive consciousness'* ⁴¹ because a reflective consciousness depends on concepts and concepts cannot exist without language. ⁴² The 'PLA' renders Descartes' concept of the isolated questioning individual, incoherent.

This result is of considerable importance because, had the 'atomistic' approach to personhood been sustainable, it would have provided substantial grounds for arguing against (T). Conversely, the social approach grounds personhood irrevocably in social interaction and, as communication to some minimal extent ⁴³ is a necessary condition ⁴⁴ for such interaction, (T) readily follows.

The term 'ability to communicate' has been much used in these last pages in relation to the definition of 'personhood' and plays a crucial role in the development to the argument. Difficulties exist in connection with it: for example, the problem of distinguishing between *'communication'* and *'random, or reflex, or echo response'* must be resolved and the level of communication that is envisaged in (T) must be specified; these problems are considered in [Section 4](#).

Finally, conceiving of the term 'personhood' in terms of 'ability to communicate' is an oversimplification as it links the status of personhood too *closely to current abilities*. *The attribute of 'personhood' has a certain 'momentum' - what I term 'stickiness' - so that once the term is assigned to an individual, it adheres for a time even in the absence of ability to communicate*. This occurs, for example, when an individual sleeps or is unconscious. The concept also has a certain presumptive quality - what I term *'precociousness'* ⁴⁵ - so that if it is believed that at some future time the concept will be applicable, then it is considered to be *currently* applicable, albeit in an attenuated form; for example, it is 'precociousness' which enables a baby, and in some cases a foetus, to be considered to be a person. ⁴⁶ These properties will be briefly discussed in the final conclusions section, [Section 5](#).

⁴⁰ By a 'private language' Wittgenstein means " ... a language in which a person could write down or give vocal expression to his inner experience - his feeling, moods and the rest - for his own private use ... The individual words of this language are to refer to what can only be known to the person speaking: to his immediate private sensations. So another person cannot understand the language." [Wittgenstein, PI-1 § 243]

⁴¹ See Chapter 1, Section 3.

⁴² The 'Private Language Argument' has an interesting implication for Descartes two tests of personhood (which were the possession of a reflexive consciousness and the possession of language). Because the ability to communicate to some minimal level is a necessary condition for acquiring language capability, it follows that ability to communicate to some minimal level is a necessary condition for 'reflexive consciousness' and, indeed, for personhood if this is defined as the possession of reflexive consciousness. Thus, Descartes two conditions for 'personhood' essentially reduce to only one - the possession of language.

⁴³ The paradigm here is the case of Jean-Dominique Bauby [author of [The Diving Bell and the Butterfly](#)] which showed that a method of 'yes/no' signalling - Bauby used the blink of an eye - is all that is required.

⁴⁴ Wittgenstein's 'PLA' is considered in Section 3 as are the arguments of those such as P.F. Strawson, and others, who argue in favour of the social characterisation of personhood. The arguments for the implication in the text are there considered more fully.

⁴⁵ As mentioned in Appendix F:

Precociousness' should be distinguished from 'potential': an individual who is a potential person is no more a person that is an acorn, a tree; consequently, a potential person is not a person and has no rights; in contrast - if personhood is accepted to be a precocious attribute - an individual who will become a person is deemed to possess an attenuated personhood and thus presently partakes of personhood and presently possesses rights.

⁴⁶ Since neither have an existing ability to communicate

In summary this chapter focuses on establishing the two propositions (T) and (U):

(T): "It is a necessary condition for the ascription of personhood to an individual that communication, to some minimal standard, be possible with that individual."

(U): "The possession of 'personhood' is a necessary condition for the ascription of rights."

The chapter will be developed in the following Sections:

Section 1: A sketch of Locke's theories of definition and personhood.⁴⁷

Section 2: Some examples of everyday usage of the term 'person'.⁴⁸

Section 3: Some philosophical authorities for a 'social definition' of personhood.⁴⁹

Section 4: Some problems associated with the 'communication criterion'.⁵⁰

Section 5: Should rights be restricted to those with whom it is possible to communicate? The terms '*precociousness*' and '*stickiness*'. Conclusions.⁵¹

⁴⁷ A more detailed schema for Section 1 is as follows:

Section 1: A sketch of Locke's theories of definition and personhood.

On Definition

On Personhood

Locke's theory of identity

An ambiguity

Identity of 'man' and identity of 'person'

A reformulation of Locke's position

A final reformulation of Locke's position

Locke: Conclusions

⁴⁸ A more detailed schema for Section 2 is as follows:

Section 2: Some examples of everyday usage of the term 'person'

(i). The contrast between an 'impersonal', and a 'personal', God

(ii) The difference between treating an individual 'as a person' and 'as an object'

(iii) The link between the terms '*person*' and '*persona*'

(iv) The term 'non-person'

⁴⁹ A more detailed schema for Section 3 is as follows:

Section 3: Some philosophical authorities for a 'social definition' of personhood.

Wittgenstein and the 'Private Language Argument'

Introduction

The 'Private Language Argument'

The 'Robinson Crusoe' Problem

Is Crusoe able to follow a rule?

Can Crusoe have a private language?

Conclusions: Wittgenstein

Strawson

Strawson's solution

Strawson: some implications

Proposition (T)

Dennett's 'Intentional Stance' (cont.)

The 'Personal Stance'

Crusoe (and PVS) revisited with the help of Strawson and Dennett

Some preconditions for adopting the 'personal stance'

A precondition for the attribution of 'personhood'

Strawson on the possible nature of exclusively 'private' experience

Conclusions: Strawson

⁵⁰ A more detailed schema for Section 4 is as follows:

Section 4: Communication

The meaning of the term 'communication' in the context of PVS-like patients

The level of communication envisaged

The standard of responsibility required

⁵¹ A more detailed schema for Section 5 is as follows:

Section 5: Conclusions

Conclusion from Appendix F

Is there a consensus in favour of (T) and (U)?

The proposition (T)

The proposition (U)

Should (T) and (U) be accepted or are amendments necessary?

The concepts of '*stickiness*' and '*precociousness*' as applied to an attribute

A revised proposal

Section 1: A sketch of Locke's theories of definition and personhood.

On Definition

An understanding of Locke's view on the nature of definition is crucial to an understanding of his treatment of general terms such as '*man*' and '*person*'. Locke's approach to these questions differs radically from the Platonic approach and is best understood when seen in contrast with it.

Plato, in his 'Theory of Forms', considered that our use of general words presupposes the existence of some abstract form or pattern which 'embodies' the general concept; for example, in stating '*X is a man*', we presuppose that some 'essence of man' exists in its own right and that '*X*' instantiates or fits this pattern. From such a perspective, the method for resolving problematic cases lies in attempting to lay bare the essence of the concept - *i.e.* by finding its definition - so that a comparison might take place between the supposed instance and the essence, to see whether there is, in fact, a congruence. To Plato, such definitions⁵² were antecedent to human activity and belonged to the very nature of things.

Locke, in contrast, considered that general terms had no existence prior to human activity and were simply a product of human classification:

*"There are creatures in the world that have shapes like ours, but are hairy and want language and reason. There are naturals amongst us that have perfectly our shape, but want reason, and some of them language too. ... If it be asked whether these be all men or no, all of human species, it is plain the question refers only to nominal essence ... But if the inquiry be made concerning the supposed real essence, ... it is wholly impossible for us to answer, ... the next thing to be considered is how and by whom these essences become to be made. ... it is evident that they are made by the mind and not by nature ..."*⁵³

Locke takes an example that closely touches the questions at the heart of this chapter:⁵⁴

*"... if several men were to be asked concerning some oddly-shaped foetus, as soon as born, whether it were a man or no, it is past doubt one should meet with different answers. Which could not happen if the nominal essences, whereby we limit and distinguish the species of substances, were not made by man with some liberty, but were exactly copied from precise boundaries set by nature, whereby it distinguishes all substances into certain species."*⁵⁵

Thus, to Locke, a resolution of the question '*Is X a person?*' cannot be found by attempting to lay bare some actual essence - '*personhood*' - which exists antecedent to human activity but is to be found by finding the common thread, if such exists, linking the various uses of the word '*person*' in

⁵² Though not, of course, their particular linguistic expression.

⁵³ John Locke, John W. Yolton (ed.), *An Essay Concerning Human Understanding*. Book III, Chapter VI, Para 22-26.

[Yolton's edition of Locke is henceforth cited as Locke Y, followed by the Book number then the section number and finally the paragraph number e.g. Locke, Y-3.6.22. The marks of emphasis in Yolton's text have been reproduced in the quotations following.]

⁵⁴ *i.e.* 'Is a PVS patient or a severely disabled infant, a person?'

⁵⁵ Locke, Y-3.6.27.

The concept of '*man*' is, in modern times, regarded as unproblematic in that it is considered to be equivalent to the concept '*human*' and this in turn is defined in purely biological terms; thus '*X is human*' if and only if its parents are human; the possibility that one parent was human and the other not, is not countenanced. In earlier ages the concept was more problematic; for example, Jesus was regarded as having only one human parent, and in the Middle Ages freak births were often attributed to the direct intervention of God in the affairs of man. (See William Reville '*Abnormal births focus of scientific curiosity*' *The Irish Times* 5-7-1999).

The term '*man*' can also be used as a synonym for '*person*' and such usages are considered later in this section.

everyday language, *i.e.* finding its 'nominal essence'.⁵⁶ It is to be expected that the boundaries of this 'nominal essence' will have some indeterminacy.

On Personhood

E. J. Lowe argues⁵⁷ that Locke was responsible for setting the terms of the modern debate on personhood and personal identity and that it was he who first discerned 'a question to which previous philosophers had been oblivious'. Scruton believes that the modern distinction between 'being human' and 'being a person' is attributable to Locke:

*"Man, he argued, is not the same concept as person. The first describes a part of the natural world; the second is a 'forensic concept': it features in our inquiries into responsibilities and rights."*⁵⁸

Locke's primary concern was to explain the concept of 'personal identity'. This necessitated a clarification of the term 'person':

*"... to find wherein personal identity consists, we must first consider what person stands for; which, I think, is a thinking intelligent being that has reason and reflection and can consider itself as itself, the same thinking thing in different times and places; which it does only by that consciousness which is inseparable from thinking and, as it seems to me, essential to it ..."*⁵⁹

This functions as a denotation of the term person and it bears a considerable resemblance to Descartes' *res cogitans*.⁶⁰ It differs from the Cartesian concept in that, to Descartes, a *res cogitans* was a thinking *substance*, Locke, in contrast, does not locate personhood in substance but in continuity of consciousness which he believes to be independent of substance. The reason for so doing is intimately connected with his connotation of the term 'person':

*"It is a forensic term, appropriating actions and their merits, and so belongs only to intelligent agents, capable of a law, and happiness and misery. This personality extends itself beyond present existence to what is past, only by consciousness;..."*⁶¹

To further explore these ideas it is necessary to first examine the meaning of the term 'identity' - as used in such phrases as 'personal identity' - and to then consider how Locke elucidates the distinction between the concepts of 'man' and 'person'.

⁵⁶ Flew suggests that some insight into Locke's ideas can be gained by comparing the Biblical picture of the origin of the species with Darwin's. The Biblical description is that:

"And out of the ground the Lord God formed every beast of the field, and every fowl of the air; and brought them unto Adam to see what he would call them ..."

Such was the perspective of Linnaeus (who was said to have discovered 'the essential nature of insects'); Darwin, in contrast, ended his 'Origin of the Species' with the words:

"... we shall have to treat species in the same manner as those naturalists treat genera, who admit that genera are merely artificial combinations made for convenience. This may not be a cheering prospect; but we shall at last be freed from the vain search for the undiscovered and undiscoverable essence of the term species."

[Flew (1971) p.449].

⁵⁷ E. J. Lowe. Locke p.102.

⁵⁸ Scruton *op.cit.* p.304.

Locke, in fact, distinguished between 'substance', 'man' and 'person':

"... it being one thing to be the same substance, another the same man, and a third the same person, if person, man and substance are three names standing for three different ideas; ..." [Locke, Y-2.27.7]

⁵⁹ Locke, Y-2.27.9.

⁶⁰ Literally a 'thing which thinks'.

⁶¹ Locke, Y-2.27.26.

Locke's theory of identity

Locke first considers the concept of identity as it applies to plants and animals. In so far as an animal, or a tree, might be said to be the same animal or tree, notwithstanding that each constituent element of the original had changed so that no atoms of the original still remain, it is clear that this sameness cannot consist in identity of substance. Much as we commonly say a river is the same river as flowed yesterday although it contains none of the same water, Locke locates the identity of plants and animals in a subsisting principle of organisation which persists although the substance through which it manifests, changes continually.⁶² This principle of organisation is expressed in the physical form of the animal or plant. Let us next consider the principle of identity as applied to 'man' as distinct from 'person'.

An ambiguity

A difficulty arises in that the term 'man' is ambiguous both in its present usage and, to some extent, as used by Locke. In modern speech the term 'man' can have purely biological connotations such as when it is used in contrast to 'animal'. In this usage - man_B - the term is synonymous with 'male, human of a minimum age'. The term can also be used as a term of value - man_V - as in 'He is a (real) man' where it has a meaning similar to 'male person'. Locke appears to use the term in both senses; he uses it in the sense of man_B when, for example, he says:

"... it being one thing to be the same substance, another the same man, and a third the same person, if person, man and substance are three names standing for three different ideas: ..." ⁶³

Later he discusses⁶⁴ the case of the Abbot of Saint Martin:

"When the Abbot of St. Martin, says he, was born he had so little of the figure of a man that it bespoke him rather a monster. It was for some time under deliberation whether he should be baptised or no. However, he was baptised, and declared a man provisionally (till time should show what he would prove). Nature had moulded him so untowardly that he was called all his life the Abbot Malotru, i.e. ill-shaped." ⁶⁵

Flew, commenting on the latter passage, reads 'man' as ' man_V ', and argues⁶⁶ that Locke abandoned his earlier position where questions regarding the 'real essence' of the term 'man' - as distinct from the 'nominal essence' - were regarded as unanswerable. To Flew, Locke, at this crucial juncture, momentarily lost his nerve and implicitly accepted a definition of man stated in Cartesian terms. I suggest that Flew is mistaken and that an adequate defence to his charges can

⁶² Locke, Y 2.27.8.

"An animal is a living organised body; and consequently the same animal, as we have observed, is the same continued life communicated to different particles of matter as they happen successively to be united to that organised living body."

⁶³ Locke, Y-2.27.7.

⁶⁴ Quoting from a Monsieur Menage.

⁶⁵ Locke, Y-3.6.26.

⁶⁶ Flew states:

"Locke's momentary failure of nerve occurs in dealing with the Abbott Malotru when he appears to retreat from ontology to epistemology. Here Locke seems to be taking it, in the special case of our own species, that the impossibility is only that of being legitimately sure of the answer. The question itself, it is suggested, is susceptible in principle - but not in practice by us - of an absolutely clear-cut and unqualified answer: yes or no. The tests which fail in this puzzle case are, apparently, tests for the presence or absence of a substantial soul. In so far as this remains the crux the actual line between men and brutes presumably retains - independent of our discernment - all the clarity and distinctness for which Descartes longed."

[Flew, An Introduction to Western Philosophy, p.454]

be furnished by a reading of 'man' as 'man_B' in the above passage in conjunction with a further elaboration of Locke's distinction between 'man' and 'person'.

Identity of 'man' and identity of 'person'

To return to the problem of identity as it applies to 'man' and to 'person', the continuity of the identity of a man (i.e. as 'man_B') is - like that of an animal or a plant - expressed in the continuity of the physical form of the man. The continuity of the identity of a man (i.e. as 'man_V' or 'person') is expressed in continuity of consciousness.

A reformulation of Locke's position

A path through the difficulties encountered in Locke's exposition of personhood can be found by expressing his distinction between 'man' and 'person' in terms of a number of criteria :

Criterion 1: X has the bodily form of a man.⁶⁷

Criterion 2: X has the 'mental form' of a man - i.e. X can talk and reason.

Criterion 3: X has self-consciousness i.e. in Locke's words 'can consider itself as itself, the same thinking thing in different times and places'.⁶⁸

The test for ascribing the term 'man' is primarily 'Criterion 1' though 'Criterion 2' may be used to resolve cases of doubt.⁶⁹ The criterion for ascribing the term 'person' is 'Criterion 3'.⁷⁰

That Locke uses *Criterion 1* as the necessary, and usually sufficient, condition for using the term 'man' is evident from the following:

*"... the idea in our minds of which the sound man in our mouths is the sign, is nothing else but of an animal of such a certain form: since I think I may be confident that whoever should see a creature of his own shape and make, though it had no more reason all its life than a cat or a parrot, would still call him a man; or whosoever should hear a cat or a parrot discourse, reason, and philosophise, would call or think it nothing but a cat or a parrot and say the one was a dull irrational man, and the other a very intelligent rational parrot."*⁷¹

Locke then relates the story of Prince Maurice and the talking parrot and poses the question:

"... if this parrot and all of its kind had always talked ... as this one did, whether, I say, they would not have passed for a race of rational animals; but yet whether for all that they would have been allowed to be men and not parrots? For I presume it is not the idea of a thinking or rational being alone that makes the idea of a man in most people's sense, but of a body so and so shaped, joined to it; ..." ⁷²

Locke later returns to a discussion of the term 'man' when - just before discussing the case of the Abbot of St. Martin - he says:

⁶⁷ In respect of some individual 'X'.

⁶⁸ Locke, Y-2.27.9.

⁶⁹ Though not in cases where there is no doubt that *Criterion 1* does not apply - vide the rational parrot example which follows.

⁷⁰ In addition to *Criteria 1 and 2* (but this is not a logical requirement).

⁷¹ Locke, Y-2.27.8.

La Mettrie discusses this story:

"Locke, who was certainly never suspected of credulity, found no difficulty in believing the story told by Sir William Temple in his memoirs, about a parrot which could answer rationally, and which had learned to carry on a kind of connected conversation as we do."

[Julien Offray De La Mettrie, *Man a Machine*, p.101].

⁷² Locke, Y-2.27.8.

*"... it has been more than once debated whether several human foetus should be preserved or received to baptism or no, only because of the difference of their outward configuration from the ordinary make of children, without knowing whether they were not as capable of reason as infants cast in another mould; some whereof, though of an approved shape, are never capable of as much appearance of reason all their lives as is to be found in an ape or elephant, and never give any signs of being acted by a rational soul. Whereby it is evident, that the outward figure, which only was found wanting, and not the faculty of reason, which nobody could know to be wanting in its due season, was made essential to the human species."*⁷³

If my reading of Locke is correct, then the discussion of the examples of the Abbot and of the foetus relates not to whether they were *persons* (i.e. *man_V*) but to whether they were *men* (i.e. *man_B*). Had they the obvious form of men then, to Locke, there would be no question but that they were men, but in cases of doubt it was permissible to see if they developed reason and the ability to communicate. This does not imply that Locke - as suggested by Flew - accepted the possession of reason as the definitive criterion for personhood. This is evident from his treatment of cases where there is no doubt that *Criterion 1* - i.e. that X has the bodily form of a man - is not satisfied, for example in the case of the 'rational parrot', just considered, Locke is emphatic that they are parrots and not men. Further evidence that Locke did not accept the Cartesian concept of person is clear from his statement that:

*"It would possibly be thought a bold paradox, if not a very dangerous falsehood, if I should say that some changelings, who have lived forty years together, without any appearance of reason, are something between a man and a beast: which prejudice is founded upon nothing else but a false supposition, that these two names, man and beast, stand for distinct species so set out by real essences, that there can come no other species between them ... Here everybody will be ready to ask, if changelings may be supposed something between man and beast, pray what are they? I answer, changelings; which is as good a word to signify something different from the signification of man or beast, as the names man and beast are to have significations different one from the other."*⁷⁴

My use of *Criterion 3* in defining personhood may seem to be an unjustified interpolation on Locke's distinctions, in that it explicitly separates rationality from personhood. It can, however, be justified but it is first necessary to contrast Locke's view of the linkage between 'possession of thinking substance' and 'personhood', with Descartes'.

Descartes believed that man consisted of two substances, a bodily substance and an immaterial 'thinking substance'; the possession of such a thinking substance, or 'soul', being the necessary and sufficient condition for being a person. Locke, in contrast, found the idea of thinking substance unhelpful; it did not advance - in fact it confused - the search for personal identity. He argued - at considerable length and using many 'thought experiments'⁷⁵ - that 'personhood' could not be equated with the possession of such a thinking substance because the one person might have two

⁷³ Locke, Y-3.6.26.

⁷⁴ Book 4, Chapter 4; quoted in Antony Flew, Body, Mind and Death p.165.

⁷⁵ In one such thought experiment the consciousness of a poor cobbler was exchanged with that of a prince whilst they both slept.

thinking substances⁷⁶ or different persons may have the one thinking substance.⁷⁷ Thus, ability to think - i.e. possession of a thinking substance - was of no concern to Locke in his attempt to clarify personal identity. He appeared to acknowledge that animals⁷⁸ might have such a thinking substance but since he considered possession of personal identity as the crucial condition for the ascription of rights - i.e. for personhood - this does not present the difficulties to him that it would present to Descartes.

To Locke 'continuity of consciousness' - and not possession of thinking substance - is the crucial criterion,⁷⁹ this is so because his concept of person is intimately connected with the assigning of rights and responsibilities:

*"In this personal identity is founded all the right and justice of reward and punishment ..."*⁸⁰

This suggests the conclusion - also supported by the discussion of the case of Abbot Malotru⁸¹ - that the judgement that 'X was not a person' implied that 'rights' were not to be accorded to X and in particular that the killing of X would not be murder;⁸² this permits the conclusion:

Conclusion 10-5 : To Locke, possession of personhood is a necessary and sufficient condition for the ascription of rights.

A final reformulation of Locke's position

Locke's definition of the term 'person' suggests that the concept 'person' was logically prior⁸³ to that of 'personal identity'.⁸⁴ This, however, is not borne out in the development of his argument

⁷⁶ [Locke, Y-2.27.13]:

"... it will be possible that two thinking substances may make but one person."

And again [Locke, Y-2.27.23]:

"Could we suppose two distinct incommunicable consciousnesses acting in the same body, the one constantly by day, the other by night ... I ask ... whether the day- and the night-man would not be two as distinct persons as Socrates and Plato?"

⁷⁷ [Locke, Y 2.27.14]:

"... whether, the same immaterial substance remaining, there may be two distinct persons?"

See also Locke 2.27.20:

'Absolute oblivion separates what is thus forgotten from the person, but not from the man. ... it is past doubt the same man would at different times make different persons; which we see ... [in] human laws not punishing the mad man for the sober man's actions, not the sober man for what the mad man did, - thereby making them two persons: ...'

[Digital Classics Edition]

⁷⁸ [Locke, Y -2.27.12]:

"... unless they will say, it is one immaterial spirit that makes the same life in brutes, as it is one immaterial spirit that makes the same person in men; which the Cartesians at least will not admit, for fear of making brutes thinking things too."

⁷⁹ [ibid. Y-2.27.19]:

"This may show us wherein personal identity consists: not in the identity of substance but ... in the identity of consciousness, ..."

Also [ibid. Y-2.27.21]:

"... personal identity can by us be placed in nothing but consciousness (which is that alone which makes what we call self), without involving us in great absurdities."

⁸⁰ *ibid.* Y-2.27.18.

⁸¹ This example concerns ascription of the term 'man' rather than 'person'; however, to Locke 'person' was a narrower category than - and wholly contained within that of - 'man'; thus if the term 'man' could not be ascribed, a *fortiori* neither could the term 'person'.

⁸² [ibid. Y-3.6.26]:

"This child ... was very near being excluded out of the species of man, barely by his shape. He escaped very narrowly as he was; and, it is certain, a figure a little more oddly turned had cast him, and he had been executed as a thing not to be allowed to pass for a man."

It is also implied by [ibid. Y 3.6.27]:

"Who would undertake to resolve what species that monster was of which is mentioned by Licetus, with a man's head and hog's body? ... If any of these creatures had lived, and could have spoke, it would have increased the difficulty. Had the upper part to the middle been of human shape, and all below swine, had it been murder to destroy it?"

⁸³ A is logically prior to B if B can be defined in terms of A but not conversely.

⁸⁴ [ibid. Y-2.27.9]:

"... to find wherein personal identity consists, we must first consider what person stands for; which, I think, is a thinking intelligent being that has reason and reflection and can consider itself as itself, the same thinking thing in different times and places; which it does only by that consciousness which is inseparable from thinking and, as it seems to me, essential to it ..."

and, furthermore, it has the disadvantage that it does not clearly distinguish his position from Descartes'. I suggest an alternative formulation of Locke's theory, in which '*personal identity*' is regarded as being logically prior to '*person*'; this permits '*person*' to be defined as one who possesses '*personal identity*'; '*personal identity*', in turn, being defined in terms of '*continuity of consciousness*'.⁸⁵ This permits a clearer view of the structure of Locke's arguments.

The suggested approach is similar to that adopted by Owen Flanagan in his discussion of personhood.⁸⁶ Flanagan considers personhood to reside in the possession of a reasonably viable '*story of the self*' which allows the individual and the world to interrelate⁸⁷ - the individual to relate to the world out of a sense of a personal history or personal continuity, and the world to relate to the individual through its having (from a knowledge of the personal history) the ability to predict the individual's likely responses. Flanagan describes the case of 'Jimmie' who lost his long term memory to alcoholism:

"... '*whatever was said or done to him was apt to be forgotten in a few seconds' time*' ...
Jimmy was 'isolated in a single moment of being, ... He is a man without past (or future) stuck in a constantly changing, meaningless moment.'"⁸⁸

From a Cartesian perspective, Jimmy - who is a thinking human being - would be categorised as a person. From Locke's perspective, Jimmy - in that he satisfies *Criteria 1* and *2* but not *3* - would not be categorised as a person: he lacks continuity of consciousness and he, therefore, lacks a personal identity;⁸⁹ hence, he cannot be considered to be a person.

Locke: Conclusions

In an attempt to see how the proposition (T)⁹⁰ would be resolved from within Locke's philosophy, we can pose the following question:

Can the term 'person' denote an individual with whom communication can never be established?

Because a third party could ascribe the term '*person*' to another only if he could first communicate with that other and determine that the other possessed a '*continuity of consciousness*' and furthermore, since personhood is - to Locke - '*a forensic concept*' and communication is required before responsibility can be assigned, it is clear that

Conclusion ^{10 - 6} : *To Locke, the ability to communicate is a necessary condition for ascription of personhood.*

Could, however, an isolated individual ascribe the term 'person' to himself? In that, to Locke, the term 'person' was essentially a:

*"... forensic term, appropriating actions and their merit, and so belongs only to intelligent agents, capable of a law, and happiness and misery."*⁹¹

it is clear that Locke embeds 'personhood' in a social context.⁹²

⁸⁵ This criterion is reminiscent of a saying of St. Augustine (*Confessions* X.17):
"I am the recollecting and ordering of my past."

⁸⁶ Owen Flanagan, *Consciousness Reconsidered*. See also Appendix F.

⁸⁷ This concept could better be described by the term '*persona*'; the relationship between the concepts '*person*' and '*persona*' is discussed in the following Section.

⁸⁸ Flanagan (*op.cit.* p.168) quoting a case history given by Oliver Sachs.

⁸⁹ He has an identity in how he is regarded by the world, but - because continuity of consciousness is missing - this is an identity as a 'man' not as a 'person'; this is also the situation as viewed from his own standpoint as he has no stable foundation from which he can relate to the world.

⁹⁰ (U) is implied by Conclusion ^{10 - 5}.

⁹¹ Locke, Y-2.27.26.

Section 2: Some examples of everyday usage of the term 'person'

As has been discussed in the Introduction to this chapter, philosophical questions are rarely concerned exclusively with how particular words are used in everyday speech,⁹³ consequently it is not to be expected that an exhaustive cataloguing of current uses of the term 'person' would resolve the philosophical problems associated with the concept of personhood. However, it is important that the opposite error is not made and that the concept of 'person' is sought to be defined without reference to its many usages in contemporary language; to do so can only exacerbate confusion in that a further shade of meaning - a '*philosophical meaning*' - is added to an already heady mix of ambiguity. If it is desired to define a term which is in current use and to assign to it a meaning different to that which the word normally bears, then it is surely wiser to coin a new word for what is after all a new concept. These questions were much discussed by the Oxford philosopher J. L. Austin. Austin, having noted that certain words had only a philosophical usage, continued:

*"... but most words are in fact used in a particular way already, and this fact can't be just disregarded. (For example, some meanings that have been assigned to 'know' and 'certain' have made it seem outrageous that we should use these terms as we actually do; but what this shows is that the meanings assigned by some philosophers are wrong.) Certainly, when we have discovered how a word is in fact used, that may not be the end of the matter; ... we may wish to tidy the situation up a bit, ... draw the boundaries and distinctions rather differently."*⁹⁴

Austin counsels against attempting to find a characteristic common to all usages of a word⁹⁵ particularly when attempts to do so involve:

*"... dismissing some (if not all) the ordinary uses of a word as 'unimportant'."*⁹⁶

Aside from the problem of the relationship of the existing uses of a term to a proposed definition of that term, Austin also points out a further problem that may arise: this concerns the question of whether a word can refer to a novel object which shares many, but not all, of the characteristics of objects to which the word usually refers;⁹⁷ Austin takes an example:

"Suppose that one day a creature of the kind we now call a cat takes to talking. ... then other cats, not all, take to talking as well; we distinguish between talking and non-talking cats. But again we may, if talking becomes prevalent and the distinction between talking and not

⁹² Thus, Locke belongs to the school of philosophers who regard 'personhood' as a *social* (or, - as Gellner terms it - *organic*) rather than an *atomistic* concept (See the discussion of Wittgenstein '*Private Language Argument*' in the Introduction to this Chapter); support for this viewpoint is also found in the relationship between Locke's use of the term '*person*' and the term '*persona*' - meaning social mask or guise; this relationship has been explored by Kenneth P. Winkler in his essay '*Locke on Personal Identity*' [included in Vera Chappell (ed.), *Locke*, p.149-174]. Winkler's ideas are discussed in Section 2 in contrasting the terms '*person*' and '*persona*'.

⁹³ For a discussion of this problem in relation to Locke's philosophy, see Lowe *op.cit.* p.104 *et seq.*

⁹⁴ J L Austin, G J Warnock (ed.), *Sense and Sensibilia*, p.62-63 [emphasis in original].

⁹⁵ Austin, speaking of the term '*real*' - but also applicable to the term '*person*' - says:

"... I don't know just how to take the assertion that it's a real duck unless I know just what, on that particular occasion, the speaker has in mind to exclude. This, of course, is why the attempt to find a characteristic common to all things that are or could be called 'real' is doomed to failure; ..." [ibid. p.70]

⁹⁶ *ibid.* p.63

⁹⁷ Umberto Eco in his *Kant and the Platypus* gives examples to the same effect: If some tinkering with the genetic code produced a mouse 80 meters long and weighing 80 kg., what, he wonders, would this new creature be called? Would it be a mouse or a new species? A second example concerns the story of Marco Polo who, when he broke his journey in Java was astonished to see a one-horned beast which he took to be a unicorn - but which we 'know' to be a rhinoceros; Eco argues that he did not have the Kantian 'schema' or aprioristic category, to know what a rhino was.

*talking seems to us to be really important, come to insist that a real cat be a creature that can talk."*⁹⁸

Austin's solution lies in the use of 'adjuster-words'⁹⁹ such as 'real', 'true' or 'like' - though we could, of course, insist that talking cats were to be called by a different name, 'tats', for example. The appropriate solution to be adopted would appear to hinge on the importance to us of the consequences of the distinction between talking, and non-talking, cats. Assume that certain important consequences followed on being designated 'a cat' and we ask '*Do these consequences equally apply to 'tats'?*' It is certainly clear that retaining the old term 'cats,' - rather than using the new term 'tats' - would mainly serve to obfuscate the problem.

How does this relate to our discussion of PVS patients? Firstly, it counsels against too readily describing PVS patients as persons since the differences between them and those to whom the term normally refers are obviously of considerable importance. Secondly, it clearly shows that the question '*Are PVS patients persons?*' is to some extent tangential to the essential issue which is whether '*Should PVS patients have rights?*'¹⁰⁰

Has, then, the linguistic investigation of the term '*person*' any point? To answer this let us assume that the results of an exhaustive investigation of the uses of the term '*person*' show that the term:

- * always signifies one '*worthy of respect*' and
- * is never applied to one who has not the ability to communicate;

What conclusions can be drawn? It may be that some who are not persons are also worthy of respect. Let us rule out this possibility so that '*person*' is synonymous with '*worthy of respect*'. Can we now conclude that an individual who has permanently lost the ability to communicate is not worthy of respect? We can certainly say (given our assumptions) that, traditionally, this has been the case. Let us next assume the permanent inability of PVS patients to communicate, what now follows? Had the PVS condition not been a recent phenomenon, but existed for some considerable time, it would be possible to conclude from the results of our hypothetical investigation that PVS patients had not *traditionally* been accorded the status of persons and were not considered to be bearers of rights. However, the situation is more complex in that both the term PVS and the condition itself are of recent origin. Thus, no linguistic investigation can resolve the question of whether PVS patients are persons. At most our linguistic investigation of the term '*person*' could show that traditionally those who had no ability to communicate were not accorded rights.¹⁰¹

Conclusion¹⁰⁻⁷ : *The maximally relevant conclusion (in relation to the 'personhood' of PVS patients) that could be drawn from a linguistic investigation of the term 'person' is*

⁹⁸ Austin op.cit. p.76.

⁹⁹ *ibid.* p.73.

¹⁰⁰ Strictly speaking, the right at issue here is the '*right not to be killed*'.

¹⁰¹ The questions can then be posed as to whether this situation should be allowed to continue and whether it should apply to PVS patients; if it was argued that PVS patients should be accorded rights, this would necessitate a radical revision of some of the concepts which we have been discussing, as is made clear by the following schema:

Since

1) The term '*bearer of rights*' is equivalent to the term '*person*'; and

2) The term '*person*' (implies) '*one who can communicate*'

implies

3) Being '*a bearer of rights*' (implies) being '*one who can communicate*'.

Therefore, if it is accepted that:

4) '*PVS patients have permanently lost the ability to communicate*'.

then, to assert that:

5) '*PVS patients have some rights*'.

necessitates that either 1) or 2) must be rejected.

that, traditionally, rights were not accorded to those with whom, it was believed, communication was not possible.

The above discussion shows not only the maximal relevant conclusion that could be drawn from a linguistic investigation but also the direction in which such an investigation should proceed; for if the maximal relevant conclusion which could be drawn from a linguistic investigation of the term 'person' is that traditionally those who had no 'ability to communicate' were not considered 'worthy of respect'¹⁰² then our linguistic investigation should concentrate on contexts where the relationship of the term 'person' with the concepts of 'ability to communicate' and 'worthy of respect' is put under strain; the following have been chosen as providing examples of such contexts:

- (i) *The contrast between an 'impersonal', and a 'personal', God.*
- (ii) *The difference between treating an individual 'as a person' and 'as an object'.*
- (iii) *The link between the terms 'person' and 'persona'.*
- (iv) *The term 'non-person'.*

(i) The contrast between an 'impersonal' and a 'personal' God

The Vedas which are the sacred books of the Hindus, have an impersonalist conception of the Absolute; concepts of a personal God and of devotion to such a God are considered only appropriate to lower forms of religion.¹⁰³ Buddhism, in so far as it deigns to consider such questions, has similar beliefs. The Taoist concept of a 'supreme being' is also impersonal:

*"It is proper to view the self-existent cosmos and its majestic changes and transformations with reverence and awe, but to compose prayers or hymns to it would be merely futile. The Tao is not concerned with the rise and fall of individuals, but with the smooth effortless progress of its transformations, the well-being of the whole. Therefore [the Taoist] achieves his goal not by imploring the Tao to favour him but by learning to accommodate himself to its harmonious workings."*¹⁰⁴

This concept of an impersonal God is also found in Western philosophy as, for example, in the writings of Spinoza:

"[Spinoza] treats of God, understanding, and human passions as though they were circles and triangles. Nature becomes an enormous silent machine which is indifferent to the value of man. Even if we call the former by the name of God, it does not come nearer the human being. 'For the reason and will which constitute God's essence must differ by the breath of all heaven from our reason and will, have nothing in common with them, except the name; as little, in fact, as the dog star has in common with the dog the barking animal.'"¹⁰⁵

Ideas of an impersonal God are also to be found in Western religious thought though they do not predominate: Mircea Eliade, writing on the development of ideas of God in European civilisation, suggests that the Greeks paid honour, not to statues, but to unwrought stones:¹⁰⁶

¹⁰² The phrase 'worthy of respect' - being less technically legalistic than the phrase 'owner of rights' (which was used earlier) - is more suited to a linguistic investigation.

¹⁰³ Mircea Eliade (ed.), *The Encyclopedia of Religion*, (in the entry under 'anthropomorphism' pp. 316-320) at p.320.

¹⁰⁴ John Blofeld, *Gateway to Wisdom*, p.17.

¹⁰⁵ S. Radhakrishnan, *Eastern Religions and Western Thought*, p.13.

Wittgenstein's belief that the world is 'a matter of complete indifference for what is higher' [quoted in Sluga *op.cit.* at p.343] echoes the stance taken by Spinoza.

¹⁰⁶ Though not as stones *qua* stones but as symbols of 'otherness', Eliade states:

“... Hermes, before becoming the ‘person’ we know in post-Homeric religion and literature, was at first simply a theophany of stone. These *hermai* indicated a presence, embodied a power, and at once protected and made fertile. That Hermes came to have the form of a man was due to the action of the Greek imagination, and the tendency people had from very early on more and more to personalise their divinities and sacred forces.”¹⁰⁷

Eliade notes that two tendencies can be thus identified; one where *images* of the divine are created and another where there is a refusal to create such images - at most *symbols* of the divine being permitted;¹⁰⁸ both these tendencies were present in ancient times and have persisted to the present day. Eliade cites the example of Xenophanes who (writing in the 5th Century BC) noted that whilst the Ethiopians represented their gods as black, the Thracians depicted them as blue-eyed and red-haired and that ‘if oxen and horses ... had hands and could pain^t their gods would be in the image of oxen and horses, thus suggesting that men create gods in their own image; yet Xenophanes himself speaks of one God ‘who neither in shape ... nor in thought’ resembles anything human; he has no eyes and no ears, but himself is ‘wholly eye, wholly spirit, wholly ear.’¹⁰⁹ Eliade’s suggestion¹¹⁰ that an image can function as an image of God precisely in so far as it is nonhuman, helps explain why both of the tendencies, just mentioned, have persisted into modern times. On the one hand a stripping away of those human qualities which ‘cloud’ ideas of God is required, yet the logical development of this tendency is a concept of God of which nothing can be said; Maimonides for example, taught¹¹¹ that no positive attributes whatever can be predicated of God. This tendency culminates in the *via negativa* of mystical religion and is open to David Hume’s objection that it is indistinguishable from atheism;¹¹² a conclusion which in turn generates the opposite tendency leading to anthropomorphism.

Eliade believes that the distinction between a personal and an impersonal God is essentially reducible to the question of anthropomorphism, if not in its crudest forms then, certainly as ‘*psychological anthropomorphism*’¹¹³ where the divine takes on not human physical shape, but human feelings of loving, pitying *etc.*:

“The ultimate residual anthropomorphism, however, is the theistic notion of God as personal, in contrast to an impersonal conception of the divine.”¹¹⁴

Eliade concludes his article with the question:

“The religious, as distinct from the philosophical, problem could be summarised in the simple question: can one pray to a nonanthropomorphic deity?”¹¹⁵

What conclusions can be drawn from this discussion relating the term ‘*person*’ to the concepts of ‘*ability to communicate*’ and ‘*worthy of respect*’?

“Nowhere in the history of religions do we find an adoration of any natural object in itself. A sacred thing, whatever its form and substance, is sacred because it reveals or shares in ultimate *reality*. Every religious object is always an ‘incarnation’ of something: of the *sacred*.” [Eliade, *Patterns in Comparative Religion*, p.158].

¹⁰⁷ *ibid.* p.234.

¹⁰⁸ Where the term ‘image’ is used as in the Biblical prohibition against making graven images; the distinction between *image* of and *symbol* for God is, perhaps, still found in Islam.

¹⁰⁹ Eliade, *The Encyclopedia of Religion* p.318

¹¹⁰ *ibid.* p.317. Eliade refers to Rudolf Otto as saying that “It is precisely the nonhuman quality of theriomorphic or thieranthropic [i.e. animal or animal/human] representations that enables them to function as symbols of the ‘wholly other’.”

¹¹¹ *ibid.* p.318.

¹¹² *ibid.* p.319.

¹¹³ or ‘*anthropathism*.’

¹¹⁴ *ibid.* p.317.

¹¹⁵ *ibid.* p.320.

With regard to communication the answer lies, I suggest, in Elides' last question. A personal God is one with whom communication is possible. It may be suggested that the distinction between a personal and an impersonal God rests not in '*communication*' but in '*influence*' since the omniscience¹¹⁶ of God implies that attempts at communication would be redundant. This objection can be countered by noting that the concept of omniscience is itself anthropomorphic and thus presupposes a personal God.

With regard to '*worthy of respect*' the answer is more problematic in that the very concept of God usually implies omnipotence and an obligation to show respect, though it can again be objected that these concepts are again anthropomorphic. Yet this objection itself can in turn be dismissed in noting that the Taoist respects the Tao even though it is impersonal.

The conclusions - especially that relating to the concept '*worthy of respect*' - may seem unsatisfactory yet a further conclusion can be drawn which is helpful, for it seems indubitable that the distinction between a personal and an impersonal God lies *not* in the qualities of a God but in the *relationship* between God and man. This would support the earlier contention that '*personhood*' was a concept applicable only in a context of possible relationship between two entities and is not applicable to an isolated entity itself.

Conclusion 10 - 8 : *The distinction between a 'personal' and an 'impersonal' God lies in the existence or otherwise of a relationship based on the possibility of communication between man and God. However, whilst this interpretation is consistent with (T), it is not meaningful in relation to (U').*

(ii) The difference between treating an individual 'as a person' and 'as an object'

Elizabeth Kübler-Ross discussed the practice of treating patients as objects;¹¹⁷ she has described the typical medical practice in relation to a severely ill patient as beginning by considering him as a '*person with no right to an opinion*'¹¹⁸ and progressing to treating him as '*an object*'.¹¹⁹ The treating of a patient 'as an object' does not suggest any lack of care on the doctor's part; indeed, the physician may be acting from the most altruistic of motives - acting, as he sees it, *solely* in the 'best interests' of the patient. Where then does the objection lie?

Foot's distinction between those moral obligations that flow from Justice and those that flow from Charity is helpful at this point as it shows that although a doctor who treats his patient as an object may well fulfil the obligations that flow from Charity - his interventions may be solely '*for the sake of*' the patient - he neglects the obligations that flow from Justice. Thus, to suggest that a patient is being treated as an object does not imply that their *welfare* is being neglected but rather their *rights* are being ignored. The crucial point is that to treat a patient solely from the perspective of what is believed to be their 'best interests' is a *denial* of 'personhood' in that the requirements of Justice - which are not to intervene without consent - are ignored.

These issues are discussed by Paul Ramsey who sees '*patient consent*' as the crucial component in the doctor-patient relationship and as being fundamental to the patient being treated '*as a person*':

¹¹⁶ usually implicit in the concept of God.

¹¹⁷ These issues are discussed more fully in Chapter 9.

¹¹⁸ Kübler-Ross (1970) p.7.

¹¹⁹ "Slowly but surely he is beginning to be treated like a thing. He is no longer a person. Decisions are made often without taking his opinion. If he tries to rebel he will be sedated." [*ibid.* p.8]

*"The principle of an informed consent is a statement of the fidelity between the man who performs medical procedures and the man on whom they are performed. Other aspects of medical ethics ... treat the man as a purely passive subject or patient ... But any human being is more than a patient or experimental subject; he is a personal subject - every bit as much a man as the physician-investigator. Fidelity is between man and man in these procedures. Consent expresses or establishes this relationship, and the requirement of consent sustains it."*¹²⁰

The obligation to desist from medical procedures in the absence of patient consent is not out of concern for the patient's welfare - for the patient may not consent to the procedure and possibly suffer damage in consequence - but out of concern for the patient's *rights*. However, the obligation to seek consent rests on an even more fundamental obligation which is the obligation to seek to communicate with the patient, for unless communication is attempted, questions of consent are otiose.

It is convenient at this point to draw some conclusions concerning patient rights:¹²¹

Conclusion ₁₀₋₉ : *In taking health care decisions affecting a patient, the principal obligation imposed by the virtue of Justice is to attempt to communicate with the patient; this obligation overrides all obligations to the patient flowing from Charity.*

Conclusion ₁₀₋₁₀ : *To take health care decisions for a patient without first attempting to communicate with the patient in order to determine their wishes, is in effect a denial of their 'personhood' and this is so even if all such decisions are taken solely on the basis of what is believed to be in the patient's 'best interests'.*

The conclusion to be drawn in relation to linguistic usage is:

Conclusion ₁₀₋₁₁ : *In speaking of a carer treating a patient as 'an object' rather than as 'a person' what is being alluded to is the unwillingness of the carer to communicate with the patient and the refusal to recognise the patient's rights. Thus, this usage is consistent with both (T) and (U').*

(iii) The link between the terms 'person' and 'persona'

Heinrich Zimmer, discussing what he calls *'the mask of the personality'*, contrasts the Western concept of personality with the Eastern:

"For the Western mind ... the personality is eternal. It is indestructible not to be dissolved. This is the basic idea in the Christian doctrine of the resurrection of the body ... The term 'personality' is derived from the Latin persona. Persona, literally, means the mask that is worn over the face by the actor on the Greek or Roman stage; the mask 'through' (per) which he 'sounds' (sonat) his part ... Originally the term persona in the sense of 'personality' must have implied that people are only impersonating what they seem to be.[¹²²] ... It is not a manifestation of his true nature, but a veil. And yet the Western outlook - which originated

¹²⁰ Paul Ramsey, *The Patient as Person*, p.5.

¹²¹ Strictly speaking, *Conclusion* ₁₀₋₉ and *Conclusion* ₁₀₋₁₀ depend on (U') and (T) and should be placed at the end of this Chapter when both (U') and (T) have been established; they have been placed at this point in order to save a needless repetition of some of the arguments.

¹²² As in Eliot's poem *'The Love Song of J. Alfred Prufrock'*:

*"There will be time, there will be time
To prepare a face to meet the faces that you meet;"*

*with the Greeks themselves and was then developed in Christian philosophy - has annulled the distinction, implied in the term, between the mask and the actor whose face it hides. The two have become, as it were, identical. When the play is over the persona cannot be taken off; ..."*¹²³

Indian philosophy, on the other hand:

*"... insists upon the difference, stressing the distinction between the actor and the role. ... Indeed, one of the dominant endeavours of Indian thought throughout the ages has been to develop a dependable technique for keeping the line clear between the two."*¹²⁴

Alan Watts takes up a similar theme in arguing that the term 'person' is used in the West to designate the basic spiritual reality of the human being:

*"... [who] is said to have spiritual dignity because he is a person, as God is three Persons. But a person is strictly what one is as mask or role, at the social or conventional level. The word which should have been used for the ego is used for the self (atman) or spirit (pneuma), which in other traditions is supra-individual. Hence the Christian identification of the spirit with ego, and the inability to see that man is more than ego, ..."*¹²⁵

This discussion may seem to be travelling down an esoteric path, yet an essay¹²⁶ by Kenneth Winkler entitled '*Locke on Personal Identity*' reunites us with our earlier discussion. Winkler writing on Locke's concept of a 'person' says:

*"The suggestion that a person is a mixed mode¹²⁷ is not as far fetched as it may seem, because there was a long tradition, rooted in the ancient understanding of persona as a mask or guise, according to which persons are constructions - often social constructions - somehow placed on naturally occurring human beings."*¹²⁸

Winkler quotes Law (a contemporary of Locke's) as saying that the term 'person' stands for an attribute of a thinking intelligent being which, Law explained, was the sense in which Cicero used it as when he said:

*"If on account of my actions you impose this person on my whole life, Torquatus, you are badly mistaken. Nature wished me to be compassionate: my country wished me to be firm; neither my country nor Nature wished me to be cruel; further, inclination and Nature itself have now drawn off the violent and harsh person [persona] which occasion and the state then imposed."*¹²⁹

Commenting on this passage, Winkler states:¹³⁰

"A role or guise, Cicero warns, is something imposed by human beings, acting individually or in concert, and is not to be confused with the human being on whom it is imposed. That

[T. S. Eliot, *Selected Poems*. London: Faber, 1954; p.12].

¹²³ Heinrich Zimmer, *Philosophies of India*, p.236-7.

¹²⁴ *ibid.* p.237. Zimmer notes that in Oriental depictions of Hell - unlike Christian depictions - none of those suffering retain the traits of their earthly individualities.

¹²⁵ Alan Watts, *Nature, Man and Woman*, p.141, footnote.

¹²⁶ Included in Vera Chappell (ed.), *Locke*, p.149-74.

¹²⁷ *i.e.* rather than a 'substance'.

¹²⁸ Chappell *op.cit.* p.160.

¹²⁹ Cicero, *Pro Sulla* 3.8..

¹³⁰ Chappell *op.cit.* p.161.

human being might be several persons at once - he might that is occupy several roles or guises at the same time - and he might shake off a persona earlier imposed upon him.”¹³¹

In conclusion: the term ‘person’ when understood as ‘persona’ - i.e. possessor of a ‘social role’¹³² - clearly implies an ability to communicate.¹³³ This interpretation also helps explain why the terms ‘person’ and ‘bearer of rights’ have the same extension because, without participation in society, one is an ‘outcast’ or a ‘non-person’, and - as we shall see in the next sub-section - the mark of such an individual is that he is without rights.

Conclusion 10 - 12 : *The usage of the term ‘person’ - when understood in the sense of ‘persona’ - is consistent with having an ability to communicate and with the possessing of rights i.e. with (T) and (U).*

(iv) The term ‘non-person’¹³⁴

The aim of this subsection is to examine how the term ‘non-person’ is used in everyday speech particularly in relation to the concepts ‘worthy of respect’ and ‘ability to communicate’; the hope being that such an examination will help clarify the meaning of the term ‘person’. One difficulty which immediately arises is that the term ‘non-person’ is not in common use though some recent examples¹³⁵ of its use not only clearly link the term to loss of rights but also carry overtones of one who is being ignored or whose communications are being discounted. These perceptions are confirmed by the definition of ‘non-person’ contained in The New Shorter Oxford Dictionary, which is of “A person regarded as non-existent or unimportant, or as having no rights; an ignored, humiliated, or forgotten person.”¹³⁶ Because ‘non-person’ is not a term in common use, a more indirect strategy is required: remembering that our underlying goal is to examine the linguistic evidence for the implication ‘inability to communicate’ implies ‘unworthiness to bear rights’ and

¹³¹ *ibid.*

¹³² The saying ‘Death is no respecter of persons.’ also supports such a meaning.

The New Shorter Oxford Dictionary also gives as its first meaning for the term ‘person’:

“A part played in a drama or in actual life; a character (in a play or story); a persona; a guise.”

and gives as an example, the quotation “I take on a different person with each song I sing.”

It also notes the legal meaning of the term ‘person’:

“An individual ... regarded as having rights and duties recognised by the law.”

¹³³ Unless - as in the example of the mediaeval fool - the absence of a social role is taken to be a social role.

¹³⁴ Jonathan Glover takes the idea of non-person as the starting point of his philosophical investigation of personhood:

“One way of thinking about what it is to be a person is to look at cases where there is doubt about where one person ends and another perhaps begins. Such anomalous cases are found in both psychiatry and neurology.”

[Jonathan Glover, *I: The Philosophy and Psychology of Personal Identity*, at p. 21]

¹³⁵ A recent article in the New York Times was entitled “From China’s Gulag to the Grey Life of a Nonperson”

The article concerned the treatment of a Chinese dissident subsequent to the Tiananmen Square demonstrations. It began:

“In this grey industrial city in central China, Tong Yi lives a life of internal exile, reduced to the status of a nonperson by the Chinese security apparatus. As the secretary and research assistant to Wei Jingsheng during the only seven months of freedom that China’s most famous democracy activist has enjoyed since 1979, Ms. Tong made an excursion across the stage of international fame that was all too brief. And it has carried a very high price: three years in labor camp, from which she emerged last October to find China a harsher place and herself in a continuing state of persecution. Chinese police officials refuse to issue her a national identity card, so Ms. Tong cannot get a job. She cannot get a passport to travel ... The government just want me to be forgotten, she says matter-of-factly.”

[The New York Times on the Web February 6, 1997 By Patrick E. Tyler.]

A second example is taken from a recent edition of the Irish Times:

“Mr. Mandelson is now back in office, while Mr. Robinson languishes on the back benches. Worse, he languishes there as something of a non-person as far as the Labour high command is concerned.”

[The Irish Times 28-10-1999, Frank Millar ‘London Letter’]

¹³⁶ The New Shorter Oxford Dictionary defines ‘unperson’ as “A person whose existence is denied or ignored and whose name is removed from public records, usu. for political misdemeanour; gen. an ignored or forgotten person”; it gives as an example a quotation from Orwell:

“<!DOCTYPE html> <html> <head> <meta charset=

The Concise Oxford Dictionary defines ‘non-person’ as “A person regarded as non-existent or insignificant (cf. unperson).” and ‘unperson’ as “A person whose name or existence is denied or ignored.”

that the term 'non-person' is, as it where, no more than a vehicle enabling this implication, let us look for linguistic evidence of the implication itself in contexts where the attribution of 'personhood' is doubtful. It is not to be expected that the assessment of 'inability to communicate' will necessarily be explicit; for example, the statement that some individuals are '*just animals*' implies both that they have no rights and that communication with them would not be possible; an instance of such a usage is found in the correspondence of the novelist Charles Kingsley who when visiting Sligo in 1860, wrote of the native Irish:

*"I am haunted by the human chimpanzees I saw along that hundred miles of horrible country. ... To see white chimpanzees is dreadful; if they were black, one would not feel it so much."*¹³⁷

Similar examples are legion: Bruce Chatwin mentions¹³⁸ that the Indians in Patagonia were treated by the English as being of lesser worth than animals; the Kalahari bushmen were dismissed by General Smuts as '*mentally stunted*' and as '*desert animals*'¹³⁹ and were hunted as game;¹⁴⁰ a fate which also befell the gypsies:

*"In the past, gypsies could be placed on the rack or killed as fair game by huntsman. In several European countries heathen hunts - what were in effect 'gypsy hunts' - were still common down to the 18th century."*¹⁴¹

In yet more recent times the Nazi Germans considered the Slavs as being subhuman and treated them accordingly.¹⁴² This list could be continued indefinitely and is in danger of becoming a catalogue of man's inhumanity to man. Whilst, doubtlessly, treating another 'as an animal' has implications for the rights of this other and for whether he is believed to be able to communicate, the link between possessing the '*ability to communicate*' and being a '*bearer of rights*' is in danger of being lost in the wealth of historical detail. A narrower focus is required; to this end only two examples will be considered; the first concerns the attitudes of the Greeks in classical times to those who could not speak their language and the second is more modern and concerns the attitudes adopted to those who have been reared outside society and who consequently have, at most, a very restricted ability to communicate. In discussing both examples the focus will be on the question of whether the inability to communicate implies a diminution of rights.

The attitude, in classical times, of the Greeks to foreigners

Justin Leiber, in discussing the attitudes of the ancient Greeks to other nations, says:

*"Aristotle ... claimed that Persians and other non-Greeks were incapable of rationality and, therefore, were natural slaves."*¹⁴³

Leiber traces Aristotle's opinions to the sense of awe felt by the Greeks towards their alphabet and language. To the Greeks, their language accorded them a natural preeminence; their alphabet was an '*explosive invention, one stolen from the Gods, along with fire, by Prometheus*';¹⁴⁴ other 'languages' being mindless noisemaking:

¹³⁷ The Irish Times, 2-9-1999.

¹³⁸ In his book *In Patagonia*.

¹³⁹ The Sunday Times (14-12-1997) in an article by Waldemar Januszczak on the art of the African Bushman.

¹⁴⁰ The Sunday Times (14-9-1997) interview with some African Bushmen.

¹⁴¹ Dr Jim Mac Laughlin of UCC interviewed in the Irish Times 1-12-1998.

¹⁴² cf. for example the BBC documentary 'The Nazis: a Warning from History'.

¹⁴³ Justin Leiber *An Invitation to Cognitive Science* p.13.

¹⁴⁴ *ibid.* p.13.

*"Tradition has it that the ancient Greeks invented the word 'barbarian,' because they supposed non-Greeks were vocally restricted to mouthing 'bah, bah'."*¹⁴⁵

Leiber discusses how Aristotle's pupil Alexander did not accept his tutor's views:

*"He [Alexander] envisaged a brotherhood of man in which there should be neither Greek nor barbarian, ...[he believed that] a man was no longer just part of his city-state ... He is an individual bound by relations to the other individuals of the world."*¹⁴⁶

Leiber uses Alexander's views¹⁴⁷ as a step in his argument for taking the 'ability to reply appropriately to what is said in one's presence' as being a criterion of 'personhood'; on reformulation, this becomes the 'Turing Test' and is discussed in Appendix F, Section 1.

Feral children and others without language

The 18th and 19th century saw many attempts to find criteria to distinguish between animals and humans. This problem was fundamental to the philosophies of Descartes, La Mettrie, Locke¹⁴⁸ and others; the scientific writings of such as Linnaeus added a further impetus to attempt its resolution. The cases of 'feral children'¹⁴⁹ - that is children raised outside society, presumably by animals - was considered by many to offer the means both to enable the nature of the distinction between man and animals to be clarified, and many of the philosophical controversies of the day (such as, for example, the question of whether ideas were innate) to be resolved. La Mettrie, for example, argued that when such children were interrogated, no evidence was revealed for the existence of prior notions: "Where then", he asked, "is this immortal share of divinity."¹⁵⁰ The most famous of these 'feral children' was known as 'The Wild Boy of Aveyron' and is the subject of a study by Harlan Lane.¹⁵¹ Much of Lane's analysis concerns the validity of the judgement that the child - called Victor - was mentally retarded; Lane suggests that Victor may have been autistic - a condition not diagnosed until this century.

In looking at this example our goal is to see whether the inability to communicate traditionally led to a diminution of rights; it seems that, traditionally, 'inability to communicate' lead to a diagnosis of idiocy and it is incontrovertible that the labelling of an individual as 'an idiot' led to a loss of rights. However, this result is unsatisfying as introducing the idea of idiocy appears to be something of a distraction. Two insights - one due to Wittgenstein, one to Lane - show its relevance.

¹⁴⁵ *ibid.* p.14.

¹⁴⁶ Radhakrishnan, *Eastern Religions and Western Thought*, p.153-4.

¹⁴⁷ which, Leiber argues, originated with Plato.

¹⁴⁸ Descartes 'language criterion' and Lock's concept of 'personal identity' have already been considered.

¹⁴⁹ This is the term used by Douglas Keith Candland in his *Feral Children, Clever Animals*.

¹⁵⁰ Harlan Lane, *The Wild Boy of Aveyron*, p.24-25.

¹⁵¹ *ibid.*

The facts are briefly as follows: In 1799, whilst hunting in a French forest some men encountered and eventually captured 'a child of 11 or 12 who some years before had been seen completely naked seeking acorns and roots.' [Candland *op.cit.* p.18]. The boy was brought to Paris and became a source of wonder with people expecting to see a 'noble savage' such as portrayed in the writings of Rousseau. Pinel (the great reformer of mental asylums) examined the boy and concluded that he was retarded and that nothing could be learned from him. However, a colleague of Pinel's, Itard, undertook the task of attempting to educate the child, now named Victor. Itard described Victor on first meeting him, as:

"... a disgustingly dirty child affected with sporadic movements, and often convulsions, who swayed back and forth ceaselessly like certain animals in a zoo, who bit and scratched those who opposed him, who showed no affection for those who took care of him; and who was, in short, indifferent to everything and attentive to nothing."

[Candland *op.cit.* p.20]

Lane argues that the difficulty in distinguishing between Victor and an animal was accentuated by his not being deaf, had he been deaf his case could have been assimilated to other well known cases of human 'deaf-mutes' and not posed the difficulties that it did for finding a definition of 'man'. Itard struggled for five years in a vain attempt to establish communication with Victor; a colleague concluded:

"That the doctor scientist had judged rightly. The alleged savage was nothing other than an idiot. Such was Pinel's opinion on the Savage of Aveyron. Let us conclude from all this that men utterly without intelligence found isolated in the mountains, in the forests, are imbeciles, idiots lost or abandoned." [Lane *op.cit.* p.164].

Wittgenstein argued that language ability might be crucial to thought,¹⁵² absence of language ability would thus appear to imply idiocy if that term is understood as inability to reason.¹⁵³ Wittgenstein's arguments will be discussed in the Section 3 but the arguments are restricted to those who *never* learned a language. What of those who once learned a language but were by force of circumstance - such as social isolation or abandonment - unable to use it for a protracted length of time? Lane addresses this problem; he argues firstly, that the ability to learn language is dependant on the ability to imitate and that there is only a very narrow timespan in the life of a child within which the a child can - if presented with an appropriate social environment - grasp the opportunity to learn a language. Outside of this 'window of opportunity', language acquisition is unlikely. Lane's second conclusion was that even if language ability has been acquired, it can be extinguished through disuse¹⁵⁴ and, if the critical period for language acquisition has passed, it cannot be easily reacquired. In support of his second conclusion Lane documents the other cases including that of a Californian girl who was kept in isolation tied to a chair and not released until she was fourteen years old. The example¹⁵⁵ of most relevance to the situation of PVS patients is that of the Scottish sailor, Selkirk, who was the inspiration for Defoe's Robinson Crusoe. Lane describes Selkirk's rescue: a Captain Rogers, landing at the island of Juan Fernandez in 1709, there found a sailor '*as wild as the animals perhaps more so*', who had been put ashore as a punishment over four years earlier. By the time he was discovered he had "... '*almost entirely forgotten the secret of articulating intelligible sounds ... If he had not had books, or if his exile had lasted two or three years more,*' he would have lost all ability to speak."¹⁵⁶ The relevance of Lane's conclusions to the not dissimilar problem of a PVS patient who is conscious but unable to communicate but who was once (before the advent of his condition) proficient in a language will be considered in Section 5.

The final example to be considered is that of John Merrick - known as '*The Elephant Man*'. This example is useful both because a first-hand account¹⁵⁷ of the doctor-patient relationship exists (written by Sir Frederick Treves, the doctor who first found and subsequently treated Merrick) and because certain parallels can be drawn between Treves' initial attitude to Merrick and some of the attitudes which appear to be commonly adopted towards PVS patients by their physicians.

'The Elephant Man'

Treves describes his first meeting with Merrick:

*"The showman pulled back the curtain ... and speaking as if to a dog - called out harshly 'Stand up!' The thing arose slowly and let the blanket that covered its head and back fall to the ground. There stood revealed the most disgusting specimen of humanity that I have ever seen."*¹⁵⁸

¹⁵² "The experience of thinking may be just the experience of saying." See Sluga and Stern The Cambridge Companion to Wittgenstein, p.332.

¹⁵³ This was also the conclusion of Condillac, a contemporary of Pinel's:

"Gestures signs, sounds, numbers, letters; it is with instruments as foreign to our ideas as these that we bring them into play to raise ourselves to the highest levels of knowledge ... take away the use of all kinds of signs [from a superior mind] so, that he cannot make even the least gesture correctly to express ordinary thoughts, and you will have an idiot." [Lane, *op.cit.* p.25].

¹⁵⁴ *ibid.* p.178.

¹⁵⁵ *ibid.* p.179.

¹⁵⁶ *ibid.* p.179.

¹⁵⁷ Sir Frederick Treves, The Elephant Man and Other Reminiscences.

¹⁵⁸ Treves *op.cit.* p.8.

Merrick was 'denied all means of escape from his tormentors' and, had he shown himself in the streets, 'he would have been mobbed by the crowd and seized by the police'.¹⁵⁹

That Merrick was not accorded 'rights' is clear. Could he, however, have been judged to be 'a person'? Treves - in words redolent of the attitudes of many who discuss PVS patients but showing an acute self-knowledge - said:

*"I supposed that Merrick was imbecile and had been imbecile from birth. The fact the his face was incapable of expression, that his speech was a mere spluttering and his attitude that of one whose mind was void of all emotions and concerns gave us ground for this belief. The conviction was no doubt encouraged by the hope that his intellect was the blank I imagined it to be. That he could appreciate his position was unthinkable."*¹⁶⁰

It was to be a number of years before Treves again encountered Merrick and the story of 'The Elephant Man' could unfold:

*"It was not until I came to know that Merrick was highly intelligent, that he possessed an acute sensibility and - worse than all - a romantic imagination that I realised the overwhelming tragedy of his life. ... He had passed through the fire and come out unscathed. His troubles had ennobled him. ... He showed himself ... free from any trace of cynicism or resentment."*¹⁶¹

Crucial to this development was Treves' attempt to establish communication with Merrick; but a precondition exists even for *attempts* at communication: Treves' willingness to recognise that his judgement that Merrick's intellect was a blank might be 'a denial' based on nothing other than a projection of Treves' own discomfiture with the supposition that Merrick might be conscious of his situation.

Conclusions to Section 2

The aim of this section was to show - by considering some examples of the use of the term 'person' - the connection between it and the concepts of 'ability to communicate' and 'bearer of rights'. The distinction between a personal and an impersonal God was found to support the link between 'personhood' and 'ability to communicate'. The close link between 'being a person' and 'possessing a persona' also suggested that 'personhood' is a concept that cannot be understood outside a context of social interaction and, as such, implies an ability to communicate. Conversely, the refusal to recognise an ability to communicate, whether in treating a patient as an object, or, as in Aristotle's case, treating the communication as meaningless has as a consequence, the treating of the other as a non-person and as lacking in rights. In short, excommunication entails a loss of rights.

Conclusion ^{10 - 13} : The usage of the term 'non-person' suggests an individual who is excommunicated from society and without rights; as such it is consistent with both (T) and (U).

¹⁵⁹ *ibid.* p.8-10.

¹⁶⁰ *ibid.* p.11 [emphasis added]. Compare with the response of the medical expert witness in the Karen Quinlan case (mentioned in Chapter 4, Section 4) to the suggestion that Karen might have some consciousness:

"There is such a situation that can occur, and its theoretically possible, in terms of animal experiments. We've seen such patients with such things. There may be, who knows, meditation, but I don't know how you're going to find out. I think it's one of the most horrendous things you can imagine."

¹⁶¹ *ibid.* pp.11,16.

The examples given in the section on 'non-persons' - particularly the case of John Merrick - help explain why the connection between possessing an '*ability to communicate*' and being a '*bearer of rights*' occurs: in the absence of even rudimentary communication, it is difficult for empathy to get even a foothold; disgust and horror hold the centre-stage but - being unpleasant emotions - occasion as a response (as if by reflex reaction) the attempt to suppress the emotion or, if this is not possible, to remove the source - *i.e.* that which is causing the emotion to arise. But the urge to remove the source creates its own difficult emotion - guilt; this, in turn, is assuaged by 'a denial' - by protestations of one's own disinterest and by asserting that what is proposed is '*for the sake of*' the other. Many of these responses were evident in Treves original attitude to Merrick and they are no less evident in the current attitudes of many physicians towards PVS patients.¹⁶² The key to resolving these difficulties - as Treves found - lies in attempting to establish communication; this opens the gate to compassion and it is only then that the terms '*person*' and '*rights*' can be anything other than empty rhetoric. The conclusion that I wish to draw here is that an initial 'leap' of empathy is required before communication is possible; this 'leap' is also a precondition for the according of moral value and rights;¹⁶³ as a corollary, a refusal to make this leap entails that communication will not be attempted and neither rights nor moral value will be accorded.

Conclusion 10 - 14 : *An initial leap of empathy is a precondition for seeing another as a fitting subject for possessing rights, for being an 'Object of Intrinsic Moral Worth' or for possessing the ability to communicate; this gesture of empathy is not a product of rational determination but flows from the adoption of an 'attitude'. It is the gesture of 'seeing oneself in another' that enables 'personhood' to be conferred on that other; conversely, the refusal to 'see oneself in that other' precludes the attribution of 'personhood'.*¹⁶⁴

Section 3: Some philosophical authorities for a 'social definition' of personhood

The aim of this section is to show that the concept of '*personhood*' can be applied to an individual *only* if that individual has been previously involved in social interaction with others. It indicates that, amongst other things, certain minimal social capacities - in particular, the ability to communicate - have been achieved.¹⁶⁵ It cannot be applied to an individual who has been isolated from all social contact. In this it is similar to, for example, the concept of '*sociability*'. More specifically, the aim is to show that of the two concepts '*the individual*' and '*society*', (where '*the individual*' is considered to mean a thinking - and therefore language-using¹⁶⁶ - being) '*society*' is, logically, the more fundamental.¹⁶⁷

¹⁶² See the testimony of the medical expert witness in the Karen Quinlan case *supra*.

¹⁶³ See also the discussion in Appendix F on Rawls (no. 3 especially footnotes) and on Dennett (no. 6); Dennett's arguments are also discussed in the following section. Dennett's theory of stances emphasises that the determination of personhood is essentially a choice of *attitude* resting on a *decision*, rather than being a *conclusion* implied by the results of some internal examination.

¹⁶⁴ Further argument in support of this conclusion will be given in Section 3; in the subsection entitled "*The 'personhood' of PVS patients*"; it is, however, convenient to state the conclusion at this point.

¹⁶⁵ Once this is established then (T) readily follows.

¹⁶⁶ This implication is considered more fully in the discussion of Wittgenstein's '*Private Language Argument*' later in this Section.

See also Steiner, Heidegger :

"*'Simultaneously with man's departure into being, he finds himself in the word, in language.'* Invoking Heraclitus, Heidegger will give to logos and to *legein* a very particular sense: that of '*collecting*,' '*ordered gathering*,' and a '*laying side by side*.' (But the Johannine formula, '*In the beginning was the Word*,' is obviously present in his whole paradigm of being and saying)." [op.cit. p.52].

In furtherance of this aim two arguments are advanced. The first is due to Wittgenstein and is essentially the argument known as the '*Private Language Argument*' ['PLA' for short]. This is to the effect that the concept of an isolated *thinking* individual - as, for example, envisaged by Descartes in his *Meditations* - is incoherent.¹⁶⁸

The second argument is due to P.F. Strawson and is to the effect that the concept of '*personhood*' is logically primitive and that mental concepts such as '*consciousness*' must be defined in terms of it and not conversely:

*"So the concept of the pure individual consciousness - the pure ego - is a concept that cannot exist; or, at least, cannot exist as a primary concept in term of which the concept of person can be explained or analysed."*¹⁶⁹

Strawson also argues that the concept 'person' arises out of a process of mutuality between two individuals and cannot arise in relation to an isolated individual.

Many other arguments can be adduced in favour of the 'social definition' of personhood: Gellner's has been mentioned previously¹⁷⁰ and those of Jaspers,¹⁷¹ Sartre,¹⁷² Herbert Mead¹⁷³ Quassim Cassam¹⁷⁴ and John Mac Murray¹⁷⁵ should be noted; however, for reasons of space, these will not be considered in this thesis.

We turn first to a consideration of Wittgenstein's '*Private Language Argument*'; then Strawson's arguments will be considered and finally some conclusions will be drawn.

Wittgenstein and the 'Private Language Argument'

Introduction

Descartes, in his *Mediations*, set himself the task of finding secure foundations upon which to build his philosophy; his method was that of universal doubt.¹⁷⁶

"I suppose, then, that all the things that I see are false; I persuade myself that nothing has ever existed of all that my fallacious memory represents to me. I consider that I possess no senses; I imagine that body, figure, extension, movement and place are but the fictions of my

and also:

"Heidegger now postulates the absolute primacy of language: 'Language is the house of Being. Man dwells in this house.'" [op.cit. p.127].

¹⁶⁷ Meaning that the existence of society is a prerequisite for the emergence of a thinking individual.

¹⁶⁸ see also Hacker, *Wittgenstein* p.5:

"... the Cartesians ... subtly and progressively twisted our concept of person ... out of all recognition."

¹⁶⁹ P. F. Strawson, *Individuals*, p.98.

¹⁷⁰ In the Introduction to this Chapter.

¹⁷¹ Karl Jasper in his essay '*On My Philosophy*' [included in Kaufmann *Existentialism from Dostoevsky to Sartre*] says:

"The thesis of my philosophizing is: The individual cannot become human by himself. Self-being is only real in communication with another self-being." (p. 174)

¹⁷² *"The others' gaze at me - and in virtue of their gaze I find myself a person."* quoted in Passmore *op.cit.* p.496.

¹⁷³ Charles W. Morris (ed.), *Works of George Herbert Mead: Mind, Self and Society*, Vol. 1, p.182:

"The self is not something that exists first and then enters into relationship with others, but it is, so to speak, an eddy in the social current and so still part of the current."

¹⁷⁴ Quassim Cassam, *Self and World*.

P. F. Strawson summarises Cassam's thesis as:

"... a necessary part of being conscious of oneself as a subject of thought and experience is the being conscious of oneself as a corporeal object among others." [included in publicity material for Cassam's book.]

¹⁷⁵ John Mac Murray, *Persons in Relation: Vol 2 of The Form of the Personal*, p.12:

"... the result which concerns us especially is that it ends the solitariness of the 'thinking self', sets man firmly in the world which he knows, and so restores him to his proper existence as a community of persons in relation. It is the purpose of this book to show how the personal relations of persons is constitutive of personal existence; that there can be no man until there are at least two men in communication."

¹⁷⁶ Even to the extent of supposing that God was some evil genius who '*employs all his powers in deceiving me.*' Enrique Chavez-Arviso (ed.), *Descartes: Key Philosophical Writings* p.141.

*mind. What, then, can be esteemed as true? Perhaps nothing at all, unless that there is nothing in the world that is certain.”*¹⁷⁷

But there is one proposition that, he finds, he cannot doubt:

*“I find here that thought is an attribute that belongs to me; it alone cannot be separated from me. I am, I exist, that is certain. ... I am, however, a real thing and really exist; but what thing? I have answered: a thing which thinks.”*¹⁷⁸

This is the famous ‘*cogito*’ argument. This argument is best understood not as an exercise in deductive logic, but experientially in the sense that in the act of thinking, I cannot doubt that I am thinking because to do that would itself be thinking.

The belief that there are areas of ‘*subjective self-certainty*’¹⁷⁹ upon which philosophy can be constructed is not confined to Descartes; it has been the unquestioned assumption of much of modern philosophy.¹⁸⁰ The belief that sensations, such as pain, are incorrigible, known only to the subject, is one example of such beliefs. However, many philosophers - Descartes included¹⁸¹ - went further and believed, not only that sensations were private but that it was possible for the subject to philosophise about these sensations and to do so in an essentially private way. Marie McGinn discusses how William James, believing that the gateway to knowledge of psychological states was through introspection, thought that the nuances of these states might be lost or distorted if described in ordinary everyday language. James believed that a ‘*pure language of subjectivity*’- whose terms could be defined entirely on the basis of introspection - was required.¹⁸² Stewart Candlish describes how Bertrand Russell believed it to be theoretically possible to construct a ‘*logically perfect language*’ in which ‘*there will be one word and no more for every simple object*’ and which:

*“... would be very largely private to one speaker. That is to say, all the names that it would use would be private to that speaker and could not enter the language of another speaker.”*¹⁸³

Wittgenstein’s ‘*Private Language Argument*’ was a response to the assumptions implicit in such arguments. Wittgenstein had noted how, in discussions of mental processes,:

*“The first step is the one that altogether escapes notice. ...[and that as a result] The decisive movement in the conjuring trick has been made, and it was the very one that we thought quite innocent.”*¹⁸⁴

The decisive, and innocent, assumption in Descartes’ line of reasoning - and in James’s and Russell’s - was that an isolated individual could *create* a language within which thoughts (and doubts!) could be expressed. Wittgenstein argued - in his ‘*Private Language Argument*’ - that that assumption is incoherent.

¹⁷⁷ *ibid.* p.139.

¹⁷⁸ *ibid.* p.141.

¹⁷⁹ Robert J. Fogelin, *Wittgenstein*, p.166.

¹⁸⁰ Anthony Kenny, *Wittgenstein*, p.179.

¹⁸¹ Hans Sluga ‘*Whose house is that? Wittgenstein and the self.*’ [included in Sluga and Stern *The Cambridge Companion to Wittgenstein*, p.342]:

“... the language which the subject of the first two Cartesian Mediations speaks cannot be an external language - for it is accepted that we may be confused and deceived about everything external - it must be an internal language which only the speaking subject can use.”

¹⁸² Marie McGinn, *Wittgenstein*, p.117 *et seq.*

¹⁸³ Bertrand Russell, *The Philosophy of Logical Atomism* - quoted in Stewart Candlish ‘*Private Language*’ in *The Stanford Encyclopedia of Philosophy*, p. 3.

¹⁸⁴ PI-1 § 308.

The 'Private Language Argument'

The 'PLA' is the most discussed aspect of Wittgenstein's philosophy.¹⁸⁵ The argument is also a source of controversy,¹⁸⁶ not only are there differing views on its validity and implications but there is even a dispute as to the precise statement of the argument.¹⁸⁷ In this discussion only a brief outline of the argument will be given and the focus will be on the application of the argument to the question of whether an individual, solitary from birth, could develop a private language. This is the so-called '*Robinson Crusoe*' thought experiment. First, however, it is necessary to explain what is meant by a '*private language*'.

Wittgenstein first asks us to "*... imagine a language in which a person could write down or give vocal expression to his inner experiences - his feelings, moods, and the rest - for his private use.*"¹⁸⁸ He then continues:

*"Well, can't we do so in our ordinary language? - But that is not what I mean. The individual words of this language are to refer to what can only be known to the person speaking; to his immediate private sensations. So another person cannot understand the language."*¹⁸⁹

Wittgenstein's thesis is that such a language is impossible.¹⁹⁰ The reasons¹⁹¹ offered in support of this contention are:

- (i) Wittgenstein considers the notion that experiences are private to be fundamentally flawed,
- (ii) Wittgenstein argues that a language cannot be learned simply by *bare* ostensive definition, i.e. a process of '*pointing*', whether 'inner' or outer, is not sufficient. Some public component of interactive training is essential.

However, these are not the points that are normally taken to constitute the 'PLA' - though they may well be sufficient to establish it; the 'PLA' is usually understood to refer to a much narrower question, namely how, in such a private language, a word could be said to *refer* to a sensation. To bring the discussion into even greater focus, Wittgenstein asks us to imagine that:

*"I want to keep a diary about the recurrence of a certain sensation. To this end I associate it with the sign 'S' and write this sign in a calendar for every day on which I have the sensation."*¹⁹²

The problem that Wittgenstein has set is whether a sensation could be *named*. Just before discussing this question, he has noted that *even if* it could be so named, we could not use this name as we would have no grammar for it's use - we would not have any context in which it could be placed - because the grammar "*... shews the post where the new word is stationed.*"¹⁹³ Noting, but not pursuing, this objection he then returns to the question of whether the sensation could in fact be *named*. In discussing this he uses the rhetorical device of subjecting himself to

¹⁸⁵ Fogelin *op.cit.* p.166.

¹⁸⁶ Honderich, *The Oxford Companion to Philosophy*, p.719.

¹⁸⁷ Candlish *op.cit.* p1.

¹⁸⁸ PI-1 § 243.

¹⁸⁹ *op.cit.*

¹⁹⁰ Candlish [*op.cit.*, p.1] summarises the thesis of the 'PLA' as:

"... a language in principle unintelligible to anyone but its originating user is impossible. The reason for this is that such a so-called language would, necessarily, be unintelligible to its supposed originator too, for he would be unable to establish meanings for its putative signs."

¹⁹¹ Kenny argues (*Wittgenstein*, p.180) that Wittgenstein considered that the notion of a private language rested on two fundamental mistakes: firstly, that experiences are private and secondly that - in learning language - words can acquire meaning by *bare* ostensive definition.

¹⁹² PI -1 § 258.

¹⁹³ PI -1 § 257.

interrogation. He asks '*How might this be done?*' (remembering, of course, that a definition of the sign cannot be formulated in language.)¹⁹⁴ He replies:

"... *I speak, or write the sign down, and at the same time I concentrate my attention on the sensation - and so, as it were, point to it inwardly.*"¹⁹⁵

But what, he asks, is the point of this procedure? Surely, he replies, it is to define the sign because it allows me to "... *impress on myself the connexion between the sign and the sensation.*"¹⁹⁶ But what, he asks, is the point of this impressing on myself? It is, he replies, so that I remember it *right* in the future. Then follows the crucial step:

"*But in the present case I have no criterion of correctness.*"¹⁹⁷

This has often been understood as implying a scepticism about memory: that is, that in using 'S' a second time I am not sure whether I am using it in exactly the same way that I used it the first time. Because such memory scepticism is also a problem in public languages, this suggests that the 'PLA' is trivial. Most commentators¹⁹⁸ stress the importance of not interpreting the argument in this fashion. To explain this more clearly, it is first necessary to retrace our steps somewhat and see what Wittgenstein means by the terms '*language*' and '*rule*': Wittgenstein argues that that which distinguishes language from mere noise or squiggles on paper is that language uses names in accordance with an implicit or explicit *rule* by means of which we can tell whether names which *seem* to be the same *are* in fact the same.¹⁹⁹

To return to the problem of naming a sensation 'S': in wondering whether, in using 'S' a second time, I am not sure whether I am using it in exactly the same way that I used it the first time, *three* problems - and not just one - are actually involved

Could the original correlation between 'S' and the sensation have been established?

Can, at a later time, this correlation be accessed *theoretically*? - i.e. being unconcerned with possible errors that may manifest whilst accessing the correlation.

Can, at a later time, this correlation be accessed *practically*? - i.e. is the method of retrieval so error prone as to be of little use?

Of these three questions, only the third concerns the unreliability of memory.

Fogelin is particularly insightful on one aspect of the first of these questions. He notes²⁰⁰ that if we glibly assume that we can use the letter 'S' as the *name* of a private *sensation* we forget that the concepts of 'name' and 'sensation' must be established.²⁰¹

"*We enter*", he says, "*the world of a private language semantically naked ... We cannot simply borrow logical features from the public language, ...*"²⁰²

¹⁹⁴ As Kenny points out [Kenny (1973), p.191] it is crucial that no use is made of any public language - the sign must be defined for the subject alone.

¹⁹⁵ PI -1 § 258.

¹⁹⁶ *ibid.*

¹⁹⁷ *ibid.*

¹⁹⁸ For example, Hans-Johann Glock (*A Wittgenstein Dictionary* at p.311) argues that the 'PLA' is certainly about checkability but not about memory. See also Kenny (1973) p.191; Candlish *op.cit.* p.4.

¹⁹⁹ Passmore *op.cit.* p.431.

²⁰⁰ *op.cit.* p.174.

²⁰¹ Sluga (*op.cit.* p.352 note 13) quotes Wittgenstein as saying in conversation:

"Now a scrupulously honest Descartes will not say: 'There goes my horse. A bird singing up in the tree, etc. There's a woman holding an umbrella.' ... So Descartes can present nothing. One can say that he might say 'Ah!' or 'This!' or 'Awareness!' But if he now said anything of this sort, his words would have no meaning. There would be nothing to provide a contrast. 'I think!' would be like: 'Ah!'"

note also PI -1 § 261:

"What reason have we for calling 'S' the sign of a sensation? For 'sensation' is a word of our common language, not of one intelligible to me alone."

Fogelin concludes that this does not establish the impossibility of a private language, it only indicates the difficulty involved in its construction. Kenny, however, seems to see the first problem as of crucial significance:

*"Wittgenstein is not arguing 'When next I call something 'S' how will I know it really is S?' He is arguing 'When next I call something 'S' how will I know what I mean by 'S'?' Even to think falsely that something is S I must know the meaning of 'S'; and this is what Wittgenstein argues is impossible in the private language."*²⁰³

Though this passage might appear to concern only the first problem, this appearance is mistaken. It does in fact involve the second problem, because in discussing the '*meaning*' of 'S' the term '*meaning*' necessarily imports ideas of consistency and checkability. In turn, this presumes possible recurrences of 'S'. Next, though the first use of 'S' is as a definition, subsequent uses of 'S' are propositions. It is a characteristic of a proposition that it is either 'true' or 'false'. The truth or falsity of a proposition containing 'S' cannot be established unless 'S' has a meaning. So it is clear that the problem of the meaning of a term is intimately connected with its possible recurrence. Let us attempt to make this discussion more concrete:

- * A sensation arises. I concentrate on it and decide to call it 'S'.
- * Later, a further sensation arises. A memory - M_1 - of a previous sensation arises as does the memory - M_2 - that I had called this sensation 'S'. In relation to the original sensation the memory M_2 contains no more information than M_1 .²⁰⁴ Thus, all the memory of the original sensation is contained in M_2 .
- * Next, I wonder could this new (?) sensation be the same as the sensation which I originally called 'S'. This 'wondering' necessarily brought to mind [is?] the original memory M_2 .
- * How can I now check whether the sensations are the same or different?²⁰⁵
- * The *only* tool that I have to check whether they are the same, or not, is the memory M_2 . There is no independent, or even additional, criterion available.

Wittgenstein, in a memorable simile, says that to attempt to appeal to M_2 for confirmation for that which appeared to be the case (which was itself suggested by M_2) was:

*"As if someone were to buy several copies of the morning paper to assure himself that what it said was true."*²⁰⁶

The conclusion of this argument is that, because there is no public or independent criterion to determine the truth or falsity of a proposition concerning 'S', therefore 'S' has no meaning.

Fogelin, however, distinguishes two forms of the '*PLA*': the first he calls the '*public check argument*' and the second, the '*training argument*'.

The '*training argument*' is to the effect that as '*a brute fact of human nature*' humans can *in fact* not teach themselves a language - i.e. that "... *there are no linguistic self-starters.*"²⁰⁷ The conclusion he draws is that Wittgenstein's reflections show the *contingent* impossibility of a private language.

²⁰² Fogelin *op.cit.* p.174-5.

²⁰³ Kenny (1973) p.192.

²⁰⁴ M_1 may contain other information such as, for example, that when I had the original sensation the sun was shining.

²⁰⁵ Glock [*op.cit.* p.312] argues that:

"What is at issue is not the truth of my utterance 'There's S again', but its meaningfulness."

²⁰⁶ PI -1 § 265. Other similes used by Wittgenstein are: using a rule to measure itself [Glock *op.cit.* p.313] or using my right hand to make a gift to my left hand [PI -1 § 268].

²⁰⁷ Fogelin *op.cit.* p.178.

The '*public check argument*' is to the effect that it is necessary to have a method of distinguishing between '*following a rule*' and '*thinking one is following a rule*'. This is essentially the form of the argument that was given earlier; Fogelin believes this form of the argument to be unconvincing. He argues that the distinction between '*following a rule*' and '*thinking one is following a rule*' is not valid because, in the last analysis, '*following a rule*' reduces to '*thinking one is following a rule*'. The phrase '*in the last analysis*' means that the test for '*following a rule*' is always the existence of a consensus in some group who '*believe that they are following a rule*'; to the group '*following a rule*' and '*believing that they are following a rule*' are indistinguishable. For example, the rule '*2+2=4*' is a rule of mathematics because there is a consensus amongst mathematicians that it is so. Fogelin argues that if '*thinking one is following a rule*' is indistinguishable from '*following a rule*' in the case of a group then why not so in the case of an individual.²⁰⁸ Fogelin's argument is not well founded; a counter-argument can readily be constructed from an analysis of the use of a term such as '*irrational*'.²⁰⁹

Accepting Wittgenstein's argument that a private language is incoherent what conclusions can be drawn about an individual who was solitary from birth and who was thus unable to acquire a language socially? Could such an individual develop a language of his own? What could one say of the intellectual life of such an individual? This problem is known as the '*Robinson Crusoe*' problem.

The '*Robinson Crusoe*' Problem

Candlish accepts the validity of the '*PLA*' but does not accept that it implies that Crusoe is unable to construct a private language.²¹⁰

*"Such a Crusoe, unlike a private linguist, lives in a world independent of his impressions of it and thus there could be definite occurrences in it which he could remember or forget; and some of those occurrences could be correlations of signs with objects."*²¹¹

This seems to fundamentally misconstrue the '*PLA*': the '*PLA*' concerned the impossibility of naming *sensations*. Wittgenstein explicitly discusses²¹² the possibility of linking the sensation to the symbol '*S*', and in turn to some public '*manifestation*' of the sensation,²¹³ so that some correlation might be established as in the following diagram:

[*sensation*] ↔ '*S*' ↔ [*blood pressure reading*]

²⁰⁸ From the proposition:

"We cannot ask whether everyone involved in a practice might always be mistaken in what he does, for such an assumption would destroy the practice itself." [*ibid.* p.182]

he concludes:

"... it seems to make no logical difference that there is only a single person involved in the practice." [*ibid.* p.183].

²⁰⁹ A sketch of such an argument might be as follows:

One can say, of an individual X, that they are '*irrational*' because a consensus exists amongst others as to what is '*rational*'. In other words, there is some outside standard against which X's views are judged to be '*irrational*'. But could this term be used against mankind itself? Surely the answer is no: no standpoint extraneous to mankind exists against which its views can be judged to be '*irrational*'.

In conclusion: though the distinction between '*rational*' and '*irrational*' loses its validity when applied to society as a whole this does not imply that it does so when used in more restricted situations.

²¹⁰ Candlish's reading of the '*PLA*' argument is somewhat bizarre as he interprets the argument (excluding the '*blood pressure*' section) as being *"... conducted in terms of souls unrelated to bodies or related only to inert bodies."* (p.8); such assumptions are quite foreign to the argument.

²¹¹ Candlish *op.cit.* p.9/10.

²¹² PI - I § 270.

²¹³ He chooses a manometer which is a meter for measuring blood pressure.

Wittgenstein argues that in this correlation, the sensation itself becomes utterly irrelevant²¹⁴ - it is like the beetle in the closed box²¹⁵ - and what is left is simply:

‘S’ ↔ [blood pressure reading]

In Kenny’s words:

“... ‘S’ is not the name of a private object but a word in a public language.”²¹⁶

Thus, the ‘PLA’ does not imply the impossibility of an isolated being naming ‘public’ phenomenon - i.e. movements of meter needles or of any object - but of naming private phenomena. Candlish assumes²¹⁷ that the possibility of a Crusoe *naming* public (i.e. external) phenomena implies that he could construct a private *language*. Let us assume that Crusoe could name certain objects. Does this imply the ability to create a private language? First consider a simpler question. Does the ability to name external objects imply the ability to lay down, and follow, a rule?

Is Crusoe able to follow a rule?

There is no problem in assuming that our Crusoe can distinguish between a bird and an animal;²¹⁸ both are food and he may indeed have a preference for one rather than the other. Suppose that, by drawing on the sand with a stick, he constructs a table (as in Table 10-2) so that he can keep a record of his hunting successes:



<u>animal</u>	<u>symbol</u>
	S
	R

Table 10-2: Crusoe’s hunting ‘dictionary.’

Next day he catches a bird and wishes to write down the symbol for it in his hunting record. He thinks that the appropriate symbol is an ‘S’. Can he confirm this? Surely he can go to his table in the sand and compare the animal to the pictures that he has drawn? Thus, he can independently verify that his use of ‘S’ is correct. But is this not an example of a solitary individual following a rule, and does this not invalidate the ‘PLA’?

Norman Malcolm seems to believe that such rule-following by an isolated individual cannot occur:

*“If you conceive of an individual who has been in solitude his whole life long, then you have cut away the background of instruction, corrections, acceptance - in short, the circumstances in which a rule is given, enforced, and followed.”*²¹⁹

Saul Kripke’s seems the better view:

“Does this mean that Robinson Crusoe, isolated on an island, cannot be said to follow any rules, no matter what he does? I do not see that this follows. ... The falsity of the private model need not mean that a physically isolated individual cannot be said to follow rules;

²¹⁴ See Kenny (1973), p.194-5.

²¹⁵ PI -1 § 293.

²¹⁶ Kenny (1973), p.195.

²¹⁷ see quotation *supra*.

²¹⁸ I do not mean to suggest that he possesses either of the *concepts* ‘animal’ or ‘bird’.

rather than an individual, considered in isolation (whether or not he is physically isolated), cannot be said to do so."²²⁰

Concluding then that our Crusoe can be said to follow certain rules, can he be said to have a language?

Can Crusoe have a private language?

We have concluded that Crusoe can name external objects and that he can independently verify his use of these names; is this sufficient to be considered a language?

Wittgenstein thinks not:

*"Naming is so far not a move in the language game - any more than putting a piece in its place on the board is a move in chess. We may say: nothing has so far been done, when a thing has been named. It has not even got a name except in a language-game."*²²¹

Wittgenstein considers an example:

*"William James, in order to shew that thought is possible without speech, quotes the recollection of a deaf mute, Mr. Ballard, who wrote that in his early youth, even before he could speak, he had thoughts about God and the world. - What can he have meant? ... Are you sure - one would like to ask - that this is the correct translation of your wordless thoughts into words? ... Do I want to say that the writer's memory deceives him? I don't know if I should say that. These recollections are a queer memory phenomenon, ..."*²²²

Wittgenstein's scepticism relates not to the possibility of Mr. Ballard naming, for example, 'the world' but to his having 'thoughts' about God and the world.²²³ This raises the possibility of an ambiguity in the use of the term 'to think'. Certainly, to recognise and manipulate symbols could be said to be thinking but it would be a peculiarly impoverished form of thought. A monkey, for example, might be trained to press a button with the symbol for a banana, and thereby get a banana. This might be done with other fruit so that one might even imagine a table linking fruit symbols and the appropriate buttons but could this be called the beginnings of language? Does it manifest thought? To use names - even to invent names - is not what is usually meant by thought. Thought as spoken of by Locke and Descartes, for example, relates to *conceptual* thought. Wittgenstein's point (in the quotations above) is that conceptual thought - unlike naming - requires language and this language - as distinct from naming - cannot be generated by an isolated individual.

Rush Rhees in his essay '*Can there be a private language?*'²²⁴ provides an insightful discussion on these points. Rhees argues there is a common substratum between humans which is the very precondition for language. Language is the expression of this common humanity which only becomes manifest through social interaction:

²¹⁹ An unpublished paper quoted in *The Internet Encyclopaedia of Philosophy*, 'Wittgenstein' p 6.

²²⁰ Saul Kripke, *Wittgenstein: On Rules and Private Language*, p.110. [emphasis in the original].

²²¹ PI -1 § 49. [emphasis in the original].

McGinn [*op.cit.* p.131] believes that it is the lack of a lack of a grammar for 'S', rather than the lack of an independent check, that is of importance in asserting that a private language cannot exist.

²²² PI -1 § 342. [emphasis in the original]

²²³ See Brendan Wilson, *Wittgenstein's Philosophical Investigations*:

"In fact Malcolm goes further than Kripke, holding that Wittgenstein's claim is that the actual presence of a multiplicity of persons is necessary if a person is to have thoughts. ..."
[*op.cit.* p.19; emphasis added]

²²⁴ Included in Rush Rhees, *Discussions of Wittgenstein*, p.55-70.

*"The agreement ... is something without which it would not be possible for people to 'see' that their reactions tallied or that anything else tallied. We see that we understand one another, without noticing whether our reactions tally or not. Because we agree in our reactions, it is possible for me to tell you something, and it is possible for you to teach me something."*²²⁵

Rhees distinguishes the language that arises from our shared human commonality from the use of - or invention of - marks to denote objects. This latter he compares to a dog running to get my slippers when I call out 'slippers'.²²⁶

*"A bull may charge at a red flag, and rats may be trained to react in one way to red lights ... but neither the bull nor the rat knows what red is, and neither knows that this is red. We might put this by saying that neither of them has the concept 'red' and neither of them has the concept 'colour'. ... If I have the concept, I know how the word 'red' is used. There must be a use, though; there must be what I have been calling common reactions."*²²⁷

Thus, any 'concept' - unlike a name - is irremediably embedded in the social use of language. Its 'meaning' is its 'use' or its 'grammar' and this can only become manifest through social interaction. Language is no more related to the noises or marks made by an isolated individual than is conversation, to an echo.

Rhees had been involved in a famous debate with A. J. Ayer on the '*Private Language Argument*'. Ayer had asked as to why, if Crusoe could keep a diary when Friday was present, could he not have kept one when he was alone? Furthermore, why could he not just have invented names for his sensations? Rhees responded:

*"Ayer asks why Crusoe should not invent names for his sensations. ... It is possible, certainly, to invent new expressions, ... But it is a different question whether anyone could have invented language. ... The point is that no one could invent just language. Language goes with a way of living. An invented language would be a wallpaper pattern; nothing more. ... A man might invent marks to go with various objects. That is not language. And when Ayer's Crusoe invents names to describe flora and fauna he is taking over more than he had invented. ... Defoe's Crusoe could have kept a diary, but Ayer's could not. . [Defoe's Crusoe] knows what he is talking about. Ayer's Crusoe does not and cannot. Ayer's Crusoe may use marks for particular purposes - to show where he has hidden something, perhaps - and with as great regularity as we care to think. ... But so long as [Crusoe] never has learned a language, in the sense of taking part in a language, it is as meaningless to say of him that he follows words as it would be to say this of an electronic computer."*²²⁸

Conclusions: Wittgenstein

The imaginary Robinson Crusoe, being an intelligent creature, could doubtlessly name objects and manipulate symbols but, because he lacked that background in language which enables the generation of concepts, he would not possess the ability to think conceptually. In particular, though

²²⁵ *ibid.* p.56. [emphasis in the original].

²²⁶ *ibid.* p.63.

²²⁷ *ibid.* p.57. [emphasis in the original].

²²⁸ *ibid.* p.62-7. [emphasis in the original].

he might *experience* his own self, he would not have the *concept* of self or of self-awareness.

Could such a being be considered to be a '*person*'?

Descartes, in distinguishing between man and the animals, considered man to be a 'thinking thing' - this, clearly, in the sense of being able to think conceptually. Locke, similarly, considered the ability to think conceptually as a precondition for being a person. Indeed, it is difficult to conceive of a criterion for personhood which might be less onerous than the ability to think conceptually. However, if such an ability is considered to be a necessary condition for personhood then the '*PLA*' implies that previous social interaction - to the extent necessary to learn language - is also a necessary condition for personhood.²²⁹ This, in turn, implies that the ability to communicate is a necessary condition for personhood.

Conclusion ^{10 - 15} : Wittgenstein's '*Private Language Argument*' implies that an individual's ability to think conceptually has as a precondition that that individual had, at some earlier stage, an ability to communicate which he did in fact exercise.

Strawson

P. F. Strawson begins his analysis of the concept '*person*'²³⁰ by reviewing Wittgenstein's treatment of the term '*I*'. Wittgenstein had argued that the use of the term '*I*' in the proposition:

*P*₁: "*I have a toothache.*"

is radically different from its use in:

*P*₂: "*I have a bad tooth.*"²³¹

Grammatically speaking, both propositions have a subject; Wittgenstein, however, had argued that, though in the second case this grammatical structure mirrors the underlying structure of what was in fact being asserted, in the first case the underlying structure is misrepresented by the grammatical structure. Wittgenstein argued, that if the grammatical structure of the proposition '*I have a toothache*' was taken to imply that there was an '*owner*' of the toothache, considerable philosophical confusion would result.²³² An informal distinction can be drawn between the use of the term '*I*' in both propositions. In *P*₂ the term '*I*' refers to the '*outer I*' or body of the individual, its use in *P*₂ is no different from its use in, for example, the proposition "*I have a matchbox.*" In *P*₁, in contrast, the term '*I*' is taken to refer to the '*inner I*' or '*soul*' or '*subject of experience*'; Wittgenstein disputes the existence of such an '*inner I*':

*"The thinking, presenting subject - there is no such thing. ... In an important sense there is no subject."*²³³

This problem can be considered as a special case of a problem which has been central to modern philosophy, namely, how to relate '*states of consciousness*' to material objects.²³⁴ Strawson

²²⁹ Note how this conclusion - derived from purely philosophical considerations - is reinforced by the conclusions from the earlier discussion on feral children.

²³⁰ In an essay entitled '*Persons*' and in his book *Individuals*. P. F. Strawson's '*Persons*' is included in V. C. Chappell *The Philosophy of Mind*. Strawson's book *Individuals* is, in part, (particularly the chapter entitled '*Persons*') a revised and expanded version of the original essay '*Persons*'. I have used both sources.

²³¹ Chappell *op.cit.* p 130.

See also Strawson, *Individuals*, p. 90, footnote 2.

²³² This is an example of Wittgenstein's general thesis that many philosophical problems arise because of a use of inappropriate language; the task of philosophy was, as he saw it, to disentangle the language thus 'dissolving' the problem.

²³³ Wittgenstein as quoted in Chappell *op.cit.* p. 127. [emphasis in the original]
see also Wittgenstein *Tractatus* § 5.6.31:

considers that Wittgenstein exemplifies (what Strawson terms) *'the no-ownership theory'* which is that states of consciousness do not, strictly speaking, *belong* to the person who has them. Strawson contrasts Wittgenstein's position with Descartes'; Descartes (in Strawson's words) held that:

*"When we speak of a person, we are really referring to one or both of two distinct substances (two substances of different types), each of which has its own appropriate type of states and properties; and none of the properties or states of either can be a property or state of the other. States of consciousness belong to one of these substances and not to the other."*²³⁵

Thus, if a Cartesian perspective is adopted, the proposition "*I have a toothache*" implies that there is a subject of experience - the thinking or soul substance '*I_{soul}*' - who 'owns' or has the experience of pain - and there is also a body substance '*I_{body}*', who 'owns' the tooth and to whom the physical characteristics of having a toothache are ascribed.

Strawson argues that the *'no-ownership theory'* is incoherent. His argument is beautifully simple; it is that to attribute experiences to the '*I_{body}*', I must only attribute *my* experiences, not everybody's. But in order to attribute just *my* experiences I am forced to concede an ownership of experiences i.e. an '*I_{soul}*'.²³⁶ Descartes' theory is - to Strawson - equally problematic because it cannot adequately explain the link between '*I_{soul}*' and '*I_{body}*' - why *this* particular experience should be connected to *this* particular body - nor can it explain why states of consciousness should be ascribed to anything at all.²³⁷ Furthermore, because Cartesian experiences belong to a private ego a further difficulty is occasioned. Passmore describes it thus:

*"If states of consciousness are wholly private there is no possible way in which we could ascribe them to anybody but ourselves ... It would, indeed, be impossible to ascribe them even to ourselves, since 'there is no sense in the idea of ascribing states of consciousness to oneself unless the ascriber already knows how to ascribe at least some states of consciousness to others'."*²³⁸

Strawson is led to conclude that:

*"... both the Cartesian and the no-ownership theorists are profoundly wrong in holding, as each must, that there are two uses of 'I', in one of which it denotes something which it does not in the other."*²³⁹

and that:

*"So the facts in question do not explain the use that we make of the word 'I', or how any word has the use that word has. They do not explain the concept we have of a person."*²⁴⁰

Strawson's solution

Strawson sees the problems in both Wittgenstein's and Descartes' accounts of the relationship between the 'mental' and the 'physical' as flowing inexorably from the metaphysic underlying their

²³⁴ "There is no such thing as the subject that thinks or entertains ideas."

²³⁵ Passmore *op.cit.* p. 507.

²³⁶ Chappell *op.cit.* p. 130.

²³⁷ Strawson summarises his argument: [Chappell *op.cit.* p. 131, emphasis in the original]

"It is not coherent, in that one who holds it is forced to make use of that sense of possession of which he denies the existence, in presenting his case for the denial. When he tries to state the contingent fact, which he thinks give rise to the illusion of the 'ego', he has to state it in some such form as 'All my experiences ...'."

²³⁸ Strawson, *Individuals*, p. 98.

²³⁹ Passmore *op.cit.* p.507.

²⁴⁰ Strawson, *Individuals*, p. 93.

philosophies. This metaphysics is explicitly set forth by Descartes in his theory of two substances and implicitly in Wittgenstein with a paradoxical:

*"... dualism of one subject - the body - and one non-subject."*²⁴¹

This dualistic metaphysics inexorably leads to the problem of how the mental and the physical substances are related and why they find expression as a unity in an individual subject or 'person'.²⁴² This problem can only arise if both the categories - i.e. mental and physical - are conceived of as being *logically* primitive in the sense that no more primitive term exists by means of which the relationship between mental and physical can be explained.

Strawson cuts this Gordian knot by taking as the '*basic particulars*'²⁴³ - not material and spiritual 'substances' - but '*material objects*' and '*persons*'.²⁴⁴ A 'person', he argues, must be taken, not as a compound of body and mind but, as a single particular. To Strawson, the concept of person is logically primitive, by which he means that mental terms, such as consciousness, must be explained in terms of it, and not conversely.²⁴⁵

*"So the concept of the pure individual consciousness - the pure ego - is a concept that cannot exist; or, at least, cannot exist as a primary concept in terms of which the concept of a person can be explained or analysed. It can only exist, if at all, as a secondary nonprimitive concept, which itself is to be explained, analysed, in terms of the concept of a person."*²⁴⁶

Strawson conceives of '*basic particulars*' as entities which:

*"... could be identified and reidentified without reference to particulars of other types or categories than their own,"*²⁴⁷

Other, second order, particulars are identified in terms of these basic particulars. As just mentioned, Strawson argues that there are two types of 'basic particulars' - 'material objects' and 'persons'. 'Material objects' are categorised by the fact that we only ascribe material object predicates - '*M-predicates*' - to them; 'M-predicates' are predicates of the form '*... weighs x kilo*' or '*... is 5 meters long*'. Person predicates - '*P-predicates*' - are predicates of the form '*... is in pain*' or '*... is going for a holiday*'. Persons are categorised by the fact that we ascribe *both* M-predicates and P-predicates to them. Not all P-predicates ascribe states of consciousness e.g. '*... going for a walk*',²⁴⁸ however:

²⁴⁰ *ibid.* p. 88.

²⁴¹ *ibid.* p. 93; see also:

"... Cartesian error is just a special case of a more general error, present in a different form in theories of the no-ownership type, of thinking of the designations, or apparent designations, of persons as not denoting precisely the same thing, or entity, for all kinds of predicate ascribed to the entity designated."

[Chappell *op.cit.* p. 138; emphasis in the original]

²⁴² Chappell *op.cit.* p.136:

"We are tempted to think of a person as a sort of compound of two kinds of subject - a subject of experiences (a pure consciousness, an ego), on the one hand, and a subject of corporeal attributes on the other."

²⁴³ Passmore [*op.cit.* p.506] points out that Strawson uses the term '*basic particular*' as a means by which other particulars are identified and not an element out of which they are constructed.

²⁴⁴ The problem can be compared to analysing a novel in term of its form and content. If the form and content were considered to be logically primitive then one would have the problem of explaining how both of these were related in such a fashion as to produce the unity that is a novel. If, however, the novel itself is regarded as the logically primitive concept then the form and content are derived concepts which help explain aspects of this *given* unity.

²⁴⁵ Chappell *op.cit.* p. 136:

"The concept of a person is logically prior to that of an individual consciousness. The concept of a person is not to be analysed as that of an animated body or of an embodied anima."

²⁴⁶ Chappell *op.cit.* p. 136.

²⁴⁷ Strawson, *Individuals* p. 81.

²⁴⁸ *ibid.* p 101.

*"[P-predicates] may be said to have this in common, that they imply the possession of consciousness on the part of that to which they are ascribed."*²⁴⁹

Strawson argues that P-predicates arise from a process of mutual observation between individuals and not *solely* from some introspective process. The meaning of P-predicates rests on the linking of both a personal introspective element and an observation of the behaviour of others:²⁵⁰

*"To learn their use is to learn both aspects of their use. In order to have this type of concept, one must be both a self-ascriber and an other-ascriber of such predicates, and must see every other as a self-ascriber."*²⁵¹

As an example, Strawson considers the concept of depression; this discussion is summarised succinctly by Passmore:

*"Exactly the same concept - e.g. the concept of being depressed - covers the depression which X feels but does not observe and the depression which persons other than X observe but do not feel. To deny this, Strawson argues, is 'to refuse to accept the structure of the language in which we talk about depression'."*²⁵²

Let us next turn to the implications that may be drawn from Strawson's analysis both as regards (T) and the more concrete problem of judgements of PVS patient consciousness.

Strawson: some implications

Proposition (T)

According to Strawson, the ascription of personhood is possible only:

*"... because I am a person amongst others; ..."*²⁵³

Thus, social interaction is a precondition for the very emergence of the concept of 'person'. Strawson's concept of 'person' is best understood as arising from the interaction of two individuals when each 'sees himself' in the other. It is a concept grounded in, and arising from, empathy. The mutual ascription of 'personhood' is nothing other than the recognition of a deep commonality between individuals. An immediate implication of this is that personhood is not a concept ascribable by an isolated individual to himself. Descartes' isolated subject²⁵⁴ can no more say of himself that he is a 'person' than he can say that he is gregarious. The existence of a social community is a necessary condition for the ascription of personhood. Given, however, such a social community, can the term personhood be ascribed to an individual isolated from that community?

Imagine a Robinson Crusoe figure isolated on an island but observed by others on a neighbouring, but distant, island. They observe Crusoe through a telescope but he, being without

²⁴⁹ *ibid.*

²⁵⁰ Strawson's position in relation to judging whether another is, for example, in pain, is not dissimilar to Wittgenstein's; however, Strawson's position can be distinguished from behaviourism much more clearly than can Wittgenstein's. Strawson - in common with Wittgenstein - grounds his discussion of concept formation in the learning of language.

²⁵¹ Strawson, *Individuals*, p. 105. [emphasis in the original]

²⁵² Passmore *op.cit.* p.508.

Wilson [*op.cit.* p.101] discusses the same example from the perspective of Wittgenstein's philosophy:

"...Wittgenstein's point is simple: when someone says 'I feel depressed', this is best understood, not as a report, description or effect (and therefore causal indicator) of an inner state, but as part of what it means to talk about a depressed state of mind." [emphasis in the original]

²⁵³ Strawson, *Individuals*, p. 103.

²⁵⁴ In the 'cogito' argument.

such an instrument, is not in a position to even know of the existence of his neighbours.²⁵⁵ These neighbours form a social community and can ascribe the term 'person' as between themselves. One such person - Daniel - observes Crusoe. Can Daniel describe Crusoe as possessing consciousness? Can he ascribe 'personhood' to Crusoe?

Let us assume that Daniel has no means of communication with Crusoe but can observe his daily activity. Let us further assume that the image that Daniel sees is so unclear that he cannot discern Crusoe's features or be sure whether he is man or beast. He can, however, distinguish his actions. The question of the personhood of Crusoe reduces - in Strawson's view - to whether Daniel would use P-predicates or M-predicates to describe Crusoe; the answer to this question necessarily resolves the question of Crusoe's consciousness.²⁵⁶

Daniel, let us imagine, is quite impressed with Crusoe's skill in hunting and fishing, so much so that he describes Crusoe's activities as intentional or purposive. Within Strawson's scheme M-predicates would be inappropriate, hence Daniel would conclude that Crusoe was a person. This might suggest that personhood could be ascribed in the absence of ability to communicate, thus negating (T).

This conclusion, however, is premature. Intentional activity is not the sole prerogative of persons, it is found amongst animals.²⁵⁷ Daniel Dennett considers the example of the hunter stalking a tiger, and considering what he would do if he were the tiger.²⁵⁸ Unfortunately, Strawson in considering only P- and M-predicates, has restricted himself to an oversimplified schema.²⁵⁹ A hierarchy of predicate types is required including possibly A-predicates (animal type predicates) and P_L-predicates (plant type predicates)²⁶⁰ We must conclude that Strawson's analysis, in terms of P- and M-predicates, is not of a sufficient subtlety to permit 'intentionality' to be precisely located in his schema and, accordingly, does not permit the personhood of Crusoe to be determined. Dennett, however, offers a way forward from this impasse.

²⁵⁵ This is assumed to preclude the conclusions that might be drawn had Crusoe been aware of the existence of neighbours and not attempted to communicate with them.

²⁵⁶ Strawson, *Individuals*, p. 99:

"The concept of a person is logically prior to that of an individual consciousness."

Not all P-predicates imply consciousness [e.g. 'going for a walk'] but a description of an individual *solely* in terms of M-predicates preclude consciousness.

²⁵⁷ Dennett notes [*Brainstorms*, p.241] that some philosophers make "...'*communicating with*' a hallmark of intentionality." Such philosophers would accordingly apply M-predicates to Crusoe and refuse to ascribe personhood to him in the absence of the ability to communicate, thus conceding (T).

²⁵⁸ Dennett *op.cit.* p.240.

²⁵⁹ Dennett states [*op.cit.* p.270, footnote]:

"It has often been pointed out that Strawson's definition is obviously much too broad, capturing all sentient, active creatures."

²⁶⁰ Unless, like Descartes, he considers animals as mere machines, in that case A-predicates and P_L-predicates would reduce to M-predicates and he would perhaps use M-predicates to describe Crusoe and again concede (T).

Dennett - having outlined his theory of stances and distinguished three types of stance: a '*design stance*', a '*physical stance*' and an '*intentional stance*' - asks whether a fourth type of stance, a '*personal stance*' i.e. a stance adopted towards another which regards them as being a 'person', is required. Dennett argues that the '*personal stance*' is not an independent stance but can be defined as a subtype of intentional stance. Two questions are of interest:

- (i) What is a '*personal stance*'?
- (ii) What are the criteria for adopting the '*personal stance*'?

The '*Personal stance*'

Dennett compares²⁶² his theory of stances to a distinction suggested by MacKay between those systems which have a '*personal aspect*' and those with a '*mechanical aspect*', and to one suggested by Strawson who contrasts '*participation in a human relationship*' with having an '*objective attitude*' towards another.²⁶³ Dennett argues that both MacKay and Strawson draw conclusions of an ethical nature from an adoption of a '*personal stance*' which, to Dennett, are premature; he suggests that they are '*conflating two choices into one*' by equating the choice of intentional stance with the choice of moral stance. Dennett argues that further confusion is caused if one makes:

*"... communicating with a system the hallmark of intentionality or rationality ... Communication, then is not a separable and higher stance one may choose to adopt towards something, but a type of interaction one may attempt within the intentional stance. ... It is all too easy, however, to see interpersonal, convention-dependent communication as the mark of the intentional ..."*²⁶⁴

Dennett seeks to resolve these problems by re-examining the meaning of the term '*personal stance*'; he argues that such a stance is not an independent category but is a subcategory of the intentional stance and that it is categorised by the existence of an ability to communicate.²⁶⁵ He argues, furthermore, that an 'ability to communicate' is the criterion for being admitted into the

²⁶¹ Dennett's theory of stances is discussed Dennett, *Brainstorms*, especially pp. 237- 42; it has already been outlined in Chapter 2, Section 4. To recap: Dennett argues that three types of attitudes or '*stances*' are available in confronting a system:

- (i) a '*design stance*' - such as is adopted in relation to a computer which one has designed. One's predictions will come true provided only that the computer behaves as designed.
- (ii) a '*physical stance*' - such as is adopted when we base our predictions on the physical state of the system and the laws of nature as, for example, in the movement of a pendulum.
- (iii) an '*intentional stance*' - such as is adopted when we base our predictions on imputing intentions to a system. This is equivalent to imputing rationality to the system.

Dennett argues the intentional stance is the one most appropriate to humans in all but the most exceptional circumstances, such as, for example, when in relation to the insane the '*design stance*' is occasionally adopted. Dennett argues that we hardly ever know enough about the physiology of individuals to adopt the physical stance effectively, '*except for a few dramatic areas, like surgical cure*'. (*op.cit.* p.239) The possible application of the '*physical stance*' to PVS patients will be considered below.

Dennett's analysis of 'intention' is lucid and powerful; it suggests that if one can fully predict what, for example, a lion does then one has 'got inside the skin' of the animal and no further questions can be asked; similarly, if one can *fully* predict the behaviour of a Hitler - or a serial killer or a child molester - then one knows what it is like to be them. This helps show the artificiality of Nagel's famous question '*What is it like to be a bat?*' and the false contrast that has been set up by this question with its implication that we already fully know what it is like to be another person and our ignorance relates only to non-humans: is our ignorance of the cannibal any less than of the bat?

²⁶² Dennett *op.cit.* p.239.

²⁶³ Strawson had argued:

"If your attitude towards someone is wholly objective, then though you may fight with him, you cannot quarrel with him, and though you may talk to him, even negotiate with him you cannot reason with him. You can at most pretend to quarrel, or to reason, with him."

[Dennett *op.cit.* p.239]

²⁶⁴ Dennett *op.cit.* p.241-2.

moral community - i.e. for being an 'Object of Intrinsic Moral Worth' in the terminology adopted earlier in this thesis.²⁶⁶ If Dennett's elaboration of intention is incorporated into Strawson's analysis then the following conclusion can be drawn:

Conclusion ^{10 - 16}: *Strawson's arguments (as elaborated by Dennett) are to the effect that imputing intentionality to a system is not, of itself, sufficient to permit 'personhood' to be attributed to the system; an ability to communicate is also necessary.*

Hence, Strawson's theory, as elaborated by Dennett, implies (T). Before examining the criteria for adopting the 'personal stance', let us first revisit the Crusoe example discussed earlier.

Crusoe (and PVS) revisited with the help of Strawson and Dennett

In our earlier thought experiment, we imagined Daniel observing Crusoe from a neighbouring island and we asked whether Daniel could ascribe 'personhood' to Crusoe; we assumed Crusoe's actions to be of such a complexity (e.g. hunting and fishing) that the 'intentional stance' was the obvious stance to adopt. This, as we have just seen is not, of itself, sufficient to justify an attribution of 'personhood' - communication must first be established.

Let us now assume that Crusoe's actions are of an altogether more limited nature so that an intentional stance is not an obvious choice. In such circumstances Crusoe's position - as regards attribution of consciousness and personhood - is not unlike that of a PVS patient. Let us call paradigm actions of a physical system '*reflex_P actions*', and those of an intentional system '*intentional actions*'. This will allow us to revisit the earlier discussion²⁶⁷ of PVS patient consciousness where the distinction between the medical usage of the term 'reflex' - '*reflex_M*' - was distinguished from its use in relation to a physical system - '*reflex_P*'. As noted in Chapter 2, there is a class of human actions which are unambiguously reflex (i.e. both '*reflex_P*' and '*reflex_M*') - the 'tendon jerk' is one such because it is a mechanical system where the full movement of the jerk is (theoretically) predictable. There are, however, many other responses - particularly as seen in PVS patients where eye-tracking movements and the 'pulling away from' painful stimuli are common - which are often described *medically* as reflex actions (i.e. '*reflex_M*'); these actions, however, have a degree of complexity such that, if they are considered simply to be the response of a *physical* system,²⁶⁸ they cannot be (theoretically) predicted. They can, however, be much more readily understood as intentional actions. How should this dilemma be best resolved? Is there good reason to adhere to the prevailing medical system? The differing approaches can be summarised²⁶⁹ in tabular form (see Table 10-3):

²⁶⁵ Dennett's criteria for personhood are considered in the Appendix F where it is shown that, for him, the intentional stance does not, of itself, imply personhood; in order that personhood be attributed, an ability to communicate is first necessary.

²⁶⁶ Dennett unfortunately does not distinguish between 'Objects of Intrinsic Moral Worth' and 'Persons'. One consequence of this is that he cannot accept that - as Strawson had argued - moral commitment can exist in the absence of an intentional stance; the attitude to a non-intentional system - e.g. a gardener to his flowers (Dennett *op.cit.* p.241) - may, Dennett argues, amount to '*solicitude*' but not to moral commitment.

²⁶⁷ In Chapter 2.

²⁶⁸ The inability to predict the behaviour of a system does not necessarily imply that an intentional stance should be adopted - the system may well be chaotic or random.

²⁶⁹ Anticipating somewhat the discussion to follow.

<u>PVS patients</u>	<u>The Medical Model</u>	<u>The Dennett / Strawson Model</u>
Are all actions reflex?	All actions are 'reflex _M '.	Dennett: Some actions are 'reflex _P ' and some actions are 'intentional'; this implies that the intentional stance be adopted. Strawson: P-predicates are appropriate.
Is consciousness present?	The judgement that all actions are 'reflex _M ' implies that consciousness is not present.	Dennett: The adoption of the intentional stance implies that consciousness is present. Strawson: The application of P-predicates implies that consciousness is present.
Is a decision on personhood justified?	Yes (though medical discussion of personhood is seldom explicit).	No - there is a need for further investigation to determine if communication is possible.
Is personhood to be attributed ?	Personhood is not present.	(ditto)
Is further investigation required as to whether communication is possible?	No - the ability to communicate is excluded on a <i>a priori</i> grounds by the presumed lack of consciousness.	Yes.
What conclusion can be drawn from the lack of ability to communicate?	(ditto)	Personhood is not present; Dennett: no moral obligations exist towards the patient.

Table 10-3: Contrasting implications to be drawn from the presence of 'reflex_M' responses.

Dennett's point that the stance to be adopted is not one to be discovered by an examination of the internal workings of the system is crucial at this juncture; let us examine this in more detail.

Some preconditions for adopting the 'personal stance'

According to Dennett:

*"Of central importance in MacKay's account in his remarking that the choice of stance is 'up to us', a matter of decision not discovery."*²⁷⁰

This implies that when faced with 'ambiguous' responses to a stimulus (*i.e.* 'reflex_M' but not 'reflex_P' responses) one must first choose whether to regard the system as an intentional system (*i.e.* a person²⁷¹) or as a mechanical system (*i.e.* an object). Once this choice is made then the conclusion as to whether the system possesses consciousness *necessarily* follows.²⁷² The situation is similar in respect of attributing 'personhood':

²⁷⁰ Dennett *op.cit.* p.239.

²⁷¹ Neglecting, for simplicity, the communications criterion.

²⁷² Dennett considers it important that we do not attempt to ask whether a system *really* has beliefs, desires, or intentions, as such is an inappropriate question. The appropriate question relates to the *choice* of stance, and this is to be answered pragmatically by virtue of the success, or otherwise, of the stance adopted. If the intentional stance is the most successful then this implies that the system *has* beliefs desires and intentions; according to Dennett there is no other meaningful method of assigning the terms '*belief*', '*desire*' or '*intention*'.

Strawson makes a similar point [*Individuals*, p. 109] in relation to judgements of the mental states of another. He argues that if we allow a gap to open between the behaviour of another and their mental state - he takes the example of depression - then we are forced to:

"... oscillate between a philosophical scepticism and philosophical behaviourism ... What we do not realise is that if this logical gap is allowed to open, then it swallows not only his depression, but our depression as well. For if the logical gap exists, then depressed behaviour, however much there is of it, is no more than a sign of depression."

*"... it is not the case that once we have established the objective fact that something is a person, we treat him or her or it in a certain way, but that our treating him or her or it in this certain way is somehow and to some extent constitutive of its being a person."*²⁷³

The great advantage of Dennett's approach is that it brings the ethical nature of decisions on personhood to centre stage; it removes the veil of pseudo-science surrounding such decisions and it highlights the necessity of attempting to establish communication. The medical model, in contrast, attempts to justify the assertion that consciousness (and by implication 'personhood') is lacking by means of an *internal* examination²⁷⁴ of the system which determines whether the responses are 'reflex_M' or 'intentional'. This ensures that the moral content of the decision to treat the patient as 'a person' or as 'an object' - the implicit conclusion following a determination that a PVS patient permanently lacks consciousness - is masked by the erroneous assumption that the question can be resolved by means of a scientific investigation.

A precondition for the attribution of 'personhood'

The nature of judgements which seek to attribute consciousness to PVS patients can be further analysed, first by using aspects of Dennett's analysis and then by considering some remarks by Strawson and Wittgenstein.

First, to Dennett who argues that:

- (i) if, in particular circumstances, the intentional stance is considered to be the appropriate stance to adopt towards a PVS patients, then this does not imply that the patient is to be considered to be a 'person' or that he is entitled to moral consideration, both of which require an ability to communicate. In the absence of an ability to communicate, consciousness could indeed be present but the patient would not be ascribed 'personhood' nor be entitled to moral consideration.²⁷⁵
- (ii) if, however, the physical stance is considered the more appropriate, then Dennett - who is a philosophical behaviourist - would have no hesitation in asserting that the patient had no consciousness.²⁷⁶

Strawson's and Wittgenstein's approach to this second case differs from Dennett's in that they are not philosophical behaviourists. Both would argue that though, generally speaking, experience (such as pain) must have a behavioural aspect, it is not reducible to behaviour. Particular cases may exist where consciousness might persist in a private sense.²⁷⁷ However, both Strawson and Wittgenstein, in discussing the possibility of such 'private' pain and suffering, concur with Dennett in assigning paramount importance to the attitude, or stance, to be adopted towards the individual: the suggestion being that the appropriate attitude will flow from a decision grounded in empathy with the individual rather than from one based on the result of an examination of his 'internal workings'.

²⁷³ Dennett *op.cit.* p.270.

²⁷⁴ Often just an hypothetical examination.

²⁷⁵ Dennett [*op.cit.* p.242, emphasis in the original]:

"The ethical implication to be extracted from the distinction of stance is not that intentional stance is a moral stance but that it is a precondition of any moral stance, ..."

²⁷⁶ Neither, of course, would the patient be ascribed 'personhood' or be entitled to moral consideration.

²⁷⁷ Kenny [Wittgenstein, p.190] comments:

"If a man itches, but does not scratch or report his itch, we may call that a private experience; ...And from the fact that some experiences are, in this sense, private experiences, it does not follow that all experiences could be private experiences. 'What sometimes happens could always happen' is a fallacy. Some money is forged; but it could not be the case that all money was forged."

Strawson, for example, in stating that “*The concept of a person is logically prior to that of an individual consciousness.*”²⁷⁸ suggests that the decision that an individual has consciousness, flows from the decision that he is a person, and not conversely.

Wittgenstein in discussing whether an individual might ‘really’ lack consciousness also sees the resolution of the problem in the possibility of being empathic:

*“Look at a stone and imagine it having sensations. - One says to oneself: How could one so much as get the idea of ascribing a sensation to a thing? One might as well ascribe it to a number! - And now look at a wriggling fly and at once these difficulties vanish and pain seems to be able to get a foothold here, where before everything was, so to speak, too smooth for it.”*²⁷⁹

and also:

*“My attitude towards him is an attitude towards a soul. I am not of the opinion that he has a soul. ... The human body is the best picture of the human soul.”*²⁸⁰

Guy Robinson’s comment on this last quotation is helpful:

*“My attitude is a matter of my whole demeanour toward him involving the rights and duties and customs of my culture. Not something that is simply true or false like an opinion, a matter for argument and proof. Paradigms, attitudes, and ways of looking are not matters of proof and disproof.”*²⁸¹

This reinforces the conclusion stated at the end of Section 2.²⁸²

Strawson on the possible nature of exclusively ‘private’ experience

As has just been mentioned, both Strawson and Wittgenstein conceded the possibility of purely private experience; Strawson, however, speculates on the possible nature of extended or exclusively ‘private’ experience. He does this in the context of imagining a ‘disembodied consciousness’.²⁸³

“One has simply to think of oneself as having thoughts and memories as at present, even perhaps ... some quasi-tactual and organic sensations as at present, whilst
*(a) having no perceptions of a body related to one’s experience as one’s own body is,*²⁸⁴ *and*
*(b) having no power of initiating changes in the physical condition of the world, such as one at present does with one’s hands, shoulders, feet and vocal cords.”*²⁸⁵

²⁷⁸ Strawson, *Individuals*, p. 103.

²⁷⁹ PI-1 § 284. See also the discussion of Wittgenstein’s concept of pain in Chapter 3, Section 4.

²⁸⁰ PI-II (iv), p. 178e.

²⁸¹ Guy Robinson, *Philosophy and Mystification*, p. 198.

²⁸² i.e. Conclusion 10 - 14 : *An initial leap of empathy is a precondition for seeing another as a fitting subject for possessing rights, for being an ‘Object of Intrinsic Moral Worth’ or for possessing the ability to communicate; this gesture of empathy is not a product of rational determination but flows from the adoption of an ‘attitude’. It is the gesture of ‘seeing oneself in another’ that enables ‘personhood’ to be conferred on that other; conversely, the refusal to ‘see oneself in that other’ precludes the attribution of ‘personhood’.*

²⁸³ It is, of course, part of his argument that a disembodied consciousness cannot exist as a *primary* concept; it may exist as a secondary concept. [see Strawson, *Individuals*, p. 115.]

²⁸⁴ Strawson adds an additional condition that:

“Condition (a) must be expanded by adding that no one else exhibits reactions indicating that he perceives a body at the point which one’s body would be occupying if one were seeing and hearing in an embodied state ...”

The treating of PVS patients as though they lacked consciousness may go some way to meet this additional condition.

²⁸⁵ Strawson, *Individuals*, p. 112.

Strawson argues that the experience would be such that:

*“... he must always think of himself as disembodied, as a former person. ... he has, as it were, no personal life of his own to lead, he must live much in the memories of the personal life he did lead, or ... achieve some kind of attenuated vicarious personal existence by taking a certain kind of interest in the human affairs of which he is a mute and invisible witness ... In proportion as the memories fade, and the vicarious living palls, to that degree his concept of himself as an individual becomes attenuated. At the limit of attenuation there is, from the point of view of his survival as an individual, no difference between the continuance of experience and its cessation.”*²⁸⁶

This thought experiment resonates uncannily with the possible experience of a conscious PVS patient *who is treated as if they are not conscious*. It is a rare philosophical insight into such a condition and is certainly of relevance to any ethical discussion concerning ‘end-of-life’ decisions relating to a possibly conscious PVS patient. If, however, the conscious PVS patient is treated as *if they are conscious* then one of the preconditions of Strawson’s analysis²⁸⁷ no longer applies and his conclusion no longer follows. This further reinforces the earlier conclusion that all PVS patients should be treated as *if they are conscious*.²⁸⁸

Conclusion 10 - 17: *Strawson’s analysis of how a disembodied consciousness might experience life suggests that one consequence of treating a conscious PVS patient as if they are not conscious is that, from the point of view of the PVS patient, he is as if dead.*

Conclusions: Strawson

The theoretical difficulties involved in attempting to distinguish between ‘intentional’²⁸⁹ unconscious actions and intentional conscious actions have been highlighted in Part 1.²⁹⁰ Borthwick’s arguments, Libet’s experiments and the phenomenon of ‘blindsight’ were there shown to raise difficulties of such a magnitude as to suggest that the prevailing medical model is unsustainable. Dennett gives further grounds for rejecting the medical model in that his analysis suggests that the assertion that the absence of non-reflex_M actions implies lack of consciousness is unsustainable. Even the narrower conclusion - that absence of non-reflex_P actions implies lack of consciousness - would not be accepted by either Wittgenstein or Strawson without qualification. Some further conclusions can be drawn in relation to PVS patients:

- (i) Dennett’s approach suggests that, in attempting to resolve questions of intention, the question of the stance to be adopted is to be resolved by decision and not by some ‘internal examination’. This implies that the question of the PVS patient’s intentionality (and therefore consciousness) is to be resolved *not* by an examination of such as brain states but by whether patient responses are better explained in terms of intention than in terms of the responses of a physical system. The typical responses of PVS patients to pain stimuli - as described in the literature on PVS - suggest that an intentional system is the more appropriate model.

²⁸⁶ *ibid.* p. 113. [emphasis in the original].

²⁸⁷ *i.e.* his additional condition (*supra*) that:

“Condition (a) must be expanded by adding that no one else exhibits reactions indicating that he perceives a body at the point which one’s body would be occupying if one were seeing and hearing in an embodied state ...”

²⁸⁸ See Conclusion 5.5: *All patients diagnosed as PVS, should be treated as if they are conscious and can experience pain.*

²⁸⁹ used in Dennett’s sense.

²⁹⁰ See, for example, Conclusion 2 - 10 to Conclusion 2 - 14.

- (ii) Strawson's and Wittgenstein's analysis suggests that the choice of attitude to be adopted to a PVS patient - *i.e.* whether they are to be regarded as 'a person' or as 'an object' and whether they possess consciousness and can experience pain - is primarily a matter of whether the assessor has empathy²⁹¹ towards the patient; it is not the result of some 'scientific' process though such pseudo-scientific judgements can, if allowed to go unchallenged, destroy the very possibility of empathy.
- (iii) To Strawson and Dennett, the ability to communicate is a prerequisite for the attribution of 'personhood'.
- (iv) Strawson's analysis of 'disembodied' experience suggests that the experience of a conscious PVS patient treated as if they are not conscious is such that eventually '*there is no difference between the continuance of experience and its cessation*'.

Section 4: Communication

The aim of this Section is to outline briefly some of the difficulties that may be occasioned by the term '*communication*' when used as part of a test for determining personhood and to tentatively sketch some possible solutions. The context of the discussion is that of PVS and PVS-like patients and no attempt will be made to address the wider concept of '*communication*' as this itself has generated an extensive and specialised literature. The main difficulties relating to the use of the term '*communication*', in a context of PVS and PVS-like patients relate to:

- (i) the *meaning* of the term '*communication*' in such a context.
- (ii) the *level* of communication envisaged.
- (iii) the *standard* of responsibility required in the making of judgements on the permanent loss of the ability to communicate.

Each of these topics will be discussed separately.

The meaning of the term '*communication*' in the context of PVS-like patients.

The paradigm is the Bauby case²⁹² which showed that all that is required to establish communication is a method of 'yes/no' signalling - Bauby used the blink of an eye.²⁹³ Andrews in his misdiagnosis studies used a test which assumed that the patient was not deaf.²⁹⁴ However, in both cases communication was established through fortuitous circumstances and, because such circumstances cannot be presumed to exist in other cases, a more general method of resolving the problem is required.

Assistance in this comes from an unusual source: the possibility of extra-terrestrial life has long been a source of wonder, and in the early 1970's astronomers - assuming that there was intelligent life elsewhere in the universe - attempted to find methods to communicate with it; yet, without a

²⁹¹ Dennett finds the phrase '*empathise*' objectionable as it is apt to connote '*something mystical or semi-divine*'. [op.cit. p.242]

cf. a remark by Dolores Dooley-Clarke:

"The different views of what counts as a person are by no means dependent on factual information alone." [in a 'Review of *The Practice of Death* by Eike-Henner W Kluge'; *Philosophical Studies* 25,1977 at p.305].

This remark suggests a method of contrasting Dennett's views on the attribution of consciousness or pain to both Wittgenstein's and Strawson's: Dennett would require *only* factual information - not of the internal workings - but of the behaviour; Wittgenstein and Strawson would not be dependent only such factual information; once empathy gained a foothold - as in Wittgenstein's example of the wiggling fly - judgements as to the existence of consciousness and pain might be made.

²⁹² Bauby suffered from '*locked-in syndrome*' and was the author of the *The Diving Bell and the Butterfly*; his case was discussed in Chapter 7, Section 2, Subsection 3.

²⁹³ Bauby's nurse pointed to the individual letters of the alphabet which had been previously written on a board and Bauby blinked to indicate his choice; his book was '*dictated*' solely by such means.

common language, the problem seemed insoluble. However, some astronomers believed that a common language did indeed exist - mathematics. Mathematics is nothing other than the symbolic representation, and manipulation, of abstract patterns and, whilst mathematical symbols may obviously differ between differing civilisations, the underlying mathematics is part of the very structure of abstract thought or of what is commonly meant by intelligence. A Professor Horowitz,²⁹⁵ for example, assumed such a universal ability to understand mathematics and broadcast radio signals into deep space, containing numerical codes of 1's and 0's in an attempt to elicit a response and thus generate a cosmic language. Similar experiments were described in a recent issue of the *New Scientist*²⁹⁶ where attempts to establish a universal language were described as being '*the very opposite of cryptography*' - meaning that the signal that was used was such as to bear its very meaning on its face, *i.e.* in the most obvious manner possible.

How would a response to such a signal be recognised as *communication*? Responses in which a pattern could be discerned - *i.e.* which were not chaotic or random responses - would be the preconditions for establishing communication. An example may help clarify. Imagine a radio signal sent out in bursts to embody the pattern:²⁹⁷

1 0 11 0 111 0

Imagine that, subsequently, a signal was received of the form:

11 0 111 01111 0

The 'response' certainly embodies a pattern. Must it be regarded as an 'intelligent' reply - *i.e.* as a communication? The answer is no. The response might have been a reflection or echo of the original signal; some mechanical process adding, as it were, a '1' to each number in the original signal; it might have been 'noise' or 'static' - *i.e.* a randomly generated signal. How would these other signals be distinguished from true intelligent responses? The solution would be to send a different signal and to see if a pattern again emerged in the response. If again there was doubt as to whether the response was an echo or a true intelligent response, a further signal - different from the previous two - would be sent out and the response again examined. This procedure is continued until the hypothesis that the response signal is an echo, becomes untenable. This, in turn, establishes²⁹⁸ the hypothesis that the response signal is a communication.²⁹⁹

Drawing on this discussion, I suggest (in the context of PVS and PVS-like patients) the following as a test to establish an ability to communicate:

Test: A stimulus - touch, sound etc. - be applied to the patient in a pattern similar to that shown in Diagram 10-2:³⁰⁰

A [pause] A A [pause] A A A [pause] A A A A [pause] A A A A A [pause] A A A A [pause] A A A
[pause] A A [pause] [pause] [wait for possible response]

Diagram 10-2: Test for establishing communication.

²⁹⁴ As discussed in Chapter 4.

²⁹⁵ As described in a Channel 4 TV documentary in the '*Equinox*' series (6.10.1997) entitled '*What is a number? An examination of the similarities between art and mathematics.*'

²⁹⁶ The article describes the attempts of a Professor Freudenthal to invent such a universal language; in the article it was stated that:

"But what knowledge is universal to any advanced civilisation? To Freudenthal it was obvious: mathematics. Civilisations throughout history all learnt to count before they invented a written language."

[*New Scientist*, 18th September 1999; p.36 *et seq.*]

²⁹⁷ As in a Morse code where the '1' signifies a uniform signal lasting for a determined time and the '0' the absence of a signal for the same length of time. Such signals are often superimposed on a 'carrier wave'.

²⁹⁸ Or, more accurately, strengthens the hypothesis. The problem is precisely the same as that envisaged by Dennett in his distinction between '*intentional stance*' and '*physical stance*'.

²⁹⁹ Note that the relationship between '*communication*' and '*echo*' exactly parallels that between '*intended*' and '*reflex*' action discussed in Part 1.

³⁰⁰ Where A stands for the giving of a stimulus.

What if a single muscle twitch occurs? Is this *necessarily* the beginnings of communication? The distinction between communication and echo (or reflected signal) in the astronomical case finds an exact parallel in the case of PVS patients. The '1' might well be a purely physical response - a '*reflex_P*' as discussed earlier. The solution is exactly as would be the case in the astronomical discussion: an amended signal is sent out to see the nature of the response it generates. In the case of the PVS patient, this might be:

Diagram 10-3: Second stage test for establishing communication.

The great benefit of such a methodology is:

- Once a mechanism for response is identified, then, as in the Bauby case, the method for developing a yes/no signalling system - and hence of communication - is clear.

It was suggested earlier in the introduction to this chapter that the obligations of Charity to an individual should be gainsaid by those of Justice only if that individual wished otherwise and so

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expressed his wishes. This implies that that level of communication required to attribute 'personhood' (and thus bring the obligations flowing from Justice into play) is *at least* that which is sufficient to determine whether the patient consents to a proposed intervention.

The standard of responsibility required

A medical examination which was conducted negligently and which resulted in an erroneous determination that an individual had permanently lost the ability to communicate is, depending on the degree of negligence involved, the moral equivalent of either murder or manslaughter. This clearly suggests the appropriate standard of diligence.³⁰²

Conclusion 10 - 18 : *In stating that the ability to communicate is a necessary condition for the ascription of 'personhood'; the level of communication required is at least that which is sufficient to determine whether the patient consents to a proposed intervention. Furthermore, the standard required in determining that a patient lacks the ability to communicate is indicated by the fact that an erroneous determination that such an ability was lacking is, if negligently made, morally equivalent to a wrongful killing.*

Section 5: Conclusions

The aims of this chapter were to establish the propositions:

(T): *"It is a necessary condition for the ascription of personhood to an individual that communication, to some minimal standard, be possible with that individual."*

(U): *"It is a necessary condition for the ascription of 'rights' to an individual that that individual possesses 'personhood'."*

It was noted³⁰³ that this task involved two separate questions, firstly whether (T) and (U) did *in fact* command a broad degree of acceptance (particularly amongst philosophers), and secondly, whether there are reasons, in addition to those adduced in the earlier discussion, why (T) and (U) should be accepted or amended. Earlier sections of this chapter have concentrated on the first of these questions. I will first attempt to summarise the conclusions of these earlier sections. Secondly, I will address the question of whether reasons exist whether the earlier conclusions should, in any way, be amended.

Is there a consensus in favour of (T) and (U)?

The proposition (T)

Section 1 of this chapter examined Locke's concept of person and personal identity. Locke required of a 'person' that they have a continuity of consciousness and it was shown that this condition implied an ability to communicate.³⁰⁴

In Section 2 some linguistic usages of the term 'person' were examined; examples considered were those of a '*personal God*' and the treating of an individual '*as an object*' and as a '*non-person*'.

³⁰² The conclusions arrived at earlier in relation to medical decision making in the presence of doubt (e.g. *Conclusion 5-2*) may be of assistance in resolving such questions.

³⁰³ In the introduction to this chapter.

³⁰⁴ See *Conclusion 10-6* : *To Locke, the ability to communicate is a necessary condition for ascription of personhood.*

It was found that the use of the term 'person' was intimately linked to the possibility of communication.³⁰⁵

The views of some modern philosophers on the concept of 'personhood' were examined in Section 3 of this chapter and in Appendix F. Before summarising these views, it is first necessary to distinguish between two distinct categories of individuals; this is because the implications of the definitions of the various philosophers differ, depending on the category in question. Two types of individuals need to be distinguished:³⁰⁶

- (i) 'type-A' individuals are presently unable, and have never been, able to communicate.
- (ii) 'type-B' individuals are presently unable, but once were, able to communicate to the extent of learning a language.

Wittgenstein's position in relation to 'type-A' individuals is that they cannot develop a private language and are, in consequence, deprived of the ability to think conceptually; as such they are not 'persons'.³⁰⁷ Strawson's position is not clear, though - when viewed through the lenses of Dennett's elaboration of the concept of intention - Strawson would also deny personhood to 'type-A' individuals.³⁰⁸

Neither Wittgenstein's, nor Strawson's, position is clear in relation to 'type-B' individuals. The most that can be said is that both Strawson and Wittgenstein would not necessarily deny personhood to a 'type-B' individual - all, it seems, would hinge on whether the assessor did, or did not, feel empathy towards the individual in question: once a 'foothold'³⁰⁹ for empathy could be established, then the mental predicates - consciousness and (possibly) personhood - could be ascribed.

Of the other philosophers discussed,³¹⁰ some - such as Tooley and Harris³¹¹ - believe that the ability to think conceptually³¹² is the mark of personhood. They are obliged, *provided Wittgenstein's 'Private Language Argument' is accepted*,³¹³ to refuse to accord personhood to 'type-A' individuals.

³⁰⁵ See:

- * Conclusion 10 - 8 : *The distinction between a 'personal' and an 'impersonal' God lies in the existence or otherwise of a relationship based on the possibility of communication between man and God. However, whilst this interpretation is consistent with (T), it is not meaningful in relation to (U).*
- * Conclusion 10 - 11 : *In speaking of a carer treating a patient as 'an object' rather than as 'a person' what is being alluded to is the both the unwillingness of the carer to communicate with the patient and the refusal to recognise the patient's rights. Thus, this usage is consistent with both (T) and (U).*
- * Conclusion 10 - 12 : *The usage of the term 'person' - when understood in the sense of 'persona' - is consistent with having an ability to communicate and with the possessing rights i.e. with (T) and (U).*
- * Conclusion 10 - 13 : *The usage of the term 'non-person' suggests an individual who is excommunicated from society and without rights; as such it is consistent with both (T) and (U).*

³⁰⁶ Individuals who are presently unable but who, it is believed, will at some future time be able to communicate are discussed under the concept of 'precociousness' (*infra*).

³⁰⁷ See Conclusion 10 - 15 : *Wittgenstein's 'Private Language Argument' implies that an individual's ability to think conceptually has as a precondition that that individual had, at some earlier stage, an ability to communicate which he did in fact exercise.*

³⁰⁸ See Conclusion 10 - 16 : *Strawson's arguments (as elaborated by Dennett) are to the effect that imputing intentionality to a system is not, of itself, sufficient to permit 'personhood' to be attributed to the system; an ability to communicate is also necessary.*

³⁰⁹ Wittgenstein, PI-1 § 284:

"Look at a stone and imagine it having sensations ... And now look at a wriggling fly and at once these difficulties vanish and pain seems to be able to get a foothold here, ..."

³¹⁰ In Appendix F, where it was established that:

Conclusion F - 1 : *Definitions of personhood given by 11 modern philosophers are considered in Appendix F. All of these definitions imply (T); however, in two cases - Tooley and Harris - it is necessary to rely on Wittgenstein's 'Private Language Argument'. A corollary is that Harris and Tooley accept (T) for the ascription of personhood but not for its removal; all others accept (T) as a criterion both for the ascription, and removal, of personhood. All of the definitions, with the exception of Harris's, assume (U).*

NB. (U) is less onerous to establish than is (U).

³¹¹ As mentioned in Appendix F, there is a slight gap between Harris's conclusion and (T); this gap is occasioned by those individuals who have rudimentary self awareness but not the (present) ability to communicate. The concept of 'precociousness' (which is introduced in the next subsection) helps resolve this difficulty.

³¹² Whether as the possession of a concept of self, or as an ability to think rationally.

³¹³ The validity of Wittgenstein's 'Private Language Argument' is assumed in this thesis.

Conversely they would, subject to reservations, accord personhood to 'type-B' individuals.³¹⁴

Others - such as Turing, Downie, Rawls, Kluge, Fletcher, Flanagan and Drane - argue that a *present* ability to communicate is a necessary condition for personhood. These must refuse personhood to both 'type-A' and 'type-B' individuals. In conclusion:

Conclusion 10 - 19: *The overwhelming consensus amongst philosophers is in favour of accepting 'ability to communicate' as a criterion for the ascription of personhood, less so as a criterion for its removal; this is consistent with the conventional usage of the term 'person'.*

The proposition (U')

The cornerstone of Locke's discussion on personal identity was that personhood was a 'forensic' concept intimately associated with the ascription of rights and responsibilities.³¹⁵ The examination of linguistic usage (particularly in relation to the term 'non-person' and in the contrast between treating an individual 'as a person' and 'as an object') showed the intimate link between questions of personhood and eligibility for possessing rights; the one area where this link was not apparent was in distinguishing between a 'personal' and an 'impersonal' God, in this case the discussion of 'rights' seemed inappropriate.³¹⁶

Strawson's and especially Wittgenstein's concern in relation to the term 'person' was primarily with its *denotation*; their analysis touched little on questions of rights and their ascription; thus, no conclusions can be drawn as regards the place of the proposition (U') in their philosophies.

Of the other modern philosophers which we have discussed who addressed the link between being a bearer of rights and personhood, only Dennett and Tooley sought to place limitations on this link. As was noted earlier,³¹⁷ certain difficulties were occasioned by their not distinguishing between the concept of 'personhood' (i.e. a bearer of rights) and the concept of 'Objects of Intrinsic Moral Worth' (i.e. entities, effects on which are to be considered relevant in assessing the morality of any proposed action). That they do not use this distinction - and consequently their conflating of the two categories involved - means that the loss of an individual's rights entails that that individual would be exiled from all moral consideration; this results in an unnecessary distortion of the discussion.

Tooley dissented from what he regarded as the philosophical consensus which treats 'X is a person' as being synonymous with 'X has rights'. Tooley favoured equating 'X is a person' with the proposition 'X has a (serious) moral right to life'. The reason for Tooley's dissent lay in his attempt to ensure that a perception of his - that animals had a 'right' not to be tortured whilst not having a 'right' not to be killed - could be expressed within his philosophy without engendering any inconsistency. As argued earlier,³¹⁸ the use of the distinction between 'person' and 'OMW' would have permitted this perception to be expressed without occasioning the need to depart from the consensus.

Dennett's dissent from the consensus view derived from his analysis of the example of an insane man; such a man, argued Dennett, is treated as a person even though deprived of his

³¹⁴ Since they once possessed language ability they still possess a capacity for conceptual thought (even if they are currently unable to communicate).

³¹⁵ See Conclusion 10 - 5: *To Locke, possession of personhood is a necessary and sufficient condition for the ascription of rights.*

³¹⁶ See Conclusion 10 - 8, Conclusion 10 - 11, Conclusion 10 - 12 and Conclusion 10 - 13. above.

³¹⁷ In Appendix F and - in relation to Dennett - Section 3.

³¹⁸ In discussing Tooley's arguments in Appendix F.

rights.³¹⁹ Two alternative resolutions of this problem are possible which do not challenge (U'). Firstly, it is possible to argue that the insane man has in fact no rights but is considered to be an 'OMW' and is accorded moral consideration - this was the argument of the preceding paragraph. Alternatively one can argue - and this is the better view³²⁰ - that, because there is a possibility that the insane man can recover,³²¹ his personhood subsists though in an attenuated form.³²² The following conclusion can be drawn:

Conclusion 10 - 20: *There is a widespread acceptance both amongst philosophers and the wider community (especially if the distinction between 'person' and 'OMW' is recognised) that rights can only be ascribed to an individual if that individual is deemed to be a 'person'.*

We can summarise the discussion in relation to both (U') and (T) in saying that the only reasons offered by the philosophers whose views have been examined in this chapter for *not* accepting (U') and (T) are:³²³

- (i) Whereas the ability to communicate is a necessary condition for ascribing 'personhood' to an individual it is not clear that the loss of the ability to communicate should necessitate the loss of 'personhood'.
- (ii) The case of animals who have 'rights' not to be tortured whilst not having 'rights' not to be killed. (Tooley's example).
- (iii) The case of an insane man who is treated as a person even though deprived of his rights. (Dennett's example).

The concepts of '*stickiness*' and '*precociousness*' (to be discussed below) when applied to the concept of 'personhood' and the distinction between '*personhood*' and '*Objects of Intrinsic Moral Worth*' (discussed in the introduction to this chapter) allow all of these objections to be overcome.

Are there, however, *further* reasons why (U') and (T) should not be accepted.

Should (T) and (U') be accepted or are amendments necessary?

Much of the controversy that surrounds the application of the concept of 'personhood' relates *not* to whether the ascription of 'personhood' to an individual implies that rights should be accorded to that individual - for such is, generally speaking, not contentious - but to what types of humans, if any, should not be considered to be persons; the focus of such discussion are usually either foetuses, newborn infants³²⁴ or individuals such as PVS patients. The precondition for 'personhood' envisaged in (T) - : "*It is a necessary condition for the ascription of personhood to an individual that communication, to some minimal standard, be possible with that individual.*" - does not appear to be directly applicable to these cases: it is no more possible to communicate with a year-old infant than with a foetus, yet even those who would unreservedly be in favour of an unrestricted access to

³¹⁹ as quoted earlier:

"... when we declare a man insane we cease treating him as accountable, and we deny him most rights, but still our actions with him are virtually indistinguishable from normal personal interactions ..." [Brainstorms, p.269].

³²⁰ In that not all his rights are abrogated; in particular his right not to be killed, even if this be considered to be in his 'best interests', persists.

³²¹ i.e. it is believed that he may again acquire the ability to communicate. In order to permit the inclusion of the insane in the discussion of personhood it may be that the term 'communication' must be clarified to mean '*rational* communication'.

³²² The concept of '*stickiness*' (which is discussed in the following subsection) would permit this conclusion. This concept implies that whilst an insane patient may lose rights he does not lose all of his rights; this is because the (even remote) possibility that he may recover is sufficient to make some rights persist - in particular the right to life; as such, the insane person would have an attenuated personhood.

³²³ assuming Wittgenstein 'Private Language Argument' is accepted, which, for the purpose of this thesis, it is.

abortion - thus implying that a foetus had no rights - would not accept the killing of a year-old infant. Furthermore, a person who suffered a stroke and lost the ability to communicate would, generally speaking, not be considered to have lost their 'personhood' and with it the loss of rights that this entailed.³²⁵ It seems that the concept of 'personhood' - or, equivalently the proposition (T) - needs some further modification. The concepts of '*stickiness*' and '*precociousness*' when applied to the concept of 'personhood' enable such a modification.

The concepts of '*stickiness*' and '*precociousness*' as applied to an attribute

The definition of '*precociousness*' in relation to an attribute

To say, in relation to an attribute P that it is '*precocious*' is to assert that an object which currently has not the attribute P, but which, it is believed, will most probably possess it at some future time, is considered to *presently* possess the property P but in an attenuated form ' P_{AT} '.

The definition of '*stickiness*' in relation to an attribute

To say, in relation to an attribute P, that it is '*sticky*' is to assert that an object which does not currently possess the attribute P but which once did so and, it is believed, may conceivably do so again, is considered to *presently* possess the property P but in an attenuated form ' P_{AT} '.³²⁶

An example may help clarify these definitions.

An example

The criterion for wealth is the possession of riches. Without riches one is not wealthy. Consider, however, a youth who has been promised a considerable inheritance by his rich uncle. The uncle may, of course, change his mind and the youth inherit nothing. However, because there is a high possibility that he will become wealthy the youth is treated very much as if he were already wealthy - not *exactly* the same but wealthy in a somewhat attenuated form. This could be described by saying that '*wealth*' was a '*precocious*' attribute.³²⁷

The uncle did not renege on his promise. The youth received his inheritance but squandered it, in its entirety on gambling. He no longer possesses riches so he is no longer wealthy; but because he was once wealthy and, perhaps, because of his social connections, there is a remote possibility that he may again be wealthy; accordingly he is treated very much as if he were still wealthy - not *exactly* (no one will give him extensive credit) but he is accorded a certain status and deference.

³²⁴ As mentioned in Chapter 9, the ethicist Peter Singer has argued that infanticide is permissible for parents of very deformed children during the first few days after birth. [Radio interview on BBC World Service 16.1.00].

³²⁵ This is, in essence, the problem of specifying the conditions for the removal of 'personhood' (as mentioned in the previous subsection).

³²⁶ It may seem that the concepts '*precociousness*' and '*stickiness*' overlap; however, the level of probability required in assessing a future ability to communicate is considerably greater in the case of '*precociousness*' than in the case of '*stickiness*'; the following examples may help clarify:

(i) a new born infant 'A' with severe brain damage who has a 1% chance of surviving and being able to communicate at some future time.

(ii) an adult man 'B' who had normal intellectual capacities before suffering a severe stroke and who now has a 1% chance of surviving and being able to communicate at some future time.

The probability of 'A' achieving the ability to communicate may be so slight as not to confer 'attenuated personhood' by virtue of '*precociousness*', yet the probability of 'B' achieving the ability to communicate may be regarded as sufficient to confer an 'attenuated personhood' through '*stickiness*' and this is so *even though* the probabilities of both A and B being able to communicate at some future time are identical.

³²⁷ The analogy of 'value' may also help clarify; something which will have value in the future is considered to presently have an attenuated value: if a 20-year-old Saab is generally regarded to be a vintage car, and thus valuable, then an 18-year-old Saab has (an attenuated) value in, as it were, anticipation.

One could say of such a man that he still possesses wealth but in an attenuated form. This could be described by saying that wealth was a 'sticky' attribute.

'Stickiness' and 'precociousness' as applied to 'personhood'

I suggest that 'personhood' is both 'sticky' and 'precocious' in that:

- (i) If it is believed that there is a high probability that an individual (who currently cannot communicate) will have an ability to communicate at some future time (he will, of course, then be a 'person') then he is treated as if he *presently* has 'personhood' but in an attenuated form.
- (ii) If an individual (who currently cannot communicate) once had the ability to communicate (he was, of course, then a 'person') and may conceivably do so again, then he is treated as if he *presently* has 'personhood' but in an attenuated form.

Furthermore, the attenuated form of personhood which is appropriate - call it '*personhood_{AT}*' - is simply the right not to be killed *even if* there is a unanimity that to do so is in one's 'best interests'; all other rights are in abeyance.³²⁸

As an example of the first type of attenuated 'personhood', consider the situation of newborn infants and, perhaps, foetuses; these have not the present ability to communicate yet they are treated as (attenuated) persons: '*attenuated*' because they possess none of the rights of an adult other than the right not to be killed; all other decisions in relation to their welfare are taken on *moral* grounds - *i.e.* on what is in their 'best interests' - not on grounds of their supposed *rights*; with the exception of the right not to be killed, Justice is in abeyance and Charity reigns supreme.³²⁹

As an example of the second type of attenuated personhood, consider the example of a comatose patient; their personhood persists throughout the period of unconsciousness in an attenuated form to the extent that all medical decisions can be made on a 'best interests' basis *except* a decision which foreseeably results in their death even if this is taken *solely* with their 'best interests' in mind. The situation of the insane patient envisioned by Dennett and discussed earlier can also be analysed within such a framework; the obligation on others is not to kill such an attenuated person *even if this appears to be the most charitable thing to do*. The obligations of Justice still persist - even if in an attenuated form - and cannot be overridden by the requirements of Charity. All other decisions however are taken on the grounds of Charity.³³⁰

'Precocious' distinguished from a 'potential'

'Precociousness' should be distinguished from '*potentiality*': an individual who is a potential person is no more a person that is an acorn, a tree; consequently, a potential person is not a person and has no rights; in contrast - if personhood is accepted to be a precocious attribute - an individual who will very probably become a person is deemed to possess an attenuated personhood and, thus, presently partakes of personhood and presently possesses (limited) rights. The

³²⁸ Had the concept of '*personhood_{AT}*' not been introduced then personhood would be an 'all or nothing' condition and such does not adequately describe the full complexity of the modern use of the term. The concept can also be justified in that 'attenuated persons' have a possibility of being able to communicate at some future time and so deciding their own destiny; the concept of '*personhood_{AT}*' allows this minimum whilst recognising that all other decisions are taken on the basis of what is considered best for the individual in question.

³²⁹ Remember that in Foot's schema (which has been adopted in this thesis) 'rights' flow from the virtue of Justice and are essentially a bulwark against the interventions of others even if these interventions spring from the most 'charitable' of intentions.

³³⁰ *i.e.* decisions are taken on the basis of what is adjudged to be in the '*best interests*' of the individual.

*nearness*³³¹ of the existing condition to the condition of 'personhood' is what confers attenuated personhood through 'precociousness'; the 'nearness' of the relationship would, perhaps, not be as relevant in a discussion of potentiality.

A revised proposal

Some groundwork must first be laid:

- * It is not possible to question *both* (T) and (U) simultaneously;³³² to attempt to do so would be like trying to fence the wind - there would be no secure foundation from which to conduct the discussion. Accordingly, for the purpose of this discussion, (U) is accepted without reservation and the question is then, given this understanding, should (T) be accepted?
- * The distinction between '*Objects of Intrinsic Moral Worth*' and '*Personhood*' is assumed.³³³ For the purposes of this discussion the possession of consciousness is assumed to be the criterion for being an '*OMW*'. It is most important to note that loss of personhood by an individual does *not* imply that others are no longer under moral obligations to him. The loss of personhood simply means that all the obligations that flow from the virtue of Justice cease, the obligations that flow from the virtue of Charity may still continue.
- * Personhood is assumed to be both '*sticky*' and '*precocious*'.
- * Attenuated personhood - '*personhood_{AT}*' - is understood to be simply the '*right not to be killed*'; it is a narrower right than the '*right to be let alone*' which characterises 'personhood'.

³³⁴

For convenience, the various possibilities linking ability to communicate to ascription of 'personhood' are set out in the Table 10-4:

	<u>Ability to Communicate</u>			<u>Current status</u>
	<u>in the past</u>	<u>now</u>	<u>in the future</u>	
1.	-	Yes	-	Has full personhood.
2.	Yes	No	Some possibility	Has a temporary attenuated personhood by virtue of ' <i>stickiness</i> '.
3.	Yes	No	Highly probable	Has an attenuated personhood by virtue of both ' <i>stickiness</i> ' and ' <i>precociousness</i> '; will have full personhood when communication is restored.
4.	No	No	Highly probable	Has an attenuated personhood by virtue of ' <i>precociousness</i> '; will have full personhood when communication is achieved.
5.	No	No	No	No personhood.

Table 10-4: The relationship between attribution of 'personhood' and ability to communicate.

With these understandings the question of whether an ability to communicate *should* be a necessary condition for the ascription of personhood can now be more easily addressed.

³³¹ *i.e.* the high probability of attaining 'personhood'.

³³² It is, however, possible to ask whether there should be a relationship between ability to communicate and possession of rights; Dennett has suggested a possible reason for this relationship:

"The capacities for verbal communication and for awareness of one's action are thus essential in one who is going to be amenable to argument or persuasion, and such persuasion, such reciprocal adjustment of interests achieved by mutual exploitation of rationality is a feature of the optimal mode of personal interaction." [Brainstorms, p.283 - where he elaborates on some ideas from Rawls, *Theory of Justice*.]

³³³ '*Objects of Intrinsic Moral Worth*' are entities, effects on which are considered relevant in assessing the morality of any proposed action - and '*Persons*' are entities to whom rights are ascribed.

³³⁴ Foot considered that the primary right flowing from the virtue of Justice was the '*right to be let alone*'.

Rights have been well described as '*areas of autonomy*';³³⁵ what would it mean to suggest that an individual who had permanently lost the ability to communicate possessed such areas of autonomy?

To say that '*X is a person*' is to assert the existence of domains where others have no right to take decisions which affect '*X*' *even if they are motivated solely by a desire to act in 'X's' 'best interests'*. Rights flow from the virtue of Justice and function as a bulwark against the interventions of others, even if these spring from the most 'charitable' of intentions. To say that '*X is a person*' is to acknowledge the existence of areas where the furthering of what is perceived as '*X's*' best interests should *not* be the paramount consideration. If '*X*' is unable to communicate, it is not possible to discuss with him the reasons why a certain course of action is in fact in his best interests, he is beyond persuasion. One solution might be to abstain from *any* intervention in '*X's*' affairs; however, in the cases which are at the heart of this thesis, such an Olympian stance is not possible, nor in other situations does it seem even remotely desirable. As has been pointed out by judges in both the Ward³³⁶ and the Bland cases,³³⁷ *not* to sanction the withdrawal of ANH is as much a decision as to sanction it; thus, the facts are such that in such cases an intervention *must* be made.

I suggest that, in cases where communication is not possible, a '*Principle of Minimal Intervention*' should apply:

In cases where communication is not possible and where it is reasonable to assume that had communication been possible the intervention would be requested, then the intervention is justified provided it is performed in the 'best interests' of the individual and is the minimum intervention required to preserve the situation until such time as communication can be restored.

Consider the example of a bystander on the seafront who sees a swimmer in difficulties and in danger of drowning. The bystander knows the swimmer and knows that he is a 'person' and well able to communicate; must he not intervene until he has ascertained that his intervention is consented to? Such would be the implication of a strict interpretation of the precedence of Justice over Charity; it would also be nonsensical. The '*Principle of Minimal Intervention*' would imply that the swimmer could be rescued and taken ashore and cared for until such time as he made his views known. What if he then said the he was attempting to commit suicide and wished to persist in his attempt? The '*Principle of Minimal Intervention*' is no longer applicable,³³⁸ Justice again rules supreme and intervention to prevent the suicide would infringe the person's rights.

I suggest that the '*Principle of Minimal Intervention*' in conjunction with a concept of 'personhood' which is both 'sticky' and 'precocious' allows all the difficulties mentioned earlier in this Section to be resolved:

- * Tooley's example of the kitten who has the 'right' not to be tortured but may be killed is better analysed in terms of 'Objects of Intrinsic Moral Worth' rather than 'personhood': the kitten is an 'OMW' (because it has consciousness) but has no 'personhood' and accordingly

³³⁵ A description attributed to Richard Brandt by Baruch Brody in Abortion and the Sanctity of Human Life: A Philosophical View, at p.86.

³³⁶ Denham J., the Ward case at p.456:

"To continue the treatment is as much a decision as not to do so."

³³⁷ Lord Hoffman, the Bland case at p.828:

"One way or the other a choice is being made."

³³⁸ As mentioned earlier it may be necessary to refine the term 'communication' to mean '*rational* communication'; the discussion assumes that this has been done.

has no rights (because it is not possible to communicate with the kitten). Because the kitten is an 'OMW', persons have obligations to the kitten to act in its best interests which implies that they must not torture it; because the kitten has no 'personhood' it may be killed but only if this is in its accord with Charity.

- * Dennett's example is of an insane man who is treated as a person even though deprived of his rights. Dennett is wrong in asserting that the insane man is deprived of *all* of his rights; he still retains the right to life even though all his other rights may be in abeyance. Thus, this example is best understood as one of attenuated personhood; the attenuated personhood arising because of the 'stickiness' of personhood: the insane man was once a person (before the onset of his insanity) and there is some chance that he may recover.
- * A newborn infant contrasted with a foetus: the personhood of either, if it exists, arises because of the 'precociousness' of personhood. As mentioned earlier, the 'precociousness' of personhood arises in proportion to the nearness of personhood being achieved in its own right; accordingly, the ascription of an attenuated personhood - which implies the right not to be killed - is much more readily made in respect of a newborn infant than a foetus.
- * the loss of an ability to communicate implying a loss of 'personhood': unless there is a total loss of ability to communicate, 'personhood' persists in an attenuated form because of the 'stickiness' of personhood. Thus, the stroke victim who has lost the ability to communicate still has an attenuated personhood provided there is some chance that he may regain the ability to communicate. What though of the PVS patient for whom no possibility of a restoration of the ability to communicate exists? There are, it seems, only two possibilities:
 - * either, *all* health interventions in such cases must be made on the basis of the 'best interests' of the patient. This implies that *all* decisions must be made on the basis of Charity; Justice having no relevance; this, in turn, implies that the patient has lost their 'personhood' and that a decision may be made which foreseeably results in the death of a patient if this is adjudged to be in their 'best interests'.³³⁹
 - * or, *some* health interventions *cannot* be made on a 'best interests' basis. This implies that some intervention, which is generally regarded as being in the patient's 'best interests', cannot be made because it infringes some supposed right of the patient. Whilst such a course of action is eminently justifiable if there is even a slight hope that the patient's own views can be canvassed - and might thus be found to differ from what was universally regarded as being in their 'best interests' - it seems unjustifiable if all hope of restoring communication is lost; to adhere to it would imply that a course of action which was generally regarded as being *not* the best course of action for the

³³⁹ It may seem paradoxical to suggest that, in certain circumstances, the perceived 'best interests' of a patient may dictate a course of action that will result in their death; however, the discussion (in Chapter 9) of the concept of 'a good death' has established that far from being paradoxical, it is, in certain circumstances, an appropriate response. A contemplation of the possible nature of the experience of a PVS patient may make such a conclusion less difficult to accept. Strawson's account of a 'disembodied' consciousness, given earlier in this chapter (Section 3), is one such description; Lawrence Schneiderman tentatively suggests another:

"What do we know about the patient who is permanently unconscious? Only that he or she is isolated from any form of communication - as though exiled or banished from society, a condition once regarded as punishment equal to if not worse than death, because it is, in effect, dehumanising. ... In ancient societies, including Greece and Rome, death or banishment were the retributions for capital crimes. ... banishment served along with burning at the stake as punishment for heresy - thus being deemed equivalent to the most painful death ... a condition Shakespeare had the banished Mowbrey describe ... as 'speechless death' and 'solemn shades of endless night' - descriptions surely fitting PVS."

[Lawrence J. Schneiderman, 'Exile and PVS' Hastings Center Report May/June 1990 p.5. emphasis in the original] Schneiderman assumed that PVS patients lacked consciousness. We have seen (in Chapters 1 and 4) that the evidence for such an assumption is tenuous. How much more forceful is his argument if it is acknowledged that PVS patients might indeed be conscious?

patient should be pursued. [Note: the discussion here is *only* concerned with the interests of the patient; the wider social interests are of considerable relevance and will be incorporated into the discussion in Chapter 11.]

The various principles discussed in this chapter can be summarised in the following conclusions:

Conclusion ¹⁰⁻²¹ : *The principles outlined in Chapter 10 concerning obligations to others are:*³⁴⁰

- * *Obligations to others flow either from Charity or from Justice.*
- * *Obligations flowing from Justice take precedence over obligations flowing from Charity subject only to the 'Principle of Minimal Intervention'.*
- * *The obligations to an individual flowing from Charity arise because of the ascription of consciousness to that individual; such individuals are known as 'Objects of Intrinsic Moral Worth'.*
- * *The obligations to an individual flowing from Justice arise because of the personhood of that individual.*
- * *It is a necessary condition for the ascription of personhood to an individual that communication be possible with that individual.*
- * *It is a necessary condition for the ascription of rights to an individual that they have personhood.*
- * *Individuals who are likely to achieve an ability to communicate or who once had such an ability and for whom there is some possibility that it may be regained, have an 'attenuated personhood'.*
- * *Attenuated personhood confers a right on an individual not to be killed even if this is universally regarded as being in their 'best interests'; no other rights are conferred.*

Because of their importance the following conclusions are stated explicitly:

Conclusion ¹⁰⁻²² : *The assertion that all decision-making in relation to a patient who has permanently lost the ability to communicate should be on the basis of the patient's 'best interests' necessarily entails that such a patient has lost their personhood.*

Conclusion ¹⁰⁻²³ : *On the understanding that the obligations flowing from Charity are not diminished solely by reason of the loss of personhood, it can be asserted that a loss of the ability to communicate which is judged to be permanent³⁴¹ entails a loss of personhood.*

The conclusions that were established in this chapter are:

Conclusion ¹⁰⁻¹ : *Rights (and obligations) can be ascribed to an individual if, and only if, that individual is a person.*

³⁴⁰ The interests of the wider society will be incorporated into this analysis in Chapter 11.

³⁴¹ bearing in mind that an erroneous determination, negligently made, is morally equivalent to a wrongful killing.

Conclusion 10 - 2 : *Obligations may exist towards individuals who are not persons; such obligations arise from Charity. The class of individuals to whom persons have obligations that flow from Charity are called 'Objects of Intrinsic Moral Worth' ('OMW's'). The possession of consciousness is the usual criterion for classifying an individual as an 'OMW'.*

Conclusion 10 - 3 : *Obligations flowing from Justice - of which the most important is the right 'to be let alone' - take precedence over the obligations flowing from Charity.*

Conclusion 10 - 4 : *The right to be let alone can be analysed into:*

- (i) the right to be free from 'non-beneficial' interference; this right³⁴² flows from both Charity and Justice.*
- (ii) the right to be free from 'beneficial' interference; this right flows from Justice.*

Conclusion 10 - 5 : *To Locke, possession of personhood is a necessary and sufficient condition for the ascription of rights.*

Conclusion 10 - 6 : *To Locke, the ability to communicate is a necessary condition for ascription of personhood.*

Conclusion 10 - 7 : *The maximally relevant conclusion (in relation to the 'personhood' of PVS patients) that could be drawn from a linguistic investigation of the term 'person' is that, traditionally, rights were not accorded to those with whom, it was believed, communication was not possible.*

Conclusion 10 - 8 : *The distinction between a 'personal' and an 'impersonal' God lies in the existence or otherwise of a relationship based on the possibility of communication between man and God. However, whilst this interpretation is consistent with (T), it is not meaningful in relation to (U').*

Conclusion 10 - 9 : *In taking health care decisions affecting a patient, the principal obligation imposed by the virtue of Justice is to attempt to communicate with the patient; this obligation overrides all obligations to the patient flowing from Charity.*

Conclusion 10 - 10 : *To take health care decisions for a patient without first attempting to communicate with the patient in order to determine their wishes, is in effect a denial of their 'personhood' and this is so even if all such decisions are taken solely on the basis of what is believed to be in the patient's 'best interests'.*

Conclusion 10 - 11 : *In speaking of a carer treating a patient as 'an object' rather than as 'a person' what is being alluded to is the unwillingness of the carer to communicate with the patient and the refusal to recognise the patient's rights. Thus, this usage is consistent with both (T) and (U').*

³⁴² In so far as it flows from Charity it is best considered not as a *right* but as an *obligation* on persons; though see the earlier discussion in the introduction to this Chapter on the possibility of using the terminology 'Justice Rights' and 'Charity Rights'.

Conclusion 10 - 12 : *The usage of the term 'person' - when understood in the sense of 'persona' - is consistent with having an ability to communicate and with the possessing of rights i.e. with (T) and (U).*

Conclusion 10 - 13 : *The usage of the term 'non-person' suggests an individual who is excommunicated from society and without rights; as such it is consistent with both (T) and (U).*

Conclusion 10 - 14 : *An initial leap of empathy is a precondition for seeing another as a fitting subject for possessing rights, for being an 'Object of Intrinsic Moral Worth' or for possessing the ability to communicate; this gesture of empathy is not a product of rational determination but flows from the adoption of an 'attitude'. It is the gesture of 'seeing oneself in another' that enables 'personhood' to be conferred on that other; conversely, the refusal to 'see oneself in that other' precludes the attribution of 'personhood'.*

Conclusion 10 - 15 : *Wittgenstein's 'Private Language Argument' implies that an individual's ability to think conceptually has as a precondition that that individual had, at some earlier stage, an ability to communicate which he did in fact exercise.*

Conclusion 10 - 16 : *Strawson's arguments (as elaborated by Dennett) are to the effect that imputing intentionality to a system is not, of itself, sufficient to permit 'personhood' to be attributed to the system; an ability to communicate is also necessary.*

Conclusion 10 - 17 : *Strawson's analysis of how a disembodied consciousness might experience life suggests that one consequence of treating a conscious PVS patient as if they are not conscious is that, from the point of view of the PVS patient, he is as if dead.*

Conclusion 10 - 18 : *In stating that the ability to communicate is a necessary condition for the ascription of 'personhood'; the level of communication required is at least that which is sufficient to determine whether the patient consents to a proposed intervention. Furthermore, the standard required in determining that a patient lacks the ability to communicate is indicated by the fact that an erroneous determination that such an ability was lacking is, if negligently made, morally equivalent to a wrongful killing.*

Conclusion 10 - 19 : *The overwhelming consensus amongst philosophers is in favour of accepting 'ability to communicate' as a criterion for the ascription of personhood, less so as a criterion for its removal; this is consistent with the conventional usage of the term 'person'.*

Conclusion 10 - 20 : *There is a widespread acceptance both amongst philosophers and the wider community (especially if the distinction between 'person' and 'OMW' is recognised) that rights can only be ascribed to an individual if that individual is deemed to be a 'person'.*

Conclusion ¹⁰⁻²¹ : *The principles outlined in Chapter 10 concerning obligations to others are:*³⁴³

- * *Obligations to others flow either from Charity or from Justice.*
- * *Obligations flowing from Justice take precedence over obligations flowing from Charity subject only to the 'Principle of Minimal Intervention'.*
- * *The obligations to an individual flowing from Charity arise because of the ascription of consciousness to that individual; such individuals are known as 'Objects of Intrinsic Moral Worth'.*
- * *The obligations to an individual flowing from Justice arise because of the personhood of that individual.*
- * *It is a necessary condition for the ascription of personhood to an individual that communication be possible with that individual.*
- * *It is a necessary condition for the ascription of rights to an individual that they have personhood.*
- * *Individuals who are likely to achieve an ability to communicate or who once had such an ability and for whom there is some possibility that it may be regained, have an 'attenuated personhood'.*
- * *Attenuated personhood confers a right on an individual not to be killed even if this is universally regarded as being in their 'best interests'; no other rights are conferred.*

Conclusion ¹⁰⁻²² : *The assertion that all decision-making in relation to a patient who has permanently lost the ability to communicate should be on the basis of the patient's 'best interests' necessarily entails that such a patient has lost their personhood.*

Conclusion ¹⁰⁻²³ : *On the understanding that the obligations flowing from Charity are not diminished solely by reason of the loss of personhood, it can be asserted that a loss of the ability to communicate which is judged to be permanent³⁴⁴ entails a loss of personhood.*

³⁴³ The interests of the wider society will be incorporated into this analysis in Chapter 11.

³⁴⁴ bearing in mind that an erroneous determination, negligently made, is morally equivalent to a wrongful killing.

Chapter 11: An alternative conceptual structure for 'end-of-life' decisions for PVS patients

The primary aim of this Chapter is to develop a conceptual structure that will enable a more satisfactory resolution of the problems associated with 'end-of-life' decisions for PVS patients than is possible with the conceptual structures which are presently used. The proposed structure - which I term the '*P-GD conceptual structure*' - will be developed from concepts introduced in earlier chapters, particularly the concepts of '*personhood*' and '*a good death*'.

The difficulties associated with the existing conceptual structure - which I have called the '*C-AQL conceptual structure*'¹ - have been examined in detail in Parts 1 and 2 of this thesis; suffice here to say that these difficulties concerned firstly, the problem of determining patient consciousness² and secondly, the danger of occasioning a 'slippery slope'. In Part 2, it was argued that one of the prime causes of the 'slippery slope' was the use of '*absolute quality of life*' judgements.³ Because ascriptions of 'consciousness' do not play a central role in the '*P-GD conceptual structure*' (other than in relation to decisions concerning the administration of pain relief) and because 'absolute quality of life' judgements are not permissible within this structure,⁴ the causes of the original difficulties are removed. It remains to show that the proposed conceptual structure is still sufficiently powerful to permit the resolution of problems in relation to 'end-of-life' decisions for PVS patients.

The '*C-AQL conceptual structure*' has also been used in relation to 'end-of-life' decisions for severely disabled infants who were not terminally ill;⁵ the courts analysed such cases by first considering whether the infant's 'quality of life' was considered to fall below some indeterminate minimal value - this being tantamount to a determination that it was in the infant's 'best interests' that life-sustaining treatment (including ANH⁶) be withdrawn;⁷ this, in turn, was considered to be both a legal and moral justification for the decision to withdraw life-sustaining treatment. Such cases concerned, at one extreme, anencephalic infants to, at the other extreme, cases of Down Syndrome infants with easily curable, but potentially fatal, abdominal obstructions.⁸ A secondary aim of this chapter is to show that the '*P-GD conceptual framework*' cannot only encompass the making of 'end-of-life' decisions for such severely disabled infants but that it can radically

¹ It utilises the concepts of '*consciousness*' (in that the absence of consciousness is considered to be of importance) and '*absolute quality of life*' (in that it sanctions 'absolute quality of life' judgements).

² See Conclusion 1.4: *There is no neurological test which will determine PVS patient consciousness.*

Conclusion 4.5: *A further reason for rejecting the assertion that consciousness is necessarily absent in PVS patients, is to be found in the fact that PVS is a syndrome rather than a unitary, theoretically coherent, medical condition; and that it lies on a continuum of conditions at one end of which is the Locked-In Syndrome.*

³ See the discussion in Chapter 7.

⁴ Strictly speaking 'absolute quality of life' judgements are not permitted in relation to *persons* (because they conflict with egalitarian principles) but are permitted in relation to '*Objects of Intrinsic Moral Worth*' - it is, for example, quite permissible to state of a dog (an '*OMW*' but not a '*person*') that they are better off dead.

See Conclusion 7.5: *There are at least two reasons why 'absolute quality of life' judgements should be rejected: they are unreliable and they are incompatible with the egalitarian principle that all persons be treated as equal. Furthermore 'absolute quality of life' judgements often function as a mechanism of denial so that situations which are unacceptable to the decision-maker are not permitted to continue.*

⁵ It has been so used by the English courts (see the discussion of such cases in Chapter 8, Section 2 of this thesis and in Appendix C); there is no reported case of its use by the Irish courts in a similar situation.

⁶ i.e. Artificial Nutrition and Hydration.

⁷ The 'quality of life' judgements which underlie such decisions are 'absolute quality of life' judgements; as such, they are impermissible (in respect of persons) within the '*P-GD conceptual structure*'.

⁸ See *Re B* (a minor) (wardship: medical treatment) [1990] 3 All ER 927 and discussed in Appendix C, case 7; in this case the decision of the Court of Appeal overturned the decision of the court at first instance which was that life-sustaining treatment be withheld.

For an ethical discussion of such cases see Foot *op.cit.* p.57.

distinguish between cases such as anencephaly and cases of Down Syndrome. An analysis based on 'absolute quality of life' (as in 'C-AQL conceptual structure') permits no such radical distinction because such cases are seen to lie on the same continuum differing only in degree and thus facilitating the development of a 'slippery slope'.

This chapter is composed of five sections:

- Section 1:* The elements which are required to formulate the 'P-GD conceptual structure' are briefly recapitulated.
- Section 2:* The 'P-GD conceptual structure' is explained, first in a simplified form which seeks to resolve the problem of medical decision-making simply in relation to the *individual* patient and ignores the concerns of the wider society in relation to, for example, the possible development of a 'slippery slope' and scarcity of resources. Some suggestions are then made as to how these wider social concerns can be incorporated into the 'P-GD conceptual structure'.
- Section 3:* The 'P-GD' conceptual structure is applied to medical decision-making in relation to PVS patients.
- Section 4:* The 'P-GD' conceptual structure is applied to medical decision-making in relation to anencephalic and Down Syndrome infants.
- Section 5:* Conclusions.

Section 1: The elements of the 'P-GD' conceptual structure: a recapitulation

This Section summarises the discussion in earlier chapters in relation to ten such elements.

1. A distinction made by Phillipa Foot

The foundation for the '*P-GD conceptual structure*' lies in a distinction made by Phillipa Foot in her discussion of euthanasia.⁹ Foot distinguished between the virtues of Justice and of Charity: 'Justice' has to do with what men owe each other in the way of non-interference and positive service: it is concerned with what a man has '*a right to*'. 'Charity', in contrast, is a virtue which attaches to the good of others: it is concerned with what a man has '*a need of*'.¹⁰

The primary obligation imposed by Justice is the '*right to be let alone*' and free from the interventions of others. The primary obligation imposed by Charity is to act in the '*best interests of*' - or '*for the sake of*' - another. Foot argues that one may have obligations to another flowing from Justice or from Charity or from both but that, in case of conflict, the obligations imposed by Justice take precedence.

I have argued - taking the example of someone who rescues an apparently drowning man¹¹ - that Foot's assertion that the obligations of Justice always take precedence over Charity is too broad and must be amended; I have proposed a '*Principle of Minimal Intervention*'.

Foot's final conclusion was that not only should Charity yield to Justice but that, on occasion, the requirements of Justice should yield to the requirements of the wider society;¹² this can also be

⁹ A synopsis of Foot's arguments on euthanasia is set out in Appendix D; her argument is also discussed in the Introduction to Part 3.

¹⁰ This distinction allows Foot to separate the '*goodness*' of a proposed action from its '*oughtness*'; '*goodness*' being a necessary, but not sufficient, condition for the performance of the action.

expressed by saying that Justice has two aspects: an *individual* aspect 'Justice_i' and a *social* aspect 'Justice_s' and that whilst 'Charity' must yield to 'Justice_i', 'Justice_i' itself must, on occasion, yield to 'Justice_s'.¹³

2. Principle of Minimal Intervention

Principle of Minimal Intervention states:

"In cases where communication is not possible and where it is reasonable to assume that had communication been possible the intervention would be requested, then the intervention is justified provided it is performed in the 'best interests' of the individual and is the minimum intervention required to preserve the situation until such time as communication can be restored."

3. The term 'Object of Intrinsic Moral Worth'¹⁴

Those to whom obligations are owing based on Justice are called '*persons*' and they are said to possess '*rights*'.¹⁵ A term is needed to describe those to whom obligations are owing which flow from Charity and I have proposed the term '*Objects of Intrinsic Moral Worth*'.¹⁶ The criterion for an individual being considered to be an '*OMW*' is that consciousness has been ascribed to that individual.¹⁷

In summary, '*persons*' are individuals to whom obligations are owing from both Justice and Charity; '*OMW*'s are individuals to whom obligations are owing from Charity but not from Justice.

4. A necessary condition for the ascription of 'personhood'

I have argued that an ability to communicate with an individual is a necessary condition for the ascription of 'personhood' to that individual and, furthermore, that the *level* of communication required is at least that which is sufficient to determine whether the individual consents to a proposed intervention.¹⁸ I have also argued that the concept of 'personhood' (with the entitlement to exclusive ownership of 'rights') is too much an 'all or nothing' concept and that it does not encapsulate the complexities associated with the ascription of rights in modern society. Accordingly I have introduced the concept of '*attenuated personhood*' to allow for the inclusion into the analysis of individuals who, though they have not a present ability to communicate, have - it is believed - a possibility of achieving such an ability in the future; examples of such individuals are infants, temporarily unconscious patients and the insane. Attenuated personhood confers a right on an

¹¹ In Chapter 10, Section 5.

¹² Foot applied this latter principle in discussing '*assisted suicide*', where she argued that to yield to a request from a dying patient that they be killed, although in accordance with Charity (the dying patient being in severe pain so their killing could certainly be 'for their sake') and Justice (the patient having requested their own death, their killing would not offend Justice) might nevertheless offend against the wider interests of society in that it could occasion a 'slippery slope' leading to a wider acceptance of killing which would be socially harmful. (Foot *op.cit.* p.59)

¹³ I wish to thank Dr. Dolores Dooley for this suggestion.

¹⁴ See the discussion in the introduction to Chapter 10.

¹⁵ See the arguments for proposition (U) set out in Chapter 10.

¹⁶ '*OMW*'s for short.

¹⁷ There is no *logical* requirement that this particular criterion be chosen but it appears to be standard.

¹⁸ See Conclusion 10 - 18: *In stating that the ability to communicate is a necessary condition for the ascription of 'personhood'; the level of communication required is at least that which is sufficient to determine whether the patient consents to a proposed intervention. Furthermore, the standard required in determining that a patient lacks the ability to communicate is indicated by the fact that an erroneous determination that such an ability was lacking is, if negligently made, morally equivalent to a wrongful killing.*

individual not to be killed even if this is universally regarded as being in their 'best interests'; no other rights are conferred.¹⁹

An individual whose inability to communicate is judged²⁰ to be permanent can neither be ascribed 'personhood' nor 'attenuated personhood';²¹ the only obligations that exist towards them arise from Charity; they are owed no obligations arising from Justice.²² Accordingly, all decisions affecting such individuals should be made on a 'best interests' basis.

5. Is the withdrawal of ANH an 'intervention' for the purposes of Justice?²³

Because the withdrawal of ANH features so prominently in the cases to be discussed it is important that its status be clarified - is it to be classified as an 'intervention' which would, if performed on a 'person', require their consent? What is Foot's view? Does Foot - in arguing that Justice prohibits non-consensual interventions in the life of a 'person' - intend this prohibition to apply only to 'acts' as distinct from 'omissions'?

Foot argues that the crucial distinction is not that between 'act' and 'omission' but between 'active' and 'passive'; for example 'active euthanasia' can encompass not only acts but omissions:

*"... the word 'act' is not to be taken to exclude omission: we shall speak of an act of euthanasia when someone is deliberately allowed to die, for his own good, and not only when positive measures are taken to see that he does. The very general idea we want is that of a choice of action or inaction directed at another man's death and causally effective in the sense that ... it is a sufficient condition of death."*²⁴

Foot does, however, distinguish between 'withdrawal of treatment' and 'active euthanasia':

*"But the act of turning off a respirator should surely be thought of as no different from the decision not to start it; ... and both should be counted as passive rather than active euthanasia ... The point seems to be that interference in a course of treatment is not the same as other interference in a man's life, ..."*²⁵

¹⁹ See Conclusion 10 - 21: The principles outlined in Chapter 10 concerning obligations to others are:

- * Obligations to others flow either from Charity or from Justice.
- * Obligations flowing from Justice take precedence over obligations flowing from Charity subject only to the 'Principle of Minimal Intervention'.
- * The obligations to an individual flowing from Charity arise because of the ascription of consciousness to that individual; such individuals are known as 'Objects of Intrinsic Moral Worth'.
- * The obligations to an individual flowing from Justice arise because of the personhood of that individual.
- * It is a necessary condition for the ascription of personhood to an individual that communication be possible with that individual.
- * It is a necessary condition for the ascription of rights to an individual that they have personhood.
- * Individuals who are likely to achieve an ability to communicate or who once had such an ability and for whom there is some possibility that it may be regained, have an 'attenuated personhood'.
- * Attenuated personhood confers a right on an individual not to be killed even if this is universally regarded as being in their 'best interests'; no other rights are conferred.

²⁰ Bearing in mind that an erroneous determination, negligently made, is morally equivalent to a wrongful killing.

²¹ This conclusion depends on an acceptance of Wittgenstein's 'Private Language Argument'; see Chapter 10.

²² See Conclusion 10 - 22: The assertion that all decision-making in relation to a patient who has permanently lost the ability to communicate, should be on the basis of the patient's 'best interests', necessarily entails that such a patient has lost their personhood.

Conclusion 10 - 23: On the understanding that the obligations flowing from Charity are not diminished solely by reason of the loss of personhood, it can be asserted that a loss of the ability to communicate which is judged to be permanent entails a loss of personhood.

²³ This discussion draws on the earlier discussions in Chapter 6, Section 3, Subsection 1; Chapter 7, Section 3, Subsection 2 and Chapter 8, Section 2.

²⁴ Foot *op.cit.* p.34.

²⁵ *ibid.* p.48.

This would suggest that, to Foot, withdrawal of ANH is not 'interference' and is permissible if carried out 'for the sake of' the individual (thus, being in accordance with Charity). This interpretation accords with her view of the withdrawal of life-sustaining treatment from Down Syndrome infants:

*"That they²⁶ are deliberately allowed to die is certain ... even in the case of children with Down's Syndrome who have intestinal obstructions the relatively simple operation that would make it possible to feed them is sometimes not performed. Whether this is euthanasia in our sense or only as the Nazis understood it is another matter. We must ask the crucial question, 'Is it for the sake of the child himself that the doctors and parents choose his death?' ... The fact is, of course, that the doctors ... are usually thinking not of them but rather of their parents ... or of 'the burden on society' ... It must in any case be insisted that if children with Down's Syndrome are deliberately allowed to die this is not a matter of euthanasia except in Hitler's sense, ... "*²⁷

Foot bases her objection to the non-treatment of such Down Syndrome infants - and presumably to the withdrawal of ANH in similar cases - on the fact that the obligations flowing from *Charity* are ignored; her analysis ignores the obligations flowing from *Justice*.²⁸ Thus, if a physician honestly believed that to withhold life-sustaining treatment from a Down Syndrome infant was in the infants 'best interests' then presumably - although his *judgement* might be criticised - the *morality* of his behaviour could not be impugned. This is the Achilles heel of Foot's analysis; it seems that to her the withholding of life-sustaining treatment from an anencephalic infant, foreseeably resulting in their death, is indistinguishable from a similar course of action in the case of a Down Syndrome infant provided only that the 'best interests' of the infant is the paramount consideration. Such an analysis would also imply that in cases where communication is not presently possible - such as, for example, in the case of patients who were temporarily unconscious or insane - a 'best interests' test would be appropriate for *all* medical decision-making even for those decisions which foreseeably resulted in the death of the patient. This has the result that the obligations flowing from *Justice* can be ignored in precisely those cases where it is most necessary²⁹ that they be honoured.

Foot's analysis could be saved by incorporating the concept of 'attenuated personhood' (*supra*) and the principle that:

P: If an individual has either 'personhood' or 'attenuated personhood' then procedures whose goal (whether to be achieved by act or by omission) is the death of that individual are impermissible without their consent because they contravene the obligations of Justice.

This principle asserts nothing other than that if an individual has a 'right to life' then procedures which *aim* to deprive him of that life are impermissible irrespective of whether death results from 'acts' or 'omissions'. This principle does not preclude procedures where the death of an individual is foreseen as a possible but unwanted side effect (as when, for example, the giving of morphine for purposes of pain relief may result in the death of a patient) or even procedures which necessitate the death of an individual, provided such is not the desired result.³⁰

²⁶ *i.e.* infants with mental or physical defects.

²⁷ *ibid.* p.56-7.

²⁸ Foot does discuss the impossibility of communicating with such children and canvases the possibility of a guardian being appointed to give consent; however, the 'consent' that is envisaged relates not to non-treatment but to the giving of a lethal injection.

²⁹ Because the patient's present inability to communicate precludes them arguing their case.

³⁰ However Professor Andrew Grubb - in an article entitled 'When is it just to kill a Siamese twin so that the other might live?' [The Times 12-9-00] - states:

What is (usually) the goal in withdrawing ANH? It is indeed possible that in some circumstances the goal is to remove the discomfort of the tube feeding; such cases are, however, not the norm. Imagine an invention which permitted tube feeding to be withdrawn from a patient but such that the patient could still obtain nourishment painlessly from a patch placed on the skin.³¹ Would such a procedure be used in respect of PVS patients? Would it be used in respect of the Down Syndrome infant (spoken of by Foot) who was unable to feed? I suggest that it would clearly not be used. This thought experiment allows us to conclude that the goal of such procedures is the death of the patient.³²

Thus, Foot's conclusion - i.e. that Justice prohibits intentional killing even if this be solely 'for the sake' of the individual killed - must be amended to read:³³

Conclusion ¹¹⁻¹: *The virtue of Justice prohibits not only the intentional killing of an individual but also procedures (whether by act or omission) which have the death of the individual as their goal.*

6. 'Absolute quality of life' judgements³⁴

'Incremental quality of life' judgements are quality of life judgements which seek to estimate the change in the quality of life of a patient ascribable to a proposed medical intervention; the understanding being that the intervention should be performed if, and only if, this change is positive.³⁵

"The so-called 'doctrine of double effect', whereby an undesired bad consequence of a doctor's action may be excused if incidental to achieving a good outcome, does not apply when the bad consequence is a moral certainty and which the law takes to be intended."

³¹ A similar thought experiment allows us to distinguish between cases where *death is a certainty* and cases where *death is the goal* of a procedure: consider cases of ectopic pregnancy where the mother's life is endangered by the pregnancy. The procedure usually undertaken necessarily results in the death of the foetus; imagine an invention which allowed the mother's life to be safeguarded whilst allowing the pregnancy to continue; such an invention would obviously be used in such cases, thus showing that whilst the death of the foetus may, at present, be the necessary consequence of the current medical procedure, it is not its goal.

See Chapter 7, Section 3, Subsection 2 for a fuller discussion of this problem.

³² See also Teresa Iglesias, 'Ethics, Brain-Death, and the Medical Concept of the Human Being,' *Medico-Legal Journal of Ireland* (1995) at p.57:

"The intent in the deprivation of nourishment is to bring about death, which means to kill. I cannot interpret this but as euthanasia." [emphasis in the original]

See also the earlier discussion (Chapter 8, Section 2) of a reported case concerning the withdrawal of syringe feeding from a patient who was not PVS: *Re R (Adult: Medical Treatment)*. (Appendix C - number 11). 'R' was a 23 year old who had been born with a serious malformation of the brain and with cerebral palsy; he was unable to chew and his food was syringed into the back of his mouth. The original court application had sought permission to withhold life sustaining treatment including ANH (i.e. the syringe feeding) though this was subsequently amended to a request for permission to insert a gastrostomy tube; the court granted this permission on the implicit understanding that an application to remove the gastrostomy tube might subsequently be made.

This application to the court appears, on its face, to be designed to manipulate the facts of the case in order that they fit the accepted legal categories for withdrawal of ANH.

³³ This may not be as great an amendment to Foot's position as it appears, because whilst it undoubtedly helps resolve the problem posed by the Down Syndrome infant (unlike Foot's analysis) it seems to reemphasis the point noted in Appendix C that:

"The distinction made by Foot, between active and passive euthanasia is not that between act and omission with which it is often confused. Active euthanasia is the positive choice of a behavioural strategy - whether act or omission - which is sufficient to result in death. Thus, the killing of a man by a lethal injection and the refusal to give him a life saving drug when under a duty to do so, are both examples of active euthanasia."

Foot seems not to have applied this distinction in her discussion of the Down Syndrome infant; it is possible that she believes that the doctor has a duty in such cases to the parents but that he owes no duty to the infant.

³⁴ See Chapter 7 particularly Conclusion 7-2

³⁵ For reasons of simplicity, expected changes in the 'life expectancy' of an individual due to an intervention - as distinct from changes in their 'quality of life' - have been ignored in the present discussion; the incorporation of life expectancy does not appear to present any special theoretical difficulties, though much further work is needed to examine how this be best accomplished practically. Some results recently published in the *Journal of the American Medical Association* suggest that life expectancy is of greater importance to the aged than quality of life; in examining the result of a survey of the aged only a modest correlation was found between health values and quality of life:

"Although only 30 per cent of patients rated their current quality of life as excellent or very good, over 68 per cent were willing to give up, at most, one month of 12 in exchange for excellent health."
[Reported in the Irish Times 4-2-1998]

'Absolute quality of life' judgements are quality of life judgements which seek to estimate the total quality of life of a patient; the understanding being that if this quality of life is minimal then life-sustaining medical treatment should be withheld and the patients allowed to die.

It was argued in Chapter 7 that the use of 'absolute quality of life' judgements conflict with accepted norms of equality. Because these norms are based on the virtue of Justice, 'absolute quality of life' judgements may not be used in relation to 'persons'; no such prohibition exists in relation to 'Objects of Intrinsic Moral Worth'.

7. The resolution of doubt in medical judgements

The process by which doubt in medical judgements is resolved was discussed in Chapter 5 and the conclusion was reached that judging on the basis of probability (*i.e.* choosing the most probable hypothesis) was not appropriate; the consequences of making possibly incorrect choices must be examined and the choice made so that these consequences (weighted in proportion to their probabilities) be minimised.³⁶ The example given was that of determining whether to attempt to rescue some people who had been trapped in the ruins of a building destroyed by an earthquake (it being accepted that they were most probably dead); the proposed principle would imply that the most probable hypothesis (*i.e.* that there are no survivors) should not be accepted but rather the consequence of acting as if there were survivors (when there were, in fact, no survivors) should be compared with the consequences of acting as if there were survivors (when there were, in fact, no survivors).³⁷

Because of the level of doubt implicit in diagnosis of PVS (the misdiagnosis rate for PVS is close to 50%)³⁸ it follows that PVS patients should be treated as *if* they are conscious and can experience pain; this is because the consequences of treating an individual PVS patient as being able to experience pain - when, in fact, he cannot - are slight when compared with the consequences of treating him as being unable to experience pain, when in fact he can.³⁹

8. The attribution of consciousness and ability to experience pain

The attribution of consciousness - or an ability to experience pain - to another is often thought of as a purely scientific judgement. It is not.⁴⁰ At best, correlates of pain can sometimes be studied but even this is not possible in the case of PVS patients.⁴¹

³⁶ See Conclusion 5.2: *Acting on the basis that those circumstances which are most probably true, are true, does not ensure that the unwished for consequences that flow from a (then unknowably) incorrect choice are minimised. In such cases an index should be compiled of the probabilities of various eventualities, weighted in proportion to the magnitude of their respective unwanted consequences, and the eventuality be chosen which corresponds to the minimum index. In short, the decision procedure to be adopted in such cases of incomplete knowledge, is that one should act so that the unwished-for consequences that flow from a (then unknowably) incorrect choice are minimised.*

³⁷ An example of the use of such a principle is provided by the current medical practice in relation to the disposal of hypodermic syringes (in view of the danger of AIDS being transmitted): because the consequences of treating a syringe as not-infected (when, in fact, it is infected) so greatly outweigh the consequences of treating a syringe as infected (when, in fact, it is not infected), all syringes are treated as infected. Treating only those syringes as infected which were most probably infected, would not be considered to be an appropriate practice.

³⁸ See Conclusion 4.12: *The best estimate for the rate of misdiagnosis of PVS is of the order of 50%. This implies that the diagnosis of PVS is essentially a random process.*

³⁹ See Conclusion 5.5: *All patients diagnosed as PVS, should be treated as if they are conscious and can experience pain.* The phrase 'as if' is used not in the sense of suggesting a pretence, but rather in the sense of suggesting that in the face of incomplete knowledge as to which PVS patients are conscious - and some undoubtedly are - all should be treated as if they were conscious.

⁴⁰ In Chapters 1 and 3.

see especially:

* Conclusion 1.2: *There is no area of the brain, and no specific brain activity, that is uniquely associated with the possession of consciousness.*

* Conclusion 1.4: *There is no neurological test which will determine PVS patient consciousness.*

Wittgenstein's and Dennett's analysis of pain judgements⁴² show that what is most crucial in attributing consciousness and an ability to experience pain to another, is the *attitude* that is adopted to that other and such is not susceptible to proof.⁴³ Wittgenstein expresses this point succinctly:

*"My attitude towards him is an attitude towards a soul. I am not of the opinion that he has a soul."*⁴⁴

And again:

*"Look at a stone and imagine it having sensations. ... And now look at a wriggling fly and at once these difficulties vanish and pain seems to be able to get a foothold here, where before everything was, so to speak, too smooth for it."*⁴⁵

The attitude to another that allows consciousness (or an ability to feel pain) to be attributed to them flows from having *empathy* towards them;⁴⁶ the (erroneous) belief that consciousness and pain are susceptible to a fully scientific determination is of considerable *negative* importance in that a statement such as that '*PVS patients cannot experience pain*' can - unless it is seen for the pseudo-science that it is - destroy the empathy which naturally arises.⁴⁷

* Conclusion 1 - 6: *There are theoretical limits to the determination of necessary and sufficient conditions for the ascription of consciousness. Any attempt by science to assert that particular criteria are both necessary and sufficient for ascribing consciousness is unwarranted.*

* Conclusion 3 - 2: *As yet, no particular areas of the brain have been identified, damage to which, or whose inactivity, is uniquely associated with PVS.*

* Conclusion 3 - 3: *Excepting cases where all brain activity is absent, there are no areas, or processes, of the brain that can be uniquely associated with the experience of pain to the extent that the non-activation of these areas, or the absence of these processes, would justify the conclusion that pain is not present.*

* Conclusion 3 - 4: *In PVS there are no areas, or processes, of the brain that can be uniquely associated with the experience of pain to the extent that the non-activation of these areas, or the absence of these processes, would justify the conclusion that pain is not present.*

* Conclusion 3 - 7: *'Pain' is not open to a purely scientific analysis. At best, correlates of pain can be studied but the validity of the correlation is not fully amenable to a scientific determination. This is particularly so when the ability to communicate is either non-existent (as in the case of animals) or is permanently lost (as in the case of PVS patients).*

⁴¹ Because of their inability to communicate in conjunction with the fact that brain functions are often redistributed subsequent to brain damage. See Chapters 1 and 3.

⁴² See Chapters 3 and 10.

⁴³ Guy Robinson, *Philosophy and Mystification* p.198:

"My attitude is a matter of my whole demeanour toward him involving the rights and duties and customs of my culture. Not something that is simply true or false like an opinion, a matter for argument and proof. Paradigms, attitudes, and ways of looking are not matters of proof and disproof."

⁴⁴ Wittgenstein PI-II (iv), p. 178e.

⁴⁵ Wittgenstein PI-1 § 284.

⁴⁶ See Conclusion 3 - 9: *The question 'Is X in pain?' consists of, in fact, two questions:*

"Is X a suitable candidate for a pain judgement?" - i.e. does he belong to the class to whom pain is (normally) ascribed?

"If X is a suitable candidate, is X in pain?"

Conclusion 3 - 10: *A candidate for a pain judgement is an appropriate candidate if it has the capacity to engender empathy, or, equivalently, if it possesses consciousness. The term 'capacity to engender empathy' is to be preferred in that it - unlike the term 'consciousness' - lays no claim to a spurious scientific rigour.*

Conclusion 10 - 14: *An initial leap of empathy is a precondition for seeing another as a fitting subject for possessing rights, for being an 'Object of Intrinsic Moral Worth' or for possessing the ability to communicate; this gesture of empathy is not a product of rational determination but flows from the adoption of an 'attitude'. It is the gesture of 'seeing oneself in another' that enables 'personhood' to be conferred on that other; conversely, the refusal to 'see oneself in that other' precludes the attribution of 'personhood'.*

⁴⁷ J F Miller III [*'Wittgenstein's Weltanschauung'*, *Philosophical Studies*, (1964)] helps clarify some of these issues. Miller points out that:

"It is part of Wittgenstein's methodology to show what remarks are merely grammatical, that is, having justification in language usage rather than on scientific grounds, and which are not. A remark like 'All objects are coloured and have extension,' is purely grammatical: it merely means that what we call objects are in all cases extended and coloured. Science could not dispute the sentence, for to do so would be to deny that we do call coloured and extended things 'objects' which is certainly the case." [op.cit. p.130; emphasis in the original]

Later, Miller discusses Wittgenstein's remark that we can ascribe pain only to that which behaves like a human being:

"Immediately thereafter, he says that we would not ascribe pain to a corpse or to a stone. Here he is acknowledging and recommending a Weltanschauung, namely that world-view which is prevalent in our own present day Western Society. For if we interpret this remark about pain as saying that inanimate objects and the dead have no feelings, we are openly adopting a particular world-view." [op.cit. p.134; emphasis in the original]

The conclusion to be drawn is that the categories to which pain may be ascribed is part of the *grammar* of 'pain' and *not* a subject for *scientific* investigation. Science in so far as it discusses pain must work *within* the given grammar. Hence, the question of whether PVS patients can experience pain is primarily a grammatical question - or better, a question of the *attitude* that is adopted to PVS patients - and only secondarily is it a scientific question.

See also Rush Rees *Discussions of Wittgenstein* at p.59:

9. The concept of 'a good death'

The question of whether the proposition '*Death is an evil*' is true, was the focus of Chapter 9 and the conclusion was reached that, *if unqualified*, the proposition is not sustainable; it follows that some deaths are a 'good'.⁴⁸ What obligations are imposed on others in relation to such deaths?⁴⁹

In considering whether a prospective death is 'a good death' for another it is important to distinguish between those who have the present ability to communicate, those with whom communication may be established and those who have permanently lost the ability to communicate. The first have the status of '*personhood*', the second of '*attenuated personhood*' and the third of '*Objects of Intrinsic Moral Worth*'; different types of obligations are owed to each of these groups.⁵⁰ The obligations on others to ensure that an individual achieves 'a good death' are implied by Charity (*i.e.* to act *for the sake of* another) but may be prohibited by Justice (if such interventions are unwanted). This implies that the primary obligation on carers is to attempt to communicate with the patient to determine their wishes; the occasioning of the death of a patient in the face of his objections could not be 'a good death'.⁵¹

The next question relates the timing of 'a good death': when, in relation to an individual patient, is it appropriate to consider such questions?⁵² Callahan argues that:

*"[it is] ... increasingly useless to base decisions concerning whether to terminate treatment on some medical determination that the patient 'is dying'. ... The old question was: when is a patient dying, and thus a candidate for the abatement of lifesaving treatment? The new question should be: at what point, or within what range, should lifesaving treatment be abated to enhance the likelihood of a 'a good death'?"*⁵³

I have earlier used the phrase '*entered on the threshold of death*' - *i.e.* that death is 'on the agenda' - in place of the phrase '*is dying*'; I believe that this meets Callahan's objections.

Callaghan has suggested that:

"When I say the dog is in pain I am not describing what the dog is doing, any more than I describe what I am doing when I give expression to pain. It is more like an expression of pity. At any rate, feeling pity, trying to ease him and so on - or perhaps turning away from the sight - is all part of believing that he is in pain. And to say that I was obviously justified in that - or maybe that I was mistaken - is a different sort of thing from saying that I was justified or mistaken in believing that he had a fracture."

⁴⁸ Such a death is called 'a good death'.

cf. Conclusion 9 - 15 : As the proposition '*Death is an evil*' (simpliciter) cannot be justified on either logical or psychological grounds, it is not sustainable. It follows that some deaths are a 'good'.

⁴⁹ The writings of Elizabeth Kübler-Ross and Daniel Callahan who have both written extensively on this subject, have been discussed in Chapter 9.

⁵⁰ See Conclusion 9 - 18 : In considering whether a prospective death is 'a good death' for a patient who has entered onto the threshold of death (*i.e.* one for whom death is an immanent possibility) it is important to distinguish between those patients who have the present ability to communicate, those with whom communication may be established and those who have permanently lost the ability to communicate.

⁵¹ Callahan, speaking of the necessity of communication in relation to 'a good death', says:

"If it is carried out without the informed consent of the patient, it is a basic offence against that person's dignity ... the desire for a peaceful death does not override such obligations."

[Daniel Callahan, *The Troubled Dream of Life: Living with Mortality*, p.203]

See Conclusion 9 - 16 : In stating that 'a good death' is a good, the obligations imposed on third parties are strictly circumscribed.

Conclusion 9 - 17 : The primary obligation on the carers of a patient who has entered onto the threshold of death is to attempt to communicate with the patient. Medical carers should desist from a proposed intervention if contrary to the patient's wishes and, in particular, the occasioning of the death of a patient in the face of his objections could not be 'a good death'.

⁵² See Conclusion 9 - 19 : The acceptance of human mortality implies that medical carers must, in treating a patient who has entered onto the threshold of death, consider whether - in postponing the particular death - a 'better death' is more likely. The particular circumstances of the patient and their family are of crucial importance to any such evaluation. If it is deemed that a better death is unlikely then the immanent death (termed 'a good death') is a positive good in the sense that there is a moral obligation on the medical carers to attempt to achieve that death for their patient and to do so in a manner that is in as harmonious as is possible with the patient's interests. 'A good death' is to be distinguished from a 'a least worse death' which connotes no such positive moral obligations.

⁵³ Callahan *op.cit.* p.44-46.

“... once a potentially fatal illness appears, it be considered seriously as the candidate for the cause of death, if other conditions of the timing and circumstance of death are acceptable.”⁵⁴

And that:

“Death is acceptable ... when it comes at a point in life when

- (i) further efforts to defer dying are likely to deform the process of dying, or when
- (ii) there is a good fit between the biological inevitability of death in general and the particular timing and circumstances of that death in the life of the individual.”⁵⁵

A death in such circumstances is not only morally acceptable but is a moral good.⁵⁶

The question of whether a death occasioned by the withdrawal of food could be ‘a good death’ was also considered;⁵⁷ such deaths are often described disparagingly as ‘death by starvation’ with the implication that they are an ‘evil’. However, death by withdrawal of food (or more accurately, by cessation of eating) is often the method of dying chosen by those who ‘will’ their own deaths. Because such persons are often said to die with great composure, it is permissible to draw the conclusion that death by the withdrawal of food (and, *a fortiori*, of ANH) is not necessarily destructive of ‘a good death’.

10 The ‘slippery slope’ as experienced in Germany in the inter-war years

Many deny the relevance of the Nazi ‘euthanasia’ programme to current bioethics debates but the German experience was of such horrific proportions that such claims cannot be allowed to go unexamined.

Those who argue that the Nazi experience of euthanasia was *sui generis* and, as such, irrelevant to current debates assert either:

- * that Nazi euthanasia developed from, and depended on, a racist and anti-Jewish belief system which was peculiar to Nazism and has no counterpart in today’s western democracies; or
- * that it involved especially cruel practices of a patently obvious immorality and utterly distinct from proposals currently being advocated.

These arguments have been examined in Appendix E (which sketches the intellectual climate leading to the introduction of euthanasia in Germany and its development under the Nazis). Before examining the conclusions of that appendix it may be of interest to see how some modern bioethicists treat this question of relevance.

⁵⁴ *ibid.* p.199.

⁵⁵ *ibid.* p.180.

Callahan believes that death can be deformed in three ways:

- by ‘deforming the process of dying itself’ - as in technological brinkmanship which can ‘both save life and ruin dying’ as when it results in extended loss of consciousness;

- by ‘deforming the dying self’ - as with obsessions with loss of control or loss of image.

- by ‘deforming the community of living’ as when community life is distorted thorough the denial of death or through doctrines that certain lives are not worth living. [*ibid.* p.192]

⁵⁶ *ibid.* p.200:

“I call such a death a ‘moral good’ because it allows us to achieve important personal as well as social ends.”

⁵⁷ In Chapter 9, Section 3 particularly in the discussion preceding Conclusion 9 - 21. which states:

Death by withdrawal of food - and a *fortiori* withdrawal of ANH - is not necessarily destructive of ‘a good death’.

Nazi Euthanasia - some views as to its relevance to current debates

All moral blame serves two purposes: the obvious one of condemnation, but a much more subtle and dangerous one of fuelling self-righteousness - of suggesting that we, who condemn, could never be involved in the practices which we condemn. Edmund Pellegrino in a recent Editorial in The Annals of Internal Medicine notes that adopting such attitudes allows us the smugness of believing that:

*"So obvious these moral lessons seem now, and so gross the malfeasance, that it seems redundant to revisit them. Certainly we do not need to study such gross moral pathology that could never happen again. That is a dangerous conclusion. ... These lessons must be repeatedly relearned. They are pertinent to other contexts and other issues in today's intensive bioethics debate."*⁵⁸

There is a hint of such complacency in the all too easy dismissal by Margaret Pabst Battin, for example, of the link between the scarce resources argument - as often currently formulated - and as formulated in Nazi Germany. Speaking of the current scarce resources argument, she says:

*"It is important to note that this is not the same as the 'useless eaters' argument advanced by the Nazis as grounds for the destruction of mentally retarded persons and others, though it would have been applied in some of the same cases. The 'useless eaters' argument does not assert that the use of resources is not of benefit to the person in question; it asserts that this use of resources is not of benefit to others in the sense that the person in question is 'useless' to society. There is no issue in the current question about whether the Alzheimer's patient is 'useful' to others, but instead about whether the resources are useful to him or her."*⁵⁹

Firstly, this assumes that the Nazi argument in favour of euthanasia was a simple utilitarian one, but as we shall see,⁶⁰ it was not. Secondly, she confuses questions of *futility* - which can be discussed even if resources are not limited - and scarce resources. Her formulation of the scarce resources argument, *i.e.* not using that which confers no benefit, is an argument against waste and, as such, the existence of and, *a fortiori*, the strength of any competing claims to the resources is irrelevant. Furthermore, it seems incompatible with formulation of the scarce resource argument as used by such as Raanan Gillon (describing one of Professor Andrews' patients):

*"... recovered sufficient consciousness to smile at cartoons, to show pleasure when his wife was present and to show distress when she was absent. If resources were unlimited ... then the treatment should continue. But resources are severely limited, ... the cost to others is too great for its provision to be just or fair."*⁶¹

The conclusions drawn in Appendix E

- * Though the euthanasia programme undoubtedly set the stage for the anti-Jewish holocaust and is crucial for its understanding, the converse is not so. Neither racism nor antisemitism

⁵⁸ Edmund Pellegrino, 'The Nazi Doctors and Nuremberg: Some Moral Lessons Revisited', Editorial, Annals of Internal Medicine (1997) at p.307-8.

⁵⁹ Margaret Pabst Battin, The Least Worse Death, at p.151.

⁶⁰ See Appendix E.

⁶¹ Gillon (1993) at p.1603.

was a factor in the development of euthanasia in Germany; the full development of the child euthanasia⁶² programmes could have occurred even in the absence of Nazi racial policies.

- * Many involved in the euthanasia programmes were motivated, however misguided, by compassion. Friedlander mentions⁶³ that the doctors involved in the euthanasia programmes occasionally gave lethal injections to severely injured German soldiers, suggesting that any attempt to assert that the doctors were motivated solely by ill-will is untenable. The exemption of Jews from the 'mercy death' programmes - in the context of considerable anti-Jewish sentiment - is further evidence that these programmes were not perceived in terms of punishment or conferring disadvantage, but rather as conferring advantage.⁶⁴
- * Though euthanasia - as advocated by Binding and Hoche⁶⁵ - had some societal, or 'statist', aspect to it that might serve to distinguish it from current definitions of the 'right-to-die' - which stress personal autonomy and individual rights - this is more apparent than real.⁶⁶

These conclusions show that arguments to the effect that the development of euthanasia in Nazi Germany were *sui generis* and, accordingly, of no relevance to modern bioethical debates, cannot be sustained; indeed, a clear lesson can be drawn in relation to the ease with which 'slippery slopes' can develop from small, seemingly innocuous, beginnings:

*"Whatever proportions these crimes finally assumed, it became evident to all who investigated them that they all started from small beginnings ... it is important to realise that the infinitely small wedged-in lever from which this entire trend of mind received its impetus was the attitude towards the nonrehabilitable sick."*⁶⁷

Derr believes that the most important lessons to be drawn are:

"Lesson 1: What has happened, can happen. ...

*Lesson 2: If a culture adopts the practice of active euthanasia ... the killing should be done by nonphysicians and without physician involvement. ... It was Hippocrates' genius to realise that if medicine is to avoid playing the role of society's executioner, it must renounce killing utterly and without exception. The fatal error of German medicine ... was to think it could accept a little killing ..."*⁶⁸

⁶² The development of the adult euthanasia programme is more problematic in that it was, to some extent, justified in terms of 'racial purity'.

⁶³ Henry Friedlander, *The Origins of Nazi Genocide*, p.297.

⁶⁴ Mark Rothe [in his *Amicus Curiae* brief to the US Supreme Court in the case of *Vacco v Quill* (1996) at p.13] quotes Simon Wiesenthal as saying:

"The Nazis considered euthanasia a quasi-ethical sort of murder, and reserved it for members of their own kind."

See also Patrick G. Derr, *'Hadamard, Hippocrates, and the Future of Medicine: Reflections on Euthanasia and the History of German Medicine.'* 4 *Issues in Law and Medicine*, at p. 488:

"We know, for example, that the moral collapse of German medicine was not caused by antisemitism. Ironically, as Wertham has noted: 'Jewish mental patients, old and young, were strictly spared and excluded. The reason given was that they did not deserve the 'benefit' of psychiatric euthanasia. This lasted up to the second half of 1940.'"

⁶⁵ See Appendix E.

⁶⁶ Rothe (*op.cit.* p.7) comments:

"The distinction, however, may not be that sharp. Contemporary proponents of the 'right to die' do not rely exclusively on the autonomy, but on the perceived worthlessness of the lives in question, and the economic costs of sustaining them."

See also Derr *op.cit.* p.494:

"Still, it is worth remembering that the engine which drove the early moral transformation of German medicine was not the ideology of racial discrimination, but medical economics."

⁶⁷ Leo Alexander, *'Medical science under dictatorship'* *New England Journal of Medicine*, p.46.

⁶⁸ Derr *op.cit.* p. 491-4.

Section 2: The 'P-GD' conceptual structure

In this section the 'P-GD conceptual structure' is first developed in a simplified form which focuses on the interests of the individual patient, their family and their medical carers; the wider social interests being disregarded (*i.e.* the obligations to the patient arising from Charity and Justice_i are considered but not those arising from Justice_s);⁶⁹ this is undertaken Subsection 1.

A more complete form of the structure is subsequently developed which analyses the obligations flowing from Charity, Justice_i and Justice_s; this is undertaken in Subsection 2.⁷⁰

Subsection 1: The 'P-GD conceptual structure': the simplified version⁷¹

Step 1: *The need (in other than emergencies) to establish whether communication is possible.*

Other than in cases of emergency - which are discussed below - the medical carers' primary obligation before deciding on a treatment strategy⁷² for an individual patient is to seek to establish communication with that patient. The reason for this is that if the patient is in fact able to communicate - and is thus a 'person' with 'rights' and, in particular, the right to refuse treatment - then treatment given in the absence of consent is not justifiable either *legally* (being a trespass) or *ethically* (in that it contravenes the obligations of Justice).⁷³

The *level* of communication required is, in the present context, that which is sufficient to give, or to refuse, consent.⁷⁴

The *standard of diligence* required in judging that communication is not possible is based on the recognition that an erroneous determination can result in the rights of the patient being denied; furthermore, an erroneous determination that the ability to communicate is *permanently* lost is - if negligently made - morally equivalent to a wrongful killing.

Step 2: *The situation in regard to medical emergencies.*

This concerns situations where the effort to establish communication - and the consequent delay necessitated in so doing - may be detrimental to the life or health of the patient (the example given in the earlier discussion related to the saving of a drowning man without first seeking his consent). In law, such interventions are permissible under the legal doctrine of '*necessity*'; ethically, they can be justified under the '*Principle of Minimal Intervention*'.

It is important to recognise that it is *minimal* intervention that is justified by this principle so that, in particular, an intervention whose goal was the death of the patient could not be justified irrespective of how 'desirable for the patient's sake' this appeared to be; another way of stating this is that 'absolute quality of life' judgements are not permissible in such circumstances.

⁶⁹ Justice_i stands for Justice as understood in its individual aspect whereas Justice_s denotes its social aspect. See Section 1(1).

⁷⁰ It might appear that the likely social consequences would be already taken into account in any judgement as to the morality of an act, however what is at issue here is not the social consequences of an act, considered as an isolated act, but the different question of the social consequences of permitting a (moral) act to become an accepted practice; thus, for example, no moral objection might lie against an isolated act of drinking alcohol in a public place yet the permitting of such a practice to become common is open to social objection.

⁷¹ The development of the 'P-GD conceptual structure' is set out as a sequence of steps (as would be followed in making treatment decisions).

⁷² *i.e.* to either give, or withdraw, medical treatment.

⁷³ See Conclusion 10-9: *In taking health care decisions affecting a patient, the principal obligation imposed by the virtue of Justice is to attempt to communicate with the patient; this obligation overrides all obligations to the patient flowing from Charity.*

⁷⁴ See Chapter 10, Section 4.

Step 3: *Even the permanent loss of an ability to communicate does not, of itself, imply that consciousness - and the ability to experience pain - is absent.*

The grounds for the assertions that an individual lacks consciousness and the ability to experience pain have been exhaustively examined in Part 1⁷⁵ where it was shown that such assertions have an irreducible core of uncertainty.⁷⁶ Wittgenstein's great contribution to the analysis of such propositions was in his noting that such judgements are primarily to do with the attitude adopted to an individual; scientific issues being of purely secondary importance. Thus, the attribution of consciousness and the ability to experience pain to an individual patient depends primarily on whether one feels a present sense of empathy with them.

The main concern of this thesis is with PVS patients; it has been argued⁷⁷ that the level of doubt in connection with the diagnosis of PVS and the consequences of incorrectly judging any patient as being unable to experience pain (when contrasted with the consequence of incorrectly judging any patient as being able to experience pain) justifies the conclusion:

Conclusion 5.5: *All patients diagnosed as PVS should be treated as if they are conscious and can experience pain.*

In this regard, K+bler-Ross tells an apposite story:

*"Mrs F was a terminally ill and severely debilitated Negro woman who lay in her bed for weeks, motionless. Looking at her dark-skinned body in those white bed sheets reminded me in a gruesome way of tree roots. Due to her crippling disease, it was hard to define the outline of her body or her features. ... The patient had had a stroke recently and was unable to speak; she was also unable to move any limbs, and it was presumed that her mind was no longer functioning. ... maybe it was just an old habit of mine to keep my patients informed of what was going on. I told her I was taking her daughter away for a while ... The patient looked at me and I understood two things: First, she was fully aware what was going on in her environment, in spite of her apparent inability to communicate; the second, and unforgettable lesson, was never to classify anybody as a so-called vegetable even if they appear to be nonreactive to many stimuli."*⁷⁸

In the analysis to follow it is necessary to distinguish between three situations:

- A:** where communication is believed to be presently possible;
- B:** where communication is not presently possible but is expected to be possible at some future stage; and
- C:** where it is believed that communication is permanently impossible.⁷⁹

⁷⁵ In Chapters 1, 2, 3 and 5.

⁷⁶ See also Section 1(8) *supra*.

⁷⁷ In Chapters 4 and 5.

⁷⁸ K+bler-Ross (1970), p.144 [emphasis added].

⁷⁹ The steps are labelled in accordance with the relevant category.

A: Where communication with the patient is believed to be presently possible

Step 4A: The need to obtain consent to a proposed intervention.⁸⁰

The need to obtain consent does not imply that in *all* situations it is necessary to obtain an *explicit* verbal consent: the road accident victim (who, let us assume is able to communicate) does not need to be explicitly asked for consent for permission to apply a tourniquet to stop his bleeding; consent - as in so many other areas of life - can be read from demeanour and from many of the other clues that we, as humans, are well used to interpreting.⁸¹ The important principle to recognise is that to treat a person without their consent - even in situations where the proposed treatment is unanimously agreed to be in their 'best interests' - is a denial of their 'personhood', this is especially so if against their express wishes. The argument against medical paternalism is based not on utilitarian grounds - quite the contrary, to insist on the need for consent may hinder medical efficiency and may result in 'inappropriate' medical treatment - but on the requirements of Justice,⁸² this point is well expressed in Foot's comment that:

*"It is important to emphasise that a man's rights may stand between us and the action we would dearly like to take for his sake"*⁸³

Step 5A: All treatment decisions should be made on an 'incremental quality of life' basis; 'absolute quality of life' judgements are prohibited;

The decision whether or not to give treatment to an individual must (if it is to accord with Charity) be in his 'best interests'; this implies either that his quality of life will be improved by the treatment (an 'incremental quality of life' judgement)⁸⁴ or that his quality of life is so poor that he should be 'allowed' to die (an 'absolute quality of life' judgement).

'Absolute quality of life' judgements are prohibited for patients with whom communication is believed to be presently possible⁸⁵; such patients are 'persons' and are entitled to all the rights of persons including the 'right to life'; this implies - as has been argued earlier⁸⁶ - that *all* strategies (whether by act or omission) which have the death of the patient as their goal are impermissible if activated without the consent of the patient. What of the 90 year old patient who gets pneumonia?

⁸⁰ See Conclusion 10 - 10 : *To take health care decisions for a patient without first attempting to communicate with the patient in order to determine their wishes, is in effect a denial of their 'personhood' and this is so even if all such decisions are taken solely on the basis of what is believed to be in the patient's 'best interests'.*

⁸¹ Such interventions might also be justified under the 'Principle of Minimal Intervention' (*supra*).

⁸² A recent report in the *Journal of the Royal Society of Medicine* [as reported by the Science Editor of The Times (31-7-2000)] found that the practice of administering medication to older patients by hiding it in their food, was widespread; "They found that in ... 71% [of the nursing homes surveyed] senior nursing staff admitted that medicines were sometimes administered covertly."

Such practices clearly contravene the requirements of Justice in that they ignore the obligation to obtain consent. However, in that many of the patients suffered from dementia, they might not have a present ability to communicate rationally and accordingly might have an 'attenuated personhood'; in such circumstances a 'best interests' basis for medical decision making is appropriate (the role of Justice being simply to prohibit interventions whose goal is the death of the patient). This exercise shows that the proposed 'P-GD conceptual structure' permits a more refined analysis of certain problems than do existing conceptual structures.

⁸³ Foot *op.cit.* p.49.

see also Conclusion 10 - 4 : *The right to be let alone can be analysed into:*

(i) *the right to be free from 'non-beneficial' interference; this right flows from both Charity and Justice.*

(ii) *the right to be free from 'beneficial' interference; this right flows from Justice.*

⁸⁴ As stated in Step 4A (*supra*), interventions based on 'incremental quality of life' judgements require the consent of the patient.

⁸⁵ If communication is believed to be possible at some future stage then they have an 'attenuated personhood'; see steps (B).

⁸⁶ Section 1 (5).

Assuming that such a death would be, for him, 'a good death',⁸⁷ must he give his consent to *not* getting the antibiotics which would permit him to recover?⁸⁸

Step 6A: Medical decision-making on the 'threshold of death'

I have argued⁸⁹ that death can, in certain circumstances, be a 'good'. However, to occasion the death of another and for this death to be described as a 'good', it must first be in accord with Charity (*i.e.* be *for the sake of* this other) and, secondly, it must not conflict with Justice.

The occasioning of the death of another can be accomplished 'directly' by an act - usually described as '*killing*'⁹⁰ - or by indirect means.

A 'killing' obviously breaches the patient's 'right to life' if contrary to their expressed wishes; a breach also occurs even if the killing, though not contrary to the patient's expressed wishes, is not in accordance with their explicit instructions.⁹¹ However, a 'killing' in accord with the patient's expressed wishes (*i.e.* an 'assisted suicide') would - if it is also believed to be for the 'best interests' of the patient - accord with both Justice and Charity; as such, it is ethically permissible.

What of the withdrawal of life-sustaining treatment (including ANH) which foreseeably results in death? Two cases need to be distinguished:

- (i) where the death of the patient is the goal of the withdrawal of treatment;
- (ii) where the death of the patient, though not the goal of the withdrawal of treatment, is a foreseeable or even necessary consequence.⁹²

In relation to (i) the contemplated course of action is morally equivalent to a killing⁹³ and is justified only if it is in accord with the express wishes of the patient.

In relation to (ii) an observation made by Daniel Callahan (in speaking of 'a good death') is of assistance:

*"If it [i.e. 'a good death'] is carried out without the informed consent of a patient, it is a basic offence against that person's dignity ... the desire for a peaceful death does not override such obligations."*⁹⁴

This raises extremely difficult questions: does it mean that the 90-year-old pneumonia victim *must* consent to their non-treatment? Strictly interpreted it does. Must this consent be *explicit*? What if the patient does not wish to confront such a question? Must the physician *force* a patient to discuss the issue of death in order to get an explicit consent not to treat?⁹⁵ Such a suggestion seems barbarous. A conclusion that can be tentatively drawn is that a strategy which foreseeably results in the death of a patient, and which is carried out *unknownst* to the patient, is not

⁸⁷ Pneumonia was, I believe, once known as '*the old man's friend*'.

⁸⁸ In such cases the withholding of antibiotics is a strategy whose goal is the death of the patient.

⁸⁹ See Chapter 9.

⁹⁰ I use the term '*killing*' in its normal sense as being an *act* (as distinct from an omission) whose goal is the death of the patient; *i.e.* a directly intended death.

⁹¹ *i.e.* an issue on which they have not directly expressed an opinion.

⁹² See Section 1 (5).

⁹³ As argued in Section 1(5).

⁹⁴ Callahan *op.cit.* p.203.

⁹⁵ The existence of such cases must not be allowed to give shelter to the physician who ignores the obligation to obtain an informed consent in situations where the patient is willing to confront the issues involved. In this respect the recent controversy over the seemingly widespread use of '*Do Not Resuscitate*' orders in the UK is of interest [see: an editorial and article in The (London) Independent (16-4-00) citing research done by the organisation 'Age Concern']: a BMA spokesman, commenting on the controversy, said:

"It is often easier for doctors to say I will make a decision as to what is in the patient's best interest, and perhaps overlook the necessity to share that decision with the patient." [BBC News online service 13-4-00]

permissible; some gesture of consent - even to the extent of a leaving of such questions to the judgement of the physician - must be made.⁹⁶

These problems have not been adequately resolved under the existing conceptual frameworks and the answers offered by the 'P-GD conceptual structure' are not wholly satisfactory; in defence, it can be stated that the resolution of these questions was not the focus of this thesis. The inclusion of the rights of others⁹⁷ into the analysis - as recommended by Callahan⁹⁸ - may help in finding a more fitting resolution of these problems.

B: Where communication with the patient, though presently impossible, is believed to be possible at some future stage.

Patients classified under this subsection have 'attenuated personhood'.

Step 4B: Medical treatment decisions which do not foreseeably result in death

All such decision must be made on a 'best interests' basis. As expressed in terms of the obligations imposed by Charity and Justice, the relevant principle is that all decisions must be based on Charity (*i.e. 'for the sake of' the patient*); the obligations of Justice being in abeyance.

Step 5B: Medical treatment decisions which foreseeably result in death

It is necessary to distinguish between decisions which foreseeably (or even necessarily) result in the death of the patient but where the death is not the goal of the procedure, and decisions where death is the goal of the procedure.

An example of the first type of treatment decision is the giving of morphine where the aim of the procedure is to alleviate pain but where it is recognised that death may result. The withdrawal of ANH - if done to alleviate severe discomfort occasioned by the tube feeding - also falls into this category; in such a case death would be a necessary result of the procedure but not its goal.

An example of the second type of treatment decision is the withdrawal of ANH in cases where the decision to do so is justified on the grounds of the poor (absolute) quality of life of the patient.

Step 6B: Medical treatment decisions which foreseeably (even necessarily) result in death but do not have death as their goal, are not prohibited.

Such decisions are - if made in the 'best interests' of the patient - in accord with the obligations of both Justice and Charity.

Step 7B: Medical treatment decisions which have the death of the patient as their goal, are prohibited.

Such decisions though, perhaps, in accord with obligations of Charity, conflict with the obligation of Justice.⁹⁹ The situation of infant patients is of special interest.

If the patient is an infant, then their right to be protected from procedures which have death as their goal (a right protected by their '*attenuated personhood*') is no more open to being abrogated by the decision of its parents than by any other individual. (All *other* decisions are taken on the basis

⁹⁶ Of course these issues might have been confronted *before* the onset of illness (whether by a 'living will' or otherwise) and this problem shows the desirability of so doing.

⁹⁷ Particularly the claims of other patients to the use of scarce resources.

⁹⁸ See Callahan *op.cit.* p.213.

⁹⁹ See Conclusion 11.1: *The virtue of Justice prohibits not only the intentional killing of an individual but also procedures (whether by act or omission) which have the death of the individual as their goal.*

of the infant's 'best interests' - a matter concerning which the infant's parents would normally be an appropriate judge).

Two examples show this principle in action:

- (i) The example given by Phillipa Foot¹⁰⁰ of the Down Syndrome infant with the easily curable abdominal obstruction who will die in the absence of treatment.

The goal of the withholding of such treatment is the death of the infant;¹⁰¹ the fact that the treatment is being withheld either in the 'best interests' of the infant or at the behest of the infant's parents provides no justification.

- (ii) The case *T (a minor) (wardship: medical treatment)*.¹⁰² This case concerned an 18-month-old infant 'T' who needed a liver transplant to survive but whose mother refused consent believing that the operation would lead to greater suffering and distress for T and was, thus, not in his 'best interests'. The operation had a success rate of 80-90% and, if performed, the prognosis for T was that he would survive into adulthood. The courts upheld the parents' decision holding that "*It was in T's best interests that decisions as to his future treatment be left to his parents.*"¹⁰³

Under the 'P-GD conceptual structure' T had an 'attenuated personhood';¹⁰⁴ as such, he forfeited all rights *other than* the right to life. All decisions other than those whose goal was T's death could be taken in his 'best interests' but the decision that his death was in his 'best interests' is prohibited. This implies that the operation should be performed.

Step 8B: Medical treatment decisions must be made on an 'incremental quality of life' basis; 'absolute quality of life' judgements are prohibited

This is simply a restatement of steps 4B, 6B and 7B.

C: Where communication with the patient is believed to be permanently impossible.

Patients classified under this subsection have lost their 'personhood'.

Step 4C: All treatment decisions, including those whose goal is the death of the patient, are to be taken on a 'best interests' basis.

Accepting that death could be a 'good' for such a patient,¹⁰⁵ can a distinction be drawn between the 'killing' of such a patient and indirect procedures which have as their goal the death of the patient?

From the perspective of the patient's family.

In discussing the concept of 'a good death' it was pointed out that the 'goodness' of the death related not only to the individual who was dying but also to their surviving family and the wider

¹⁰⁰ See Section 1(5).

¹⁰¹ The issue of scarce resources was not relevant to the original problem.

¹⁰² The Times of 25th October 1996; see also in Current Law Year Book 1996 at p. 179; the case is discussed in Appendix C, (number 12).

¹⁰³ Current Law Year Book 1996 at p. 179; (*per* Butler-Sloss, L.J.)

¹⁰⁴ The reports do not suggest that 'T' would have been unable to acquire the ability to communicate.

¹⁰⁵ To some, it may appear paradoxical that the death of a patient might be in their 'best interests'. However, a contemplation of the possible nature of the experience of a PVS patient may make such a conclusion less difficult to accept: Strawson's imaginary account of a 'disembodied' consciousness, given earlier, is helpful in this regard. (See Chapter 10, Section 3, where Schneiderman's arguments are also discussed.)

Note also Foot's observation (in discussing the Karen Quinlan case):

"Much could be said about this last case. It might even be suggested that in the case of unconsciousness this 'life' is not the life to which 'right to life' refers." [Foot *op.cit.* p.58]

society.¹⁰⁶ Callahan points out that for a death to be 'a good death' it must result in minimal deformation to the family and to the wider society.¹⁰⁷ Hence, even if from the patient's perspective no distinction could be drawn between a 'killing' and strategies (such as the withdrawal of life-sustaining treatment) which have the death of the patient as their goal, a distinction might be drawn from the family's perspective: a family might, for religious or other reasons, willingly accept withdrawal of life-sustaining treatment but not accept a 'killing';¹⁰⁸ conversely, a family might regard the giving of a lethal injection as being preferable to a withdrawal of life-sustaining treatment in that the resulting death was less traumatic.

Can a distinction be drawn between a 'killing' and more indirect strategies when judged solely from the patient's perspective?

From the perspective of the patient

The argument in favour of a 'killing' (by, for example, a lethal injection) is that such a death is quick and painless.¹⁰⁹ However, a recent report¹¹⁰ on the practice of euthanasia in Holland argues differently. This report - which was based on a survey carried out amongst doctors¹¹¹ - found that medically assisted suicides have not always been swift and painless: the doctors admitted to 'botching' a quarter of all cases.¹¹²

The argument against indirect procedures such as the withdrawal of ANH is that - being tantamount to starvation - they cause unnecessary suffering; yet against this it can be argued that death by the withdrawal of food and drink is the preferred method of many who 'will' their own deaths.¹¹³

The medical ethicist Mary Warnock argues that:

*"I'm not sure that in the case of euthanasia I don't believe in a bit of prevarication and deception. There's not much difference between killing and letting die. What used to happen when people had babies at home and they were severely deformed was that the doctor or midwife would 'cause' the baby to die by turning it over or smothering it. My father-in-law was a GP and he used to do it. Afterwards he would say he couldn't save it, and there would be no questions asked. A very good thing."*¹¹⁴

In a subsequent interview¹¹⁵ she reiterated the point that a serious moral difference did not exist between killing someone and letting them die, and said that the worst way of killing someone is to withdraw food from them; a 'better' way of killing them is to give them, as doctors do, massive doses of painkillers.

¹⁰⁶ The interests of the wider society are being omitted from this analysis, they will be incorporated into the analysis in the following subsection.

¹⁰⁷ See Section 1(5).

See also Callahan *op.cit.* p.180:

"Death is acceptable ... when it comes at a point in life when

(i) further efforts to defer dying are likely to deform the process of dying, or when

(ii) there is a good fit between the biological inevitability of death in general and the particular timing and circumstances of that death in the life of the individual."

¹⁰⁸ The refusal of a family to accept *both* strategies can be resolved by a consideration of the rights of other patients to scarce resources. This is discussed in the following subsection.

¹⁰⁹ The testimony of some families to this effect is given in Chapter 9, Section 3.

¹¹⁰ The Times (26th Feb 2000) in its report of a study by Professor van der Maas published in The New England Journal of Medicine (February, 2000).

¹¹¹ The doctors who participated in the study had been given immunity from prosecution.

¹¹² The 'botched' cases came mainly in the late 1980's and early 1990's when doctors used opiates, such as morphine, whose effects are unpredictable.

¹¹³ See Section 1 (9) and also the discussion in Chapter 9, Section 3 leading to Conclusion 9-21: *Death by withdrawal of food - and a fortiori withdrawal of ANH - is not necessarily destructive of 'a good death'.*

¹¹⁴ Mary Warnock interviewed in The Sunday Times 1st Dec. 1996. [emphasis added]

The conclusion that I wish to draw is that:

Conclusion ¹¹⁵⁻²: *Judged solely from the perspective of the patient involved, an act which results in the patient's death (i.e. a 'killing') is preferable to indirect procedures which have the patient's death as their goal, in that the former is likely to cause less suffering. Judged from the perspective of the patient's family, there is no a priori reason for preferring either alternative. No other moral distinction of substance can be drawn between these alternatives.*¹¹⁶

Subsection 2: The 'P-GD conceptual structure': the fuller version.

In attempting to incorporate the wider social interests - i.e. Justice_s - into the analysis given in the preceding subsection (which simply considered the obligations flowing from Charity and Justice_c) two issues are of an obvious relevance: scarcity of resources and the development of a 'slippery slope'.

Scarcity of resources

The problem of finding ethical criteria for the allocation of 'scarce resources' is, perhaps, one of the most contentious and difficult to confront medical ethics at the present time; the discussion here is restricted to simply noting one way in which the 'P-GD conceptual structure' might assist.

The 'P-GD conceptual structure' admits two classes of patients: those who are 'persons'¹¹⁷ and those who have no¹¹⁸ personhood. In a situation where resources are scarce it seems clear that that if there was a claim on such resources by two patients one of whom was a 'person' and the other an 'OMW' (but not a 'person'), equal in all other respects,¹¹⁹ then the claim should be resolved in favour of the 'person'. This would imply that¹²⁰ in cases where death was appropriate (i.e. a 'good' and contemplated 'for the sake of' the patient) but where the patient's family refused to consent to either a killing or a withdrawal of life-sustaining treatment, that the decision could be justified by appealing to the rights of other patients to these scarce resources.¹²¹

¹¹⁵ Mary Warnock participating in 'The Moral Maze' (BBC Radio 4; 5th Dec. 1996) in a discussion on euthanasia.

¹¹⁶ The incorporation of Justice_s will entail a radical revision of this conclusion. (See the following subsection.)

¹¹⁷ i.e. those who presently are, or who are expected to become, able to communicate.

¹¹⁸ Because either they never had 'personhood', e.g. infants for whom there is no expectation that they ever will be able to communicate, or because they have lost 'personhood', e.g. individuals who have permanently lost the ability to communicate.

¹¹⁹ i.e. in their distress and need for medical treatment.

¹²⁰ As mentioned in the previous subsection.

¹²¹ This discussion is not dissimilar to that concerning the conflict between the so-called 'rights' of animals and the rights of persons; see, for example, the discussion of animal rights by Lori Gruen in her essay 'Animals' [included in Peter Singer (ed.) *A Companion to Ethics*] in which Gruen states:

*"According to Regan [Tom Regan, *The Case for Animal Rights*], all beings who have inherent value have it equally. ... Whilst this position is egalitarian and respects the value of individuals, it does not provide any guiding principle for action in cases where values conflict. Consider the following example, which Regan mentions: 'Imagine five survivors are on a lifeboat. Because of limits of size, the boat can only support four. All weigh approximately the same ... Four of the five are normal adult human beings. The fifth is a dog. One must be thrown overboard or else all will perish. Whom should it be?'"*

Regan argues that we should kill the dog because 'Death for the dog ... though a harm, is not comparable to the harm that death would be for any of the humans.' Others, however, argue that 'Death is the great equaliser ... Black or white, male or female, rich or poor, human or animal, death reduces us all to nothing.' and that Regan's distinction is not sustainable.

[Singer *op.cit.* p.346-7.]

The 'P-GD conceptual structure' and its distinction between 'Objects of Intrinsic Moral Worth' and 'persons', permits conflicts between the obligations which are due to animals and to persons, to be precisely stated (surely a precondition to their being resolved!). Applying the P-GD conceptual structure to Regan's example: whilst there are obligations in Charity to animals, animals have no rights and, in particular, no 'right to life'; however, persons have a 'right to life'; thus Regan's problem is easily resolvable within the P-GD framework by virtue of the preeminence accorded to Justice over Charity - the 'right to life' of persons prevails over charitable obligations to animals.

A further example to show the usefulness of the proposed framework is given by an actual case [reported on a BBC Radio 4 discussion (6.8.00) on Veterinary Ethics] concerning a vet who was asked by a couple to 'euthanise' their cat - which was perfectly healthy - because they were expecting a baby. The vet tried to persuade the couple to let her find another home

Conclusion ¹¹⁻³: *"Patients, in losing their 'personhood', also lose the right to equality of treatment with 'persons';¹²² hence, in resolving claims to scarce resources between 'persons' and 'non-persons', the claims of 'persons' take precedence, all else being equal."*

The development of a Slippery Slope

In discussing the concept of 'a good death' in relation to a patient who had permanently lost the ability to communicate (and, thus, lost their 'personhood') it was concluded that - if judged from the perspective of the patient - a 'killing' was preferable (in that it caused less suffering) to indirect strategies which had the patient's death as their goal. If judged from the perspective of the patient's family, no general conclusion could be reached as all depended on the circumstances of the particular case.¹²³ Does the inclusion of the wider social interest (Justice_s) into the analysis give reasons for changing this conclusion? In other words, are the social consequences of permitting direct killing different from the social consequence of permitting an indirect procedure - such as the withdrawal of ANH - whose goal is the death of the patient?¹²⁴

Direct killing: the social consequences

Foot argued that certain forms of euthanasia should not be legalised, even though they were morally unobjectionable when considered as individual acts; amongst her reasons was the difficulty in ensuring that consent was truly voluntary and the possible social consequence of legalisation in so far as it might lessen the willingness of society to take care of the aged. Drawing on the experience of euthanasia in Nazi Germany, Foot argued that:

*"Apart from the special repugnance doctors feel towards the idea of a lethal injection, it may be of the very greatest importance to keep a psychological barrier up against killing."*¹²⁵

Foot's point on consent - though relevant to the debate on assisted suicide - is not immediately relevant in discussing end-of-life care for PVS patients because they have lost the ability to communicate; there is, however, a danger that the *level* of ability to communicate required might well become the subject of contention.¹²⁶ Foot's second point - on the danger of lessening the willingness to take care of the aged - also seems, at first hearing, to be of no particular relevance to proposals in relation to PVS patients because their situation differs so greatly from the normal aged.

for the cat; the couple refused and insisted that the cat be killed. The vet did, in fact, find another home for the cat but in the same town and the cat subsequently returned to its original home. A complaint was lodged with the Royal College of Veterinary Medicine and the vet was disciplined. On a first hearing, the decision seems difficult to justify - especially if analysed in terms of animal 'rights'; however, if analysed in terms of the P-GD framework, it is more easily justified: the vet owes obligations of Charity to the cat (an 'OMW') but obligations of both Charity and Justice to the cat owner (obligations of Justice flowing from contract in that the couple had contracted with the vet that she kill the cat); hence, the obligations to the cat owners should prevail. (Had they sought to have their child killed rather than their cat? Then the 'right to life' of the child would take precedence over the contractual right of the parents.)

¹²² In so far as they lose the protection of the virtue of Justice.

¹²³ see Conclusion 11-2 (*supra*).

¹²⁴ Assuming that both procedures are justified in the individual case (*i.e.* when analysed in terms of Charity and Justice, but not Justice_s).

¹²⁵ Foot *op.cit.* p.59.

¹²⁶ As has sometimes happened in relation to the obligation to obtain an informed consent when this obligation has been interpreted as casting an onus on the *patient* to show that their refusal of treatment was an informed choice (*i.e.* that they understood the treatment procedures being refused) and that they had 'rational' reasons for their refusal. In this regard the case of Carrie Coons is instructive; she was diagnosed as being in a PVS and a court application had been made to withdraw ANH. Permission was granted but before this decision could be implemented Carrie Coons woke up, began to eat and talk and then expressed her desire to continue living. The medical ethicist Bonnie Steinbock has argued that Carrie Coons' expressed wish to live was not subjectively rational and need not be heeded:

"Her capacity for assessing evidence has been affected by her own bizarre experience ... Courts should resist the temptation to oversimplify this job by treating a patient's utterances during brief periods of consciousness as determinative."

However, the level of misdiagnosis which exists in relation to PVS¹²⁷ and some recent proposals made by the BMA(1999) for widening the categories under which withdrawal of ANH should be permitted,¹²⁸ give reason for caution.

Foot's last point on the psychological danger of permitting killing is her strongest and it is here that the experience of euthanasia in Germany is most relevant. Justice Robert H. Jackson, who was Chief of Counsel for the US at the Nuremberg Trials, has argued:

*"To begin with, [the Hadamar euthanasia program] involved only the incurably sick, insane and mentally deficient patients of the Institution. It was easy to see that they were a substantial burden to society, and life was probably of little comfort to them. It is not difficult to see how, religious scruples apart, a policy of easing such persons out of the world by a completely painless method could appeal to a hard-pressed and unsentimental people. But 'euthanasia' taught the art of killing and accustomed those who directed and those who administered the death injections to the taking of human life."*¹²⁹

A conclusion which is endorsed by Derr:

*"The fatal error of German medicine ... was to think it could accept a little killing ..."*¹³⁰

A further reason for caution in permitting direct killing is that it would certainly require legislation.¹³¹ The experience of legislating on social issues¹³² is that, under the pressure of continued litigation, the categories of applicability tend to widen from that which was originally envisaged; the act of legislating *itself* becoming the initial step of the slippery slope.

Conclusion ¹¹⁻⁴: *Though individual cases of killing may - when judged as isolated cases - be morally unobjectionable; the consequences to the wider society of permitting such practices are likely to be so seriously detrimental to general social wellbeing, that they should not be permitted.*

Indirect strategies:¹³³ the social consequences

Whilst it may seem at first sight that the permitting of indirect strategies - such as the withdrawal of ANH - would involve less danger of occasioning a slippery slope than would the permitting of killing, the Nazi experience - where withdrawal of food and hydration was often used as a mechanism for euthanasia¹³⁴ - suggests caution.

The current legal position¹³⁵ in Ireland and in the UK on the withdrawal of ANH is that, if it is medically justified as being in the 'best interests' of a patient, then it is not regarded legally as being a 'killing'; though in England a court application is required prior to such a withdrawal and

[Borthwick (1996) p.186; this quotation was discussed in Chapter 4, Section 4.]

¹²⁷ See Conclusion 4-12: *The best estimate for the rate of misdiagnosis of PVS is of the order of 50%. This implies that the diagnosis of PVS is essentially a random process.*

¹²⁸ See: Conclusion 8-12: *The BMA (1999) proposals on the withdrawal of ANH are not restricted to PVS patients but appear to encompass all patients who have minimal awareness. These proposals are even more capable of being extended to the disabled than were the original proposals to restrict withdrawal of ANH to PVS patients - proposals which at the time the BMA insisted had no 'implications for other categories of severe handicap'.*

¹²⁹ see Rothe *op.cit.* p.5.

¹³⁰ Derr *op.cit.* p. 491-4 (see Appendix E). [emphasis added]

¹³¹ Some of the judges in the Bland case referred to the necessity for legislation (see Chapter 6).

¹³² As is evident in the development of the law on abortion in England subsequent to the Bourne case.

¹³³ i.e. strategies whose goal is the death of a patient in circumstance where - judged as isolated cases - such strategies are ethically unobjectionable. For simplicity, the example taken in the discussion is the withdrawal of ANH; similar points can be made in respect of other treatment strategies which - though legally classified as 'omissions' - have the death of their patient as their goal.

¹³⁴ See Appendix E.

¹³⁵ See Chapter 6.

furthermore, it is only permitted in relation to PVS patients. This has the effect of not assimilating the withdrawal of ANH to standard treatment decision-making procedures.¹³⁶ The Irish courts have not required that an application to the courts be made prior to the withdrawal of ANH and neither have they restricted the procedure to PVS patients; the effect is that decisions to withdraw ANH are (in Irish law and medical practice) fully assimilated with normal treatment decisions.¹³⁷

Considered from the wider social perspective, there are both advantages and disadvantages in not considering the withdrawal of ANH as a 'killing'; first, the advantages.

Distinguishing the withdrawal of ANH from direct killing: the social advantages

The advantage of not considering the withdrawal of ANH as being a 'killing' is that then it can be used as a strategy for resolving 'end-of-life' issues for such as PVS patients without precipitating the slippery slope that might be occasioned by sanctioning 'killing' even in circumstances which were precisely defined. Furthermore, the precise stipulation of such circumstances would require legislation, thus adding a further momentum to any slippery slope.

Distinguishing the withdrawal of ANH from direct killing: the social disadvantages

However, the pretence - and it is a pretence¹³⁸ - that the withdrawal of ANH is not morally equivalent to a killing, creates its own dangers. It permits the withdrawal of ANH to be assimilated to normal medical treatment decisions and this belies the gravity of the decision to withdraw ANH, a seriousness which would be patent in the giving of a lethal injection. In this, the withdrawal of ANH has much in common with some applications of the double effect doctrine when the latter is used as a mechanism for shedding responsibility.¹³⁹ Furthermore, when killing or its moral equivalent, is

¹³⁶ Though see the BMA (1999) proposals which are discussed in Chapter 8; see also Appendix C for a discussion of the case law.

¹³⁷ See:

- * Conclusion 8-8: *In that the Ward judgements - unlike the Bland judgements - made no distinction between the withdrawal of ANH and the withdrawal of other forms of life-sustaining medical treatment, the withdrawal of ANH would be justified under Irish law in cases of disability where it would not be justified under English Law.*
- * Conclusion 8-9: *The ethical importance to be attached by medical practitioners to the withdrawal of ANH is obscured by its assimilation to other medical treatments; this tendency is exacerbated by the Ward court's insistence that the withdrawal of ANH is not a cause of death.*
- * Conclusion 8-10: *The Irish courts, by relinquishing their supervisory jurisdiction over cases where a patient's family and medical carers unanimously agree that the withdrawal of life-sustaining treatment is in a patient's 'best interests', may facilitate the development of a 'slippery slope'.*
- * Conclusion 8-11: *Current BMA (1999) proposals on the withdrawal of ANH are more compatible with existing Irish law than with current English Law in that the Ward decision permits*
 - *the withdrawal of ANH from patients who are not strictly PVS.*
 - *the withdrawal of ANH without prior application to the courts.*

¹³⁸ See Section 1(5) and, in particular, Conclusion 11-1: *The virtue of Justice prohibits not only the intentional killing of an individual but also procedures (whether by act or omission) which have the death of the individual as their goal.* As a further argument on the point being asserted, imagine an aged patient in an old person's home. It is conceivable that both her family and medical carers consider her to be an irksome, cantankerous individual who gets no enjoyment from life; being incontinent and difficult to feed, it is considered to be in her 'best interests' that tube feeding be commenced. Now - once, in Wittgenstein's phrase, *'this decisive step in the conjuring trick has been made'* - the way is open for a decision that, because the patient's quality of life is so poor, her tube feeding should be withdrawn and she be allowed to die. What would have brought forth the full rigour of the criminal law if attempted in one step, can (with the connivance of the law) be easily accomplished in two. Lest this seem an extreme conclusion consider the case of *Re R* [Appendix C, number 11] where a court application to permit the withdrawal of syringe feeding was withdrawn in favour of an application to permit the commencement of tube feeding on the understanding that a subsequent application might be made to seek its discontinuance, if this was regarded as being in R's 'best interests'. In similar circumstances under Irish law, it appears that there would be no necessity to seek the leave of the court for any of the proposed interventions.

¹³⁹ Timothy E. Quill has argued that:

"Some patients can live in an agonising twilight between suffocation and death because of the ambiguity of our intentions. ... The double effect does not acknowledge the fact that, for some patients, death is preferable to unrelenting suffering."

Quill discusses the conclusions of an 'Ethics Committee' in regard to one particular case:

"They suggested that the physician could actively treat Mrs. B's suffering by giving her enough morphine and sedation so that she became unconscious (therefore unaware of her suffering) and then letting her die by dehydration. ... using the double effect to treat her suffering aggressively without intending death."

[Timothy E. Quill, *Death and Dignity: Making Choices and Taking Charge*, (1993) p 107-112.]

spoken of as 'treatment',¹⁴⁰ the prohibitions that spring from conscience are all too easily ignored: in considering the withdrawal of ANH simply as 'treatment' there is no obvious moral reason why it should not, in certain circumstance, be considered appropriate for non-PVS patients: no reason, for example, why it should not be applied to disabled infants, irrespective of the level of disability, provided only that it was adjudged to be in their 'best interests'. In this context a recent report of police inquiries into the deaths of more than 30 elderly patients in a mental hospital in Derby is of interest: inquiries began when nurses reported 15 senior colleagues to the police. '*They alleged that food and water were withdrawn from vulnerable patients leaving them weakened and open to secondary conditions such as pneumonia.*'¹⁴¹ It is, of course, necessary to wait until the full facts of this case become clear but, assuming the facts are as they seem, it would not be unreasonable to suppose that these same senior nurses would have been appalled at suggestions that they give lethal injections to the patients from whom they withdrew food and hydration. Further evidence of a diminution in the seriousness with which decisions to withdraw ANH are regarded is found in a recent proposal from the BMA which urged that the requirement to apply to the courts for permission to withdraw ANH should be removed,¹⁴² it also proposed that the withdrawal ANH be permitted in cases involving stroke victims and the confused elderly who were not terminally ill.¹⁴³ These developments suggest that the withdrawal of ANH is being too closely associated with normal treatment decisions.

The withdrawal of ANH in relation to a killing: a proposal

A possible path out of these difficulties is to indulge in a slight pretence¹⁴⁴ and to argue that the withdrawal of ANH should be considered not as a 'killing' - for to do so would precipitate a slippery slope both by virtue of the permitting of killing and by virtue of the legislation that this would require - but to be so close to being 'killing' that very stringent procedures are required for its use as a treatment strategy. In short, the withdrawal of ANH should be considered as if it was on the borderline, just short of being classified, both morally and legally, as 'killing'. Three alternative procedures are suggested:

- * An obligation on carers to apply to the courts for permission to withdraw ANH. This would give the courts a supervisory role and ensure that the withdrawal of ANH was considered by medical carers to be a uniquely serious procedure. This is the situation currently adopted in England.
- * An obligation on carers to apply to the courts to validate a determination that 'personhood' was lost. This would have the advantage of clarifying the treatment criteria to be subsequently used - *i.e.* all treatment withdrawal decisions to be based on the 'best interests' of the patient - and could be made in conditions other than the emergency conditions usually associated with court applications for leave to withdraw life-sustaining treatment.

See also Quill, Dresser and Brock *The Rule of Double Effect - A Critique of Its Role In End-of-Life Decision Making* New England Journal of Medicine, (1997).

¹⁴⁰ As was sometimes the practice in Nazi Germany (see Appendix E).

¹⁴¹ The Times (2-9-1999).

¹⁴² The fact that the medical profession may well have a conflict of interest in relation to proposals concerning the withdrawal of ANH from PVS and other patients should not be overlooked - see the discussion in Chapter 4 footnote 263.

¹⁴³ See BMA (1999) and discussion of the BMA proposals in Chapter 8.

¹⁴⁴ It may be argued that this discussion is tainted with hypocrisy in that whilst arguing that the withdrawal of ANH is a 'killing', the conclusion depends on the general perception that it is not so. All that can be said in defence is that - just as the double-effect doctrine, although at times something of a subterfuge, may yet be the most effective way of preventing a slippery slope - the present proposal may permit a fitting solution to a difficult problem.

- * Some regulatory system other than the courts¹⁴⁵ to ensure that the withdrawal of ANH and similar treatment strategies whose goal is the death of the patient, is permitted only in cases where 'personhood' is absent.

Conclusion 11 - 5: The withdrawal of ANH carries less risk of creating undesirable social consequences than does direct killing,¹⁴⁶ provided that the withdrawal of ANH is regarded as sui generis different from other treatment decisions and of a seriousness such as to require special safeguards.

Section 3: PVS patients under the 'P-GD' conceptual structure.

The arguments on how the 'P-GD conceptual structure' would resolve problems associated with 'end-of-life' decisions for PVS patients have been presented in the preceding Sections; they will be collated here as a series of points:

- (i) The misdiagnosis rate for PVS is of such a magnitude that, in relation to any particular PVS patient, the possibility of misdiagnosis should always be borne in mind.¹⁴⁷
- (ii) PVS patients should be treated as if they are conscious and can experience pain.

This obligation - based, as it is, on Charity - does not lapse on a determination that the patient has permanently lost the ability to communicate (and, thus, lost their 'personhood').¹⁴⁸

Whilst writing these concluding remarks, a recent Editorial in the journal *Anaesthesia* has come to hand which argues that anaesthesia should be routinely given to those classified as being brainstem dead when their organs are being removed.¹⁴⁹ This proposal is considerably in advance of what is proposed in this thesis which is that PVS patients should be treated as if they are conscious and can experience pain.

- (iii) The primary obligation¹⁵⁰ - in other than medical emergencies - is to attempt to establish communication with the patient.¹⁵¹
- (iv) Until a determination is made that a patient's inability to communicate is permanent, the patient has an 'attenuated personhood': this implies that all medical decisions in relation to the patient's care should be made on the basis of his 'best interests', but that no intervention - such as the withdrawal of ANH - should be made which has the patient's death as its goal even if such were judged to be in his 'best interests'.¹⁵²

This is equivalent to saying that 'incremental quality of life' judgements are permitted but 'absolute quality of life' judgements are prohibited.

- (v) An erroneous determination that a patient's ability to communicate is permanently lost is - if negligently made - morally equivalent to a wrongful killing.¹⁵³
- (vi) On a determination that a patient has permanently lost the ability to communicate, their 'personhood' and, with it, all their rights cease. Subsequently all health care decisions -

¹⁴⁵ Mary Warnock has suggested that 'the Dutch way - not legalisation but regulation - is an excellent way of supervision' [BBC Radio 4 'The Moral Maze' (5.12.1996)]

¹⁴⁶ In situations in which (if considered in isolation) both would be justified as being in the 'best interests' of a patient who was permanently unable to communicate.

¹⁴⁷ The differential diagnosis between PVS and other conditions such as locked-in syndrome (in which consciousness is readily ascribed) is essentially a random process; see Conclusion 5 - 5 (*supra*).

¹⁴⁸ See Conclusion 5 - 5 (*supra*); also Step 3 (Section 2, Subsection 1).

¹⁴⁹ See Young PJ, Matta BF, Editorial: 'Anaesthesia for organ donation in the brainstem dead - why bother?' *Anaesthesia*, 2000 Feb; 55(2):105-6. The editorial was a response to guidelines suggesting that anaesthesia was unnecessary in such cases.

¹⁵⁰ which is based on Justice.

¹⁵¹ See Steps 1 and 2 (Section 2, Subsection 1).

¹⁵² See Conclusion 11 - 1 (*supra*); see also Steps 4B, 5B, 6B and 7B (Section 2, Subsection 1).

including those whose goal is the death of the patient - are to be taken on the basis of the patient's 'best interests'. (Subject to the provisos that the rights of other patients to scarce resources may, in certain cases, take precedence over such a patient's 'best interests' and secondly, that the direct killing of such a patient is prohibited - by reasons of the wider social interest - even though it may be in his 'best interests'.)

- (vii) Once a determination is made that a PVS patient has permanently lost the ability to communicate, they have died 'as a person'; they have entered onto the threshold of death and the obligation¹⁵⁴ to ensure that they achieve 'a good death' arises.¹⁵⁵

In discussing this question, an insight garnered from the families of such patients is useful:¹⁵⁶ the families distinguish between the patient's '*death as a person*' and the '*death of the body*' of the patient. Accepting this distinction, it becomes possible to state that the process of death has begun with the determination of loss of personhood and accordingly the primary obligation is to ensure 'a good death' for the body.

The interests¹⁵⁷ of the patient's family are of importance in determining both the manner and the timing of the death; for example, it may be that circumstances are such that the death should be postponed.¹⁵⁸ The interests of the family are, however, not decisive in that the rights of other patients to scarce resources must be considered.¹⁵⁹

The manner of death should be by the non-treatment of a potentially fatal illness or by the withdrawal of ANH. Though active interventions which cause death (*i.e.* are a 'killing') are morally equivalent to a withdrawal of ANH in situations where the death of the patient is the goal of the procedure, they should be prohibited for social reasons.

- (viii) Stringent safeguards are required in permitting strategies - such as the withdrawal of ANH - which have the death of the patient as their goal.
- (ix) The analysis appropriate to 'end-of-life' decisions for '*near-PVS*' patients is identical to that for PVS patients.

¹⁵³ See Step 1 (Section 2, Subsection 1).

¹⁵⁴ which is based on Charity and which still persists because the PVS patient is still considered to be conscious [see (ii) above]

¹⁵⁵ See Conclusion 9 - 17 to Conclusion 9 - 21 inclusive.

¹⁵⁶ In the *Frenchay v S* [Appendix C; number 3] a consultant's report stated that the patient's mother had, for the last two years, clearly wished '*his body to be allowed to die*'. [op.cit. p.406]. Also a private communication, in the form of a memorial card, from the family at the centre of the Ward case to Dr. Dolores Dooley of UCC, spoke of the '*two deaths*' of their daughter.

¹⁵⁷ Obligations based on both Justice and Charity exist towards the patient's family.

¹⁵⁸ Callahan [op.cit. p.218] in discussing his concept of a peaceful death defined it not only in terms of the interests of the patient but also in terms of the interest of the patient's family and of the wider society. A death which involved an 'undue burden' being cast on either the patient's family or the wider society could not be a good death. This is of particular relevance in the case of PVS patients as the continued use of life support will, judged from the patients perspective, not give him any chance of a better death. As judged from his families perspective, it may well (when used as a short term measure) provide the necessary time to permit a better death; it is unlikely to do so when used as a long term measure and will then be destructive of the wider interests of society because of the demands it places on scarce resources.

¹⁵⁹ Callahan suggests that health care insurers should not reimburse families for long term care of PVS patients other than minimal nursing care or at least assign a low priority to such treatment. He argues that:

"... increasingly few people will believe for long that this form of 'life' merits being called human. It is a moribund life sustained by technological artefact in the face of a biological condition crying out to come to an end as it would ordinarily in nature." [op.cit. p.217]

Although Callahan's good will is clearly foremost his formulation is clearly problematic, particularly when viewed against the Nazi practice of 'mercy killing'. The concept of personhood permits a much more acceptable formulation.

Section 4: Anencephalic and Down Syndrome infants under the 'P-GD' conceptual structure.

The arguments as to how the 'P-GD conceptual structure' would resolve problems associated with 'end-of-life' decisions for Anencephalic and Down Syndrome infants have been presented in the preceding Sections; they will be collated here as a series of points, first for Anencephalic infants and then for Down Syndrome infants.

Anencephalic infants

- (i) In cases of anencephaly, the absence of a developed cortex indicates that communication will never be possible.¹⁶⁰ In such cases both 'personhood' and 'attenuated personhood' are absent.
- (ii) Such infants should be treated as if they are conscious and can feel pain.
In this regard the recent recommendation that 'brainstem dead' patients should be routinely anaesthetised before organs are removed is highly persuasive.¹⁶¹
- (iii) The obligations flowing from Justice, but not from Charity, are in abeyance. The infant - not having either 'personhood' nor 'attenuated personhood' - has no rights and, in particular, has no 'right to life'; all health care decisions must be taken on the basis of the infants 'best interests'.
- (iv) Procedures which have the death of the infant as their goal are permitted if they are in the 'best interests' of the infant. In other words, both 'incremental' and 'absolute quality of life' judgements are permitted.
- (v) The obligation to provide such an infant with 'a good death' arises out of the obligations to the infant which are based in Charity. They also arise - and may be diminished by (in cases where the parents do not wish the child to die) - the obligations due to the infant's parents. The obligations due to other patients arising from a scarcity of resources are also relevant. The timing of the infant's death should be decided in a manner which best accommodates these various obligations.
- (vi) The death of such an infant may not be occasioned by a 'killing' even if this be done solely from motives of compassion, as this endangers the wider social interest in preventing the development of a 'slippery slope'. Indirect strategies which have the death of the infant as their goal are permissible but only with stringent safeguards.

Down Syndrome infants

Phillipa Foot, in her discussion of euthanasia, condemned¹⁶² the withholding of routine (but life-sustaining) medical treatments from Down Syndrome infants; she concluded on a note of furious indignation reminiscent of Jonathan Swift:

*"And for our children, since we scruple to gas them, not even the manner of their death is 'quiet and easy'; when not treated for an intestinal obstruction a baby simply starves to death."*¹⁶³

¹⁶⁰ The probability of communication being possible before 'attenuated personhood' is ascribed is considerably greater in cases of 'preciousness' than 'stickiness' - see the discussion in Chapter 10, Section 5.

¹⁶¹ See the discussion on Young PJ, Matta BF, 'Anaesthesia for organ donation in the brainstem dead--why bother?' [Anaesthesia, 2000 Feb] in Section 3(ii).

¹⁶² As mentioned earlier in Section 2.

The 'P-GD conceptual framework' - using Foot's earlier analysis in term of 'Justice' and 'Charity'- is capable of translating this indignation into a more philosophical argument.

- (i) Accepting that there is a substantial possibility that a Down Syndrome infant would, in adulthood, have an ability to communicate at a level which is sufficient to give consent to medical treatment,¹⁶⁴ implies that 'attenuated personhood' should be ascribed to the infant.
- (ii) 'Attenuated personhood' implies that the infant has a 'right to life'; in turn, this implies that no medical procedure which had the death of the infant as its goal, is permitted. In other words, 'incremental quality of life' judgements are permitted but 'absolute quality of life' judgements are prohibited. If a particular procedure improved the quality of life of a child, *i.e.* the 'incremental quality of life' increased, it should be used irrespective of views as to the value of that child's life; to suggest otherwise is to seek to diminish that child's personhood.

More specifically; the withdrawal of life-sustaining treatment - if not fully justified by the pain and suffering occasioned pain of the procedures themselves - is not permitted; the withdrawal of life-sustaining treatment is justified *only* if the quality of life of the infant *after* the withdrawal of treatment is better than its quality of life whilst it was being given (*i.e.* an 'incremental quality of life' judgement).

In Foot's example of the Down Syndrome infant with the easily curable abdominal obstruction; incremental quality of life considerations imply that the operation should be performed.¹⁶⁵

- (iii) Simply from a consideration of the age of such infants, virtually the only circumstance where the question of 'a good death' might be relevant is if the infant was terminally ill.¹⁶⁶

In such cases the best death possible should be sought for the infant; however, the withdrawal of ANH or other strategies whose goal is the death of the infant are not permissible in that the requirements of Justice - and the prohibitions implied by the 'right to life' - are not in abeyance.

Section 5: Conclusions.

The 'P-GD conceptual structure' is sufficiently powerful to permit the resolution of the Ward case; in fact it permits *precisely* the same conclusion as was arrived at in that case namely that ANH should be withdrawn as being in the Ward's 'best interests' and that she be allowed to die; but it permits this solution *without* occasioning the 'slippery slope' implicit in the Ward judgement. The 'P-GD conceptual structure' does this by showing:

- ▶ that in, certain circumstances, death is a 'good'.

¹⁶³ Foot *op.cit.* p.57.

¹⁶⁴ This is the level of communication required by the argument as developed in Chapter 10; however, a level sufficient to determine consent to the continuance or withdrawal of life-sustaining treatment - *i.e.* an ability to answer the question 'Do you wish to continue living?' - is all that is required in order that the argument be sustained in the present setting.

¹⁶⁵ The concept of 'quality of life' used as a tool to enable medical treatment decisions can be applied to the case of a Down Syndrome infant with an easily curable abdominal obstruction, in two distinct ways, as an 'incremental quality of life' judgement or as 'absolute quality of life' judgement.

As an 'incremental quality of life' judgement: it is clear that the infants quality of life after the removal of the abdominal obstruction would be better than before its removal; hence incremental quality of life considerations would indicate that the operations should proceed.

As an 'absolute quality of life' judgement: in this case what is first relevant is *not* the improvement of the quality of life if the abdominal obstruction was removed. There is a logically prior question which is whether the life in question is of such poverty, and shows an absence of what are normally considered to be basic human pleasures, that it is in reality not a *human* life at all. The 'C-AQL conceptual framework' enables the judgement that if the absolute quality of life is so poor and the operation to remove the abdominal obstruction would occasion a change so marginal as to be of no consequence, the child should be allowed to die.

¹⁶⁶ Remembering Callahan's question: 'Considering all the circumstance of timing, age, etc, is death appropriate at this juncture?'

- ▶ that a 'best interests' analysis - despite its apparent attractiveness and the innocuousness suggested by its name - is *necessarily* destructive of 'personhood'.
- ▶ how to delimit and 'ring-fence' the area where a 'best interests' analysis is appropriate.
- ▶ that withdrawal of ANH is (normally) a strategy which has the death of the patient as its goal.
- ▶ that strategies which have the death of a patient as their goal infringe (if performed without the consent of the patient) the 'personhood' of the patient.
- ▶ that strategies which have the death of a patient as their goal differ radically from normal treatment decisions.
- ▶ that the crucial concept in analysing 'end-of-life' decisions for PVS patients is not the supposed lack of consciousness of the patient, but their inability to communicate.
- ▶ how the withdrawal of life-sustaining treatment from patients such as Down Syndrome infants, can be clearly and radically distinguished from its use in cases of PVS and near-PVS.
- ▶ the need for stringent safeguards in cases where withdrawal of ANH is deemed to be appropriate.

Thesis Conclusions

"Mentally perhaps there is room for enlivenment. An attempt at reflexion at least. At recall. At speech even. Conation of some kind however feeble. A trace of emotion. Signs of distress. A sense of failure. Without loss of character. Delicate ground. But physically? Must he lie inert to the end? Only the eyelids stirring on and off since technically they must. To let in and shut out the dark. Might he not cross his feet? On and off. Now left on right and now a little later the reverse. No. Quite out of keeping. He lie with crossed feet? One glance dispels."

Beckett ¹

In beginning this thesis my main concerns were that:

- * the dogmatic assertions which were often encountered in the medical literature to the effect that PVS patients lack consciousness and cannot experience pain, might not be justified;
- * although I believed that the decision in the Ward case to withdraw ANH was in the circumstances the correct one, I had doubts as to whether the grounds² used by the Irish Courts to justify that decision, were appropriate in that they appeared to be applicable to cases of disability - particularly infant disability³ - despite the protestations of the judges in the Ward case to the contrary.

I will discuss these issues separately.

The possibility that PVS patients can experience pain

There appeared to be two possible avenues of approach to this problem:

- (i) by questioning patients who had recovered from PVS in order to determine whether they did, in fact, experience pain whilst diagnosed as PVS.
- (ii) by returning to first principles to find out whether scientific tests existed which could determine whether a given patient - and, in particular, a patient diagnosed as PVS - was conscious or in pain.

The assertions that PVS patients lacked consciousness and the ability to experience pain are treated in the literature as being *scientific* propositions. As such, they are, presumably, open to independent verification, yet the rate of misdiagnosis of PVS (and, by implication, of consciousness⁴) is close to 50% - the diagnosis of PVS is no more reliable than if made by the tossing of a coin!

¹ Samuel Beckett, *Company*, p.22.

² Namely that the withdrawal of ANH was a 'medical treatment decision' which was to be made on an assessment of the 'best interests' of the patient.

³ As for example in the English case *Re B (a minor) (wardship: medical treatment)* [1990] 3 All ER 927 [see Appendix C, number 7]; this case concerned a Down Syndrome infant who required a simple operation to remove an abdominal obstruction; however, the infant's parents believed that the operation was not in the infant's 'best interests'. The courts ordered that treatment be withheld, though this decision was later overturned on appeal.

The Attorney General, in his submissions to the court in the Ward case, referred to *Re B* and said that:

"... that case uniquely illustrates why quality of life should not be adopted as a test." [The Ward case, p.449]

⁴ The presence or absence of consciousness is the criterion usually advocated as enabling PVS to be distinguished from other conditions with which it may be confused.

At this stage of my reading I had the good fortune to encounter the writings of Chris Borthwick who appeared to be a lone voice in his protestations that the emperor (*i.e.* PVS) was, if not naked, at least very scantily clad. Borthwick argued that the misdiagnoses of PVS originate in:

- * the imprecise definition of PVS;
- * the concern to identify an 'irrecoverable condition' (the ability to identify such a condition would be of considerable benefit in times of scarce medical resources);
- * the presence of 'denial' in the medical carers who find the possibility that PVS patients might be conscious, too horrendous to contemplate.⁵

Is PVS an irrecoverable condition?

Jennett and Plum, in their paper which defined the condition PVS as such, aimed at identifying an '*irrecoverable*' condition;⁶ as a result of this, most subsequent discussion of PVS has confused questions of diagnosis and prognosis. The BMA's statement that recoveries from PVS are, in fact, cases of misdiagnosis⁷ - without the BMA actually specifying the possible medical conditions which theoretically might have been correctly diagnosed - compounds this development. It also ensures that the questioning of 'recovered' PVS patients as to their experiences whilst they had been diagnosed as PVS, is *logically* irrelevant to the question of whether PVS patients are conscious and can feel pain.⁸

Do PVS patients necessarily lack consciousness?

Jennett and Plum in their original paper⁹ were scrupulous in their insistence that:

- (i) PVS was not a discrete medical condition but lay on a continuum with other conditions such as locked-in syndrome;
- (ii) the judgement that PVS patients lacked consciousness was made on *behavioural* grounds and did not preclude the possibility¹⁰ that such patients might indeed be conscious though unable to manifest their consciousness.

Discussions of PVS subsequent to Jennett and Plum have lost sight of these important reservations and have attempted to *define* PVS as being a condition where consciousness (and with it the ability to feel pain) is absent; one consequence of this development is that it implies that a determination that a patient - who had been diagnosed as PVS but who, at the time of the diagnosis, was, in fact, conscious¹¹ but showed no manifestations of this - is *necessarily* a case of misdiagnosis.¹² This adds a level of confusion to the debate on PVS that was absent in the original Jennett and Plum approach.

⁵ Borthwick (1995b) p.207:

"We wish to believe that people in unendurable situations are unaware, and we resist evidence that would indicate otherwise. Some of us avert our eyes. Others elevate our disquiet to the status of a neurological theory and an ethical imperative."

⁶ Jennett and Plum (1972) p.735.

⁷ BMA (1996) p.58:

"An enduring cause for concern, however, have been the intermittent reports of alleged 'recovery' from PVS. In the BMA's view, recoveries where they can be verified, indicate an original misdiagnosis."

⁸ Because such patients had not been 'truly' PVS.

⁹ Jennett and Plum (1972).

¹⁰ The existence of such a possibility was acknowledged by Jennett and Plum.

¹¹ As shown by, for example, his remembering of conversations that occurred in his presence at that time of the original diagnosis.

¹² Though with no clear indication as to what the correct diagnosis should have been ('locked-in syndrome' is not an appropriate diagnosis unless the patient had been, *at the time of the original diagnosis*, able to communicate by eye-blink and this had been overlooked).

The need for a recasting of the definition of PVS

The attitude of the BMA to cases of supposed 'recovery' from PVS, the extent of the misdiagnosis of PVS, the suggestion that PVS appeared to be in danger of becoming a 'catch all' category¹³ to describe those who are minimally aware:¹⁴ all show the need for a re-examination of the definition of PVS.¹⁵ In an attempt to find a path out of the philosophical confusions which underlie much of the discussion of PVS, I returned to the original Jennett and Plum definition and argued that it is capable of being recast in terms of '*inability to communicate*' rather than in terms of '*lack of consciousness*'. I have proposed the following definitions:

- * *'The persistent vegetative state is characterised by seeming wakefulness in the absence of an ability to communicate.'*¹⁶
- * *'The Locked-In Syndrome is distinguishable from PVS in that a patient with locked-in syndrome is able to communicate by using the blinking of an eye or some equally primitive bodily movement.'*¹⁷

These definitions (which are securely grounded in Jennett and Plum's original analysis) allow a clear distinction to be drawn between cases of 'recovery' and 'misdiagnosis';¹⁸ they cast an obligation on physicians to *actively* attempt to achieve communication with a patient before diagnosing PVS¹⁹ and thus, bring the diagnosis and treatment of PVS patients into line with current best practice.²⁰ Most importantly, the proposed definitions help reconcile the criteria used by a patient's family in seeking to answer the question '*Is there someone in there?*', with the diagnostic criteria used by the patient's medical carers;²¹ finally, they also provide an appropriate framework for the resolution of ethical problems associated with 'end-of-life' decisions for PVS patients.²²

Though these definitions do not *preclude* the possibility that patients (correctly) diagnosed as PVS might be conscious or experience pain; they obviously cannot resolve it. The question needs further consideration.

The determination of consciousness and ability to experience pain

A reading of the medical literature on PVS suggests that assertions that PVS patients lack consciousness and the ability to experience pain are securely based in scientific fact and open to independent verification. They are not. Wittgenstein (in his analysis of how we ascribe pain to others) and Dennett (in his analysis of why we refuse to ascribe pain to a robot) clearly show that ascriptions of consciousness and pain to others have, as a *precondition*, that we have an attitude to

¹³ See, for example, McQuillen *op.cit.* at p.375:

"In recent years, some researchers have emphasised the essentially clinical nature of the 'vegetative state' and have attempted to extend its limits to include the end stage of any chronic, progressive, neurodegenerative disorder at one end of life and to compare it with anencephaly at the other."

¹⁴ A tendency which has been given an added impetus by the use of the diagnosis of 'near-PVS' and by the recent BMA proposals that the withdrawal of ANH be permitted in cases of severe dementia and Alzheimer's Disease [see BMA (1999a)].

¹⁵ Borthwick, though his critical analysis is faultless, does not offer a solution.

¹⁶ See Conclusion 4.-17.

¹⁷ The 'locked-in syndrome' is the condition with which PVS is most often confused.

¹⁸ The fact that a patient, diagnosed as PVS, was conscious at the time of the diagnosis does not imply any misdiagnosis.

¹⁹ An erroneous determination that a patient had permanently lost the ability to communicate is, if negligently made, morally equivalent to a wrongful killing.

²⁰ As is exemplified by such as Andrews who has spoken of the need for developing stimulation programmes to help evince awareness in PVS patients [Andrews (1992) p.486].

²¹ In that the aim of both the patient's family and his carers is to seek to establish communication with the patient.

²² In that the criteria for both PVS and loss of personhood are based on an inability to communicate.

these others that they are of a 'type'²³ which may be conscious and be in pain; this precondition (being a 'value judgement') is not amenable to a scientific determination; it is dependent on the existence of empathy between the observer and the observed.²⁴ Only if this precondition is satisfied can we proceed to specify criteria for ascribing pain. Accepting, for the sake of argument, that PVS patients (being human) may be conscious and experience pain, how might we go about determining if they actually do? One possibility is in using the generally accepted correlation between brain activity and possession of consciousness; however, PVS patients *do* manifest brain activity and there is *no* specific brain activity which is unambiguously linked to the possession of consciousness and which is absent in PVS patients. The position is similar in relation to pain. There are no areas of the brain - no 'pain centres' - which automatically 'light up' when a subject is in pain. The fact that communication is not possible with PVS patients and that, in brain damaged patients, brain function is often reassigned to other areas of the brain, render the problem even more intractable in that the establishing of correlations between brain states and the felt experience of pain is not even *theoretically* possible. Thus, even accepting that PVS patients *may* be conscious and may experience pain, brings the problem no closer to a definitive resolution; doubt it seems is intrinsic to the problem.

At this stage it becomes necessary to acknowledge this doubt and to incorporate the existence of our uncertainties into our analysis. A general method for incorporating the existence of doubt into medical decision-making has been proposed which can be applied to pain judgements in relation to PVS patients: it implies that - because treating a patient as being unable to experience pain (when, in fact, they are able) is so considerably more undesirable than treating a patient as being able to experience pain (when, in fact, they are unable):

*'All PVS patients should be treated as if they are conscious and can experience pain.'*²⁵

Support for this conclusion comes from a recent editorial in Anaesthesia (the journal of the Royal College of Anaesthetists)²⁶ which has called for anaesthetic to be routinely given during operations to remove organs from those patients who had been adjudged to be 'brainstem dead'; this recommendation was based on arguments similar to those advocated above in connection with PVS patients.

The possibility that the Ward decision may engender a 'slippery slope'

My criticisms of the Ward decision are threefold:

- (i) its refusal to acknowledge that the withdrawal of ANH is a strategy which has as its goal the death of the patient.²⁷

²³ For example, only in recent times has it become generally accepted that animals have the ability to feel pain (Descartes, argued that they had no such ability); it is only within the last ten years that it has become generally accepted that newborn infants may feel pain; and the issue of whether a foetus can experience pain is currently a subject of controversy.

²⁴ The belief that there are scientific grounds for asserting that PVS patients cannot experience pain is of considerable *negative* importance in that it is destructive of the empathy which naturally arises on seeing a PVS patients manifest pain behaviour.

²⁵ See Conclusion 5 - 5 .

The phrase '*as if*' is used not in the sense of suggesting a pretence, but rather in the sense of suggesting that in the face of incomplete knowledge as to which PVS patients are conscious - and some undoubtedly are - *all* should be treated as if they were conscious. (A similar usage occurs when used hypodermic syringes are regarded as *if* they were contaminated - some are, we have no way of knowing which, and the consequences of making an incorrect decision are great.).

²⁶ Young PJ, and Matta BF. 'Anaesthesia for organ donation in the brainstem dead - why bother?' Anaesthesia, (2000) Feb;55(2):105-6.

²⁷ There may, however, be exceptional cases where the tube used in ANH is removed in order to alleviate the discomfort to the patient caused by its presence, even though it is recognised that the patient will die as a result of its removal. To distinguish such cases from those where the death of the patient is the goal of the tube removal: imagine a medical invention whereby nutrition could be given to a patient (by, for example, putting a patch on the arm) painless and without occasioning any discomfort; we can distinguish between both types of case by asking whether such an invention would be used in the instant case. I suggest that such an invention would not have been used in either the Ward or Bland cases

- (ii) its acceptance of the patient's 'best interests' as being a suitable ground for permitting the withdrawal of ANH.
- (iii) its not insisting on a continuing supervisory jurisdiction whereby the withdrawal of ANH would, in all cases, require the prior approval of the courts.²⁸

The role of death

I believe that the most important step in analysing cases such as the Ward is to bring the role of death centre stage and to acknowledge that the achievement of a peaceful death for the patient is the implicit criterion of success in the withdrawal of ANH. The greatest hindrance to the acceptance of such a proposal lies in the belief the death is necessarily an evil. I have argued that the proposition '*Death is an evil*' is, if unqualified, unsustainable; this implies that some deaths are a 'good' and that it is meaningful to speak of 'a good death'. I found the writings of Daniel Callahan, Ernest Becker and Elisabeth Kübler-Ross of considerable assistance in developing the idea of 'a good death'.

In speaking of death being, in certain circumstances, a 'good', the question immediately arises as to when it might be permissible to occasion the death of another. Is the judgement that it would be in their 'best interests' sufficient?

'Best interests' judgements

The difficulty in criticising 'best interests' as an appropriate standard on which to base health care decisions is that its very name appears to confer an ethical '*nihil obstat*'; that this is an illusion is evident if we consider our unwillingness to cede to others the right to decide on our behalf; furthermore, the existence of requirements for obtaining 'informed consent' also provides eloquent testimony to the dangers of an unfettered use of 'best interests' judgements in health care decisions. When such decisions are to the effect that a patient is '*better off dead*' then the need for vigilance is all the greater.

One of my aims in this thesis was to puncture the illusion that 'best interests' is an obvious and incontrovertible standard on which to base health care decisions and one to which only the most obdurate critic could raise objection; in furtherance of this aim I relied on two arguments - the first based on drawing a distinction between 'absolute quality of life' judgements and 'incremental quality of life' judgements, the second on building on a distinction (made by Phillipa Foot) between the obligations that flow from Charity and those that flow from Justice.

'Best interests' judgements are essentially equivalent to 'quality of life' judgements. A distinction can be drawn between quality of life judgements which seek to estimate the *incremental* change of a proposed intervention on a patient's quality of life, and those which seek to estimate the *totality* of the quality of life of a patient at any moment in time.²⁹ I have argued that though 'absolute quality of life' judgements *may* be used in making 'incremental quality of life' judgements, they are not *logically* required in doing so; and that, accordingly, 'incremental quality of life' judgements can be made in the absence of an ability to make 'absolute quality of life' judgements. I have proposed that

thus showing that the death of the patient was the goal of the withdrawal of ANH. [As mentioned earlier - see footnote 46, Chapter 6 - in Tony Bland's case, the tube was not, in fact, removed but was left in place in case it might be useful in administering medication.]

²⁸ In England, an application to the courts is required before the withdrawal of ANH (although the BMA have argued that it is required *only* in cases of PVS).

²⁹ I have called such judgements '*absolute quality of life judgements*'.

because 'absolute quality of life' judgements conflict with certain ethical principles they should not be used; 'incremental quality of life' judgements are, in contrast, ethically unobjectionable.

Foot distinguished between the obligations to an individual which flow from Charity (what the individual *'has a need of'*) and those which flow from Justice (what the individual *'has a right to'*); she argued that obligations flowing from Justice (of which the most basic is the *'right to be let alone'*) must take precedence over obligations flowing from Charity. Individuals to whom obligations are owing from both Justice and Charity are called *'persons'* (as such, they possess 'rights'); I introduced the term *'Objects of Intrinsic Moral Worth'* to describe those individuals to whom obligations are owing based *only* in Charity.

I have argued that the ability to communicate was a necessary condition for the ascription of 'personhood' (and by implication 'rights'); the concept of 'attenuated personhood' was introduced to cover those individuals for whom a possibility existed that they would at some future stage be able to communicate. Individuals with 'attenuated personhood' lose all their rights other than their 'right not to be killed': strategies whose goal is the death of the patient are prohibited even if their death was deemed to be in their 'best interests', all other decisions are taken on a 'best interests' basis.

Drawing on these concepts and distinctions, it was possible to generate a new conceptual framework³⁰ to help resolve 'end-of-life' decisions. Applying this framework to, for example, a patient diagnosed as PVS, it follows that if the patient is believed to have permanently lost the ability to communicate then the obligation flowing from Justice cease whilst the obligations flowing from Charity persist. Accordingly *all* their health care decisions - including ones which had the death of the patient as their goal - are to be taken on a 'best interests' basis.³¹

One important consequence of this method of analysis is that it shows that the making of decisions for an individual solely on the basis of what is perceived to be in their 'best interests' is *necessarily* a denial of their personhood.

The withdrawal of ANH is sui generis

The judgements in the Ward case considered the withdrawal of ANH to be a 'medical treatment'; they did not stipulate that decisions to withdraw ANH required any safeguards additional to those appropriate to more usual medical decision-making. In this, they differed from the English courts who - though they also considered ANH to be a 'medical treatment' - regarded decisions to withdraw ANH as being *sui generis* and of such seriousness as to require the consent of the courts before being implemented.

Imagine the case of an aged patient in an old person's home who was regarded by both her family and medical carers as an irksome, cantankerous individual who gets no enjoyment from life.³² Being difficult to feed, it is considered to be in her 'best interests' that tube feeding be commenced. Once this has been accomplished then the way is open for a decision that - because the patient's quality of life is so poor - her tube feeding should be withdrawn and she be 'allowed to

³⁰ The *'P-GD conceptual structure'*.

³¹ As is argued in Chapter 11, the direct killing of such a patient may be in their 'best interests' in that their death would be quick and painless; however, when wider social concerns are included in the analysis, it was concluded that the withdrawal of ANH (when used as a strategy to occasion the death of a patient) was preferable to direct killing in that it carried less risk of engendering a 'slippery slope'.

³² This example was also given in Chapter 11 where it was mentioned that it bore some disquieting resemblances to the case *Re R* [Appendix C, number 11]. In *Re R* a court application to permit the withdrawal of syringe feeding was withdrawn in favour of an application to permit the *commencement* of tube feeding on the understanding that a subsequent application might be made to seek its discontinuance, if this was regarded as being in R's 'best interests'. In similar circumstances under Irish law, it appears that there would be no necessity to seek the permission of the court for any of the proposed interventions.

die'. What would have brought forth the full rigour of the criminal law if attempted in one step - *i.e.* the killing of the patient - can, it seems, be easily accomplished in two. A consideration of this example shows that it is necessary to regard decisions to withdraw ANH to be of such seriousness as to require special safeguards (such as application to the courts) and moreover that they are appropriate only to certain, well defined, cases. The conceptual framework developed in this thesis allows these cases to be identified: the withdrawal of ANH is permissible *only* if it is believed that there is no possibility of establishing communicating with the patient either now or in the future, and then *only* if the withdrawal of ANH is in the 'best interests' of that patient.³³

Conclusion

The ability to communicate - and not the absence of consciousness - is the key to unravelling the ethical problems associated with 'end-of-life' decisions in PVS and PVS-like conditions. By using the proposed definition of PVS and necessary condition for the ascription of personhood (both framed in terms of ability to communicate), the ethical problems associated with end of life decisions in relation to PVS patients can be resolved *without* the danger of engendering a 'slippery slope'.³⁴ Furthermore, the need to distinguish between PVS and 'near-PVS' for ethical and legal reasons, is removed.³⁵

The conceptual framework proposed also helps resolve ethical problems in relation to the withdrawal of life-sustaining treatment in cases other than PVS or 'near-PVS'. When, for example, it is applied to cases of infant disability the proposed conceptual framework has the great benefit - unlike the conceptual frameworks used at present - of distinguishing sharply between cases such as Down Syndrome and cases of anencephaly; strategies whose goal is the death of the infant being absolutely prohibited in cases such as Down Syndrome.³⁶

³³ Though see the proviso in footnote 27 *supra*.

³⁴ As applied to the facts of the Ward case, the proposed conceptual structure would imply precisely the same conclusion as was in fact arrived at in that case.

³⁵ In that *both* PVS and 'near-PVS' patients are treated as being conscious and, accordingly, as individuals to whom obligation are due based on Charity. There will, of course, still be medical reasons for distinguishing between these conditions.

³⁶ Such infants - because there is a possibility that they will be able to communicate at some future stage - have an 'attenuated personhood'; as such, no procedure whose goal is the death of the infant is permitted even if it is believed to be in the infant's 'best interests'.

Appendix A: Studies on the misdiagnosis of PVS

In recent years a number of studies have attempted to quantify the level of misdiagnosis occurring in the diagnosis of PVS. This appendix attempts to summarise the main results of these studies with particular emphasis on:

- (i) the rates of misdiagnosis found.
- (ii) the medical conditions which should have been diagnosed. And
- (iii) the conceptual distinctions between these alternative conditions and PVS, which would have permitted a correct diagnosis.

An examination of the methodologies adopted in the studies is not undertaken as such an examination would bring us too far from our original purpose which is to estimate the extent of misdiagnosis and to show that misdiagnosis is of such a magnitude as to suggest that the supposed lack of consciousness of patients diagnosed as PVS is open to reasonable doubt. Although the various studies differ slightly in their definitions of PVS, they all accept that any patient who exhibits even a minimal level of awareness cannot be classified as PVS.

The studies which are examined in this appendix are listed in the following tables. Table A-1 lists those studies which are directly relevant to gauging the extent of misdiagnosis; Table A-2 identifies studies which indirectly deal with the misdiagnosis of PVS.

<i>Author</i>	<i>Date</i>	<i>Country</i>	<i>Title</i>
Donald Tresch <i>et al</i>	1990	US	'Clinical Characteristics of Patients in the Persistent Vegetative State.' <u>Archives of Internal Medicine</u> . 151, May 1991, 930 -2.
Nancy Childs <i>et al</i>	1992	US, Canada	'Accuracy of Diagnosis of Persistent Vegetative State.' <u>Neurology</u> 43, August 1993, 1465-7.
Keith Andrews	1993	UK	'Recovery of patients after four months in the persistent vegetative state.' <u>British Medical Journal</u> . 306, 12 June 1993, 1597-1599.
Keith Andrews <i>et al</i>	1996	UK	'Misdiagnosis of the vegetative state: retrospective study in a rehabilitation unit'. <u>British Medical Journal</u> , 313, 6 July 1996), 13-16.

Table A-1: Studies which directly consider the misdiagnosis of PVS.

<i>Author</i>	<i>Title</i>
Keith Andrews (1992)	'Managing the persistent vegetative state.' <u>British Medical Journal</u> Vol. 305, (29 August 1992), 486-7.
* Andrew Grubb <i>et al.</i> (1996a)	'Survey of British clinicians' views on management of patients in persistent vegetative state.' <u>The Lancet</u> 348, (6 July 1996), 35-40.
* Andrew Grubb <i>et al.</i> (1997)	<u>Doctors' views on the management of Patients in Persistent Vegetative State: A UK Study</u> . London: The Centre of Medical Law and Ethics, King's College, 1997.
Andrew Grubb <i>et al.</i>	<u>Doctors' views on the management of Patients in Persistent Vegetative State: A European Study</u> . London: The Centre of Medical Law and Ethics, King's College, (unpublished draft copy).
Andrew Grubb <i>et al.</i> (1996b)	<u>Doctors' views on the management of Patients in Persistent Vegetative State: A report of a small survey in Ireland</u> . London: The Centre of Medical Law and Ethics, King's College, 1996.
Ronald Cranford (1996)	'Misdiagnosing the persistent vegetative state'. Editorial, <u>British Medical Journal</u> Vol. 313, 6 July 1996, 5-6.

** the first of these sources is a précis of the second.*

Table A-2: Studies which indirectly consider the misdiagnosis of PVS.

The main studies¹

The Tresch Study (1990)

Introduction

From a population of 1611 patients in four nursing homes in Wisconsin, 62 had been diagnosed by nursing home personnel - both nurses and physicians - as being in a PVS.² This research project involved a re-examination of these patients to determine the correctness of the original diagnosis.

Rate of Misdiagnosis

The study found that of the 62 patients diagnosed as PVS, 11 had some level of awareness of their environment with some of these capable of demonstrating volitional movements. Given the criteria for PVS it follows that these 11 were misdiagnosed; this represents a misdiagnosis rate of 18%.

Comments

The authors expressed surprise at the large number of patients (25%) in a PVS who were diagnosed as having end stage dementia because:

*"Patients with dementia rarely develop the profound and complete loss of awareness characteristic of PVS, and it is important to distinguish between PVS and the usual dementia state."*³

The high percentage of PVS patients (27%) who were being treated with antipsychotic agents, also occasioned surprise as, in the circumstances, such treatment appeared inappropriate.⁴

The Childs Study (1992)

Introduction

This study compared the pre-admission with the post-admission diagnoses for 193 patients suffering from severe brain injuries who had been referred⁵ to a neurorehabilitation unit over a period of five years with a diagnosis of either PVS or coma.

Rate of Misdiagnosis

The study found:

*"... behaviour indicative of cognitive responsiveness in 37% of the patients, thereby invalidating the pre-admission diagnosis of PVS or coma."*⁶

¹ as listed in Table A-1.

² The criteria used were:

"Patients in a PVS were defined in our study as patients unaware of themselves or their environment ... voluntary reactions or behaviour responses reflecting consciousness, volition, or emotion at cerebrocortical level had to be absent." [Tresch *op.cit.* p. 930]

³ *ibid.* p.932.

⁴ *ibid.* :

"We are uncertain of the indications for the antipsychotic drugs, since most patients in a PVS are usually not considered behaviour problems."

⁵ by medical facilities in six US states and in Canada.

⁶ Childs *op.cit.* p.1466.

Comments, including reasons for the misdiagnosis

The authors suggested two reasons for the misdiagnosis: firstly and most importantly, a confusion over terminology; secondly, a lack of diligence in the medical staff in their observation of patients for possible signs of awareness.

Terminology

The study found that:

*"Referral sources used the terms 'coma' and 'PVS' inconsistently and interchangeably."*⁷

The authors expressed surprise at such a fundamental error because:

*"Simply put, coma is an eyes-closed state of unresponsiveness whereas in PVS the eyes are open."*⁸

The main conclusion of the report was that:

*"There is a need for consensus in description and definition of PVS. If we do not adhere to a strict and precise definition of PVS then confusion and misdiagnosis will follow."*⁹

The link between inappropriate terminology and misdiagnosis was also noted:

*"We suspect that misdiagnosis in most of these patients was due to the confusion in the terminology used to describe alterations in states of consciousness in the brain-injured. ... Additional confusion arises over appropriate terminology for patients demonstrating early awareness."*¹⁰

Observation

The report noted that because changes in patient behaviour may be subtle or occur over an extended period, they may initially appear to be random and thus be easily overlooked by the physician on his ward rounds. The report recommends that observations by the patient's family should not be casually dismissed as the family often are in a better position to observe such changes than are medical staff.¹¹

The Andrews 1993 Study¹²

This study was a retrospective review of the case notes of 43 patients admitted to a unit specialising in the rehabilitation of patients in PVS. The patients had not been preselected on the expectation that they would recover but it *"... is impossible to say whether they were a representative sample of vegetative patients."*¹³

⁷ *ibid.* p.1465.

⁸ *ibid.* p.1466.

⁹ *ibid.*

¹⁰ *ibid.*

¹¹ *ibid.*

¹² Andrews (1993b).

¹³ *ibid.* p.1599.

Rate of Misdiagnosis

Of the 43 patients in the study, 11 regained awareness though one of these patients was unable to communicate; if this one patient is included then the misdiagnosis rate is 26%; if not included, the rate is 23%.

The Andrews 1996 Study¹⁴

This was a retrospective study of 40 patients admitted between 1992 and 1995 to a rehabilitation unit dealing with profoundly brain damaged patients. All but one of the patients had been referred by a hospital consultant and the diagnosis of PVS had been made by a neurologist or neurosurgeon or rehabilitation specialist “... *all of whom could have been expected to have experience of vegetative state.*”¹⁵

The study sought - by means of sensory stimulation of the patients in conjunction with sustained observation for possible responses - to identify mechanisms which would permit communication with the patient to be established. One patient, for example, was found to have a slight shoulder shrug which could be used to achieve a morse-like communication.¹⁶ The main methods used to establish patient awareness were the “... *ability to follow a simple command to press a buzzer switch or look at a named object.*”¹⁷

Rate of Misdiagnosis

The study found a misdiagnosis rate of 43%. The survey method - in that it required patients to respond to verbal commands - implicitly assumed that none of the patients was deaf. In so far as 62% of these misdiagnosed patients were blind or severely visually impaired,¹⁸ this assumption implies that the misdiagnosis rate could - if deafness was included - have been considerably in excess of 43%; accordingly this percentage should be interpreted as a minimum figure.

The subsidiary sources¹⁹

Andrews (1992)

This article draws on Andrews' considerable clinical experience of PVS and, though not directly concerned with misdiagnosis, touches on two issues which have great relevance to it. These issues are terminology and standard of care.

Terminology

Andrews contends that PVS is one of the “... *least understood conditions in rehabilitative medicine.*”²⁰ As such there is a great danger that issues of terminology will exercise a dominance over issues of substance; therefore, it is highly important that an appropriate terminology - *i.e.* one without unjustified connotations - be used.

¹⁴ Andrews (1996).

¹⁵ *ibid.* p.15.

¹⁶ Andrews (1996); Patient B.

¹⁷ *ibid.* p.13.

¹⁸ *ibid.* p.14.

¹⁹ As listed in Table A-2.

²⁰ Andrews (1992) p.486.

Andrews considers the terms '*persistent*' and '*vegetative*' to be unfortunate. '*Persistent*' is understood by many to mean '*permanent*' - that is a statement of final outcome rather than a comment on an existing state;²¹ '*vegetative*' - in its association with '*vegetable-like*' - accentuates this tendency. Such misunderstandings hinder a positive attitude to treatment with the result that the diagnosis of PVS becomes "*A self-fulfilling prophecy - the prognosis is poor, therefore no treatment is given, therefore the prognosis is poor.*"²²

Standard of Care

Andrews considers that appropriate stimulation programmes - of touch, taste, and sound - can affect patient responses. He states:

"... [in] 10 years experience of training relatives of more than 250 patients in a persistent vegetative state to use a programme of stimulation ... only 4% of patients did not improve; one third became functionally independent."²³

Cranford (1996)

This article was a critique of the Andrews 1996 study.²⁴ Cranford questioned the method used to identify awareness - viewing '*the buzzer system with some scepticism*'²⁵ - but this objection seems disingenuous.

Cranford's distinction between the '*late recovery*' and '*late discovery*' of consciousness is of importance:

"Patients who start regaining consciousness several months after the injury (*late recoveries*) should not be confused with patients who may have been conscious for some time before discovery (*late discoveries*)."²⁶

However, Cranford's most important point is his questioning of Andrews' assertion that none of the misdiagnosed patients were vegetative at the time of admission.²⁷

The Grubb Reports (1996, 1997)

In 1994 Professor Grubb of The Centre of Medical Law and Ethics at King's College was commissioned by the EU (under its BIOMED programme) to investigate the moral, legal and medical issues which arose in the management of PVS patients. A comparative study amongst the various EU countries was undertaken to examine both the legal structures affecting the treatment of PVS patients, and the moral attitudes to such treatment. In order to determine the attitudes of the medical profession to such questions a survey of doctors involved in the management of PVS patients was conducted by means of a postal questionnaire. Various reports analysing the results

²¹ This is similar to the position adopted by 'The Multi-Society Task Force on PVS' in its insistence on distinguishing between '*prognosis*' and '*diagnosis*'.

²² Andrews (1992) p.487.

²³ *ibid.* p.486.

²⁴ see Table A-1.

²⁵ Cranford *op.cit.* p.5.

²⁶ *ibid.*

²⁷ Andrews (1996), p.15:

"It could be argued that the clinical team had introduced a successful treatment programme to bring about the emergence from the vegetative state ... it is our opinion that these patients were not vegetative at that time of admission."

of these questionnaires were published; those for Ireland, the UK and the European Comparative study have been consulted in the writing of this thesis.²⁸

These reports did not directly address the question of misdiagnosis but were of indirect relevance in that:

- (i) the level of confidence of doctors in making a '*prediction of outcome*' for PVS patients was examined.
- (ii) questions of terminology - and in particular the meaning of the term '*recovery*' - were considered.

Medical Confidence in making a diagnosis of PVS

The consensus in the medical literature is that the vegetative state may be considered permanent after one year,²⁹ yet an appreciable percentage of practitioners who responded to the survey, appeared '*not at all confident*' in predicting the outcome at this stage.³⁰ The Irish Report expressed surprise at this incongruity;³¹ the reason, however, may lie in the fact that the surveys omitted to establish the confidence level of doctors in making the original diagnosis of PVS. Because the *only* opportunity offered in the questionnaire for expressing lack of confidence was in relation to the '*prediction of outcome*', it seems not unreasonable to suggest that a low level of confidence in the predicted ultimate outcome is related to wider concerns.

<i>'not at all confident' in predicting outcome after:</i>	<i>Ireland</i>	<i>UK</i>	<i>Europe*</i>
7-12 months	13%	9%	4% - 14%
1 year	7%	6%	3% - 16%

* tabulated by countries; minimum and maximum shown

Table A-3: Lack of confidence in predicting outcome after 6 months.³²

Terminology

The Grubb Reports were insistent on the necessity for clear terminology. They regretted the developments whereby '*persistent*' has, to some ears, come to mean '*permanent*' and they noted that "... *confusion about the word 'persistent' has extremely important implications.*"³³

Some insights into the meaning of the term '*recovery*' can be drawn from the report.

Recovery

The survey sought to relate the '*predicted outcome*' to the decision to withdraw treatment. Three possibilities were offered to the respondents; the first was that the patient would continue in a vegetative state and this possibility achieved a nearly unanimous acceptance,³⁴ but it is the responses to the second and third possible outcomes³⁵ that are of most interest; these results are summarised in the Table A-4:

²⁸ As detailed in Table A-2.

²⁹ for example, see the Irish Report *op.cit.* at p.15 and the UK Report *op.cit.* at p.24.

³⁰ These results are summarised in Table A-3.

³¹ The Irish Report p.15.

³² Abstracted from Tables contained in The UK Report (p.14), The Irish Report (p.14) and The European Report (pp. 31-2).

³³ The Irish Report p.1.

³⁴ The Irish Report 100%; The UK Report 90% +.

³⁵ Do the Predicted outcomes:

A. "The patient will be severely disabled, able to speak, but totally dependent on carers but with sufficient insight to be aware of his/her condition."

B. "The patient will be severely disabled, able to communicate simple needs without speech"

justify the non-treating of acute infections or the withdrawal of ANH?

The details in this table are abstracted from tables contained in The UK Report (p.21), The Irish Report (p.19) and The European Report (pp. 47-9).

	IRELAND				UK				EUROPE*			
	Not treat acute infections		Withdraw ANH		Not treat acute infections		Withdraw ANH		Not treat acute infections		Withdraw ANH	
	A.	B.	A.	B.	A.	B.	A.	B.	A.	B.	A.	B.
Yes	13%	-	0%	-	16%	32%	12%	22%	4% - 18%	15% - 39%	0% - 14%	13% - 29%
No	53%	-	50%	-	64%	47%	68 %	52%	46% - 82%	26% - 68%	50% - 82%	25% - 78%
Other	34%	-	50%	-	19%	21%	20 %	25%	13% - 36%	13% - 34%	13% - 50%	9% - 63%

* tabulated by countries; minimum and maximum shown

Table A-4 : The willingness to withdraw treatment, if the predicted outcome from treatment continuance was severe disability with (A) with the ability to speak, or (B) with the ability to communicate but without speech.

It seems clear that such outcomes would not be classified as 'recoveries' by the doctors who were willing to withdraw treatment. This is of importance as it shows that the medical use of the term 'recovery' is not wholly amenable to, and resolvable by, scientific methods; it has an irreducible core of meaning which is amenable only to an ethical analysis.

Appendix B: Borthwick's criticism of the definition of PVS

Chris Borthwick has, in a number of articles, criticised the coherence of the definition of PVS; three of these articles are summarised in this appendix. These articles are listed in Table B-1, their respective abstracts are listed in the Table B-2:

1.	'Persistent Vegetative State; A Syndrome in Search of a Name, or a Judgement in Search of a Syndrome'. <u>Monash Bioethics Review</u> 1995, April 14, (2): 20-26.	cited as (1995a)
2.	'The Proof of the Vegetable; A Commentary on Ethical Futility'. <u>Journal of Medical Ethics</u> 1995, August 21, (4): 205-8.	cited as (1995b)
3.	'The Permanent Vegetative State; Ethical Crux, Medical Fiction?' <u>Issues in Law and Medicine</u> . 12, 2 (1996):167-188.	cited as (1996)

Table B-1: Borthwick's articles on the coherence of the definition of PVS.¹

1995(a)	<u>Abstract</u> ::- It is now over twenty years since Jennett and Plum in 1972 coined the name 'persistent vegetative state' to describe a state that is " <i>neither unconscious[ness] nor coma in the usual sense of these terms ... [but rather] wakefulness without awareness</i> ". It is a term that has been widely used since, and the mantraps and spring guns that were built into the definition at the outset are still dangerous. Definitions decided on at the outset have channelled the debate ever since, and are still influential. It is important to re-examine the first steps in this area to see why that course was adopted then and why it is still directing us now.
1995(b)	<u>Abstract</u> ::- Patients with 'persistent vegetative state' (PVS) are often cited in discussions of ethicists as examples of human beings who are unconscious and do not experience life, and a number of theoretical and practical recommendations have been made on that basis. This article examines the evidence and the theoretical rationale for the belief that people with PVS are unconscious and finds them wanting. This conclusion is related to the discipline of ethics.
1996	<u>Abstract</u> ::- In 1994 a Multi-Society Task Force made up of representatives of the American Academy of Neurology, the Child Neurology Society, the American Neurological Association, the American Association of Neurological Surgeons, and the American Academy of Paediatrics produced a Consensus Statement on the Medical Aspects of the Persistent Vegetative State (PVS). This Statement presents a picture of the degree of diagnostic certainty achievable in this area that is in many respects misleading. Its attempt to propose a condition called Permanent Vegetative State, which would be based on a high degree of medical certainty either that there is no further hope for recovery of consciousness or that, if consciousness were recovered, the patient would be left severely disabled, confuses two different issues.

Table B-2: The abstracts of Borthwick's articles as listed in Table B-1

The 1995(a) paper

This paper is a critical review of the Jennett and Plum paper of 1972 which named the syndrome PVS as such.² Borthwick's main assertions are that:

- (i) Because Jennett and Plum posit a large number of pathways into PVS,³ and a large number of brain states that produce PVS,⁴ it is *'not necessarily obvious that all these would produce an identical state.'*⁵ Essentially, Jennett and Plum in defining PVS were considering a *situation*⁶ and not a *condition*. A condition has an organic, or theoretical unity, and its symptoms manifest an inner coherence; a syndrome, in contrast, is defined

¹ These articles were consulted on the internet and accordingly the pagination may differ from that as originally published.

² See Chapter 4, Section 1.

³ e.g. by head trauma, stroke and hypoxia.

⁴ e.g. damage to cortex, the brainstem or the basal ganglia.

⁵ Borthwick (1995a) p. 20.

⁶ Although this was the term used by Borthwick, the term 'syndrome' is more appropriate.

simply by the actual coincidences of its symptoms. Borthwick argues that if many cases of a syndrome also share some property 'X', it is less justifiable to assume that *all* cases share this property 'X', than if a condition - rather than a syndrome - had been under discussion; this, he suggests, when applied to the debate on PVS casts doubt on the assertion that because some PVS patient may lack consciousness and the ability to experience pain, all do.

- (ii) Jennett and Plum's presentation was conditioned by the knowledge that ethical questions involving the possibility of terminating the lives of PVS patients would emerge. They knew that these ethical questions would be greatly simplified if it were possible to establish that PVS patients had no consciousness, that their condition was irrecoverable and that they could be reliably diagnosed. Borthwick states:

*"If it was not possible to establish these three propositions reliably from the available evidence, and Jennett and Plum concede that it was not, then it might be of assistance if they could instead be smuggled into the debate by being incorporated into the definition of PVS; and this Jennett and Plum virtually do."*⁷

- (iii) Because Jennett and Plum used behavioural observation to judge the presence of consciousness and because, at the margin between 'locked-in syndrome' and PVS, the *'behavioural characteristics that denote consciousness are minute'*,⁸ the danger of patients being diagnosed as PVS when in fact they are not, is particularly acute. The criterion often used in relation to the locked-in syndrome, is the ability to signal by using eye movements. By considering the example of such a Locked-In Syndrome patient and by imagining a medical condition which affects eye control - many of which conditions exist - Borthwick asks as to how such a patient would be distinguished from one in a PVS. Furthermore, such an example - in that it is accepted that the patient is conscious - casts doubt on the general assertion that PVS patients are not conscious.
- (iv) Borthwick questions why many who have recovered from PVS *"... have apparently never been asked whether they felt pain or not."*⁹ The question of whether PVS patients can feel pain has, he suggests, been resolved by a sleight of hand:

*"If, contrariwise, the family wish to believe that the patient is not suffering, then that, too, can be more easily dealt with by a clear statement that he or she can, by definition, feel no pain."*¹⁰

The 1995(b) paper

This paper is concerned with the indeterminacy of both patient consciousness and ability to experience pain, and the related difficulty in distinguishing conceptually between PVS and 'locked-in syndrome'. In support of this second point Borthwick quotes from the transcript of the Karen Quinlan case where an expert witness - who had been asked about the theoretical distinction between 'locked-in syndrome' and PVS - was unable to resolve the hypothetical problem of diagnosing a 'locked-in syndrome' patient who had difficulty in controlling their eye movement. The witness accepted the theoretical possibility of a PVS patients being conscious but said *"I think it's*

⁷ *ibid.* p.25. This is a point that could be made with considerably greater force against the BMA Guidelines which insist that to speak of 'recovery' from PVS was incorrect, the appropriate term being 'misdiagnosis'.

⁸ *ibid.* p.21.

⁹ *ibid.* p.25.

¹⁰ *ibid.* p.23.

one of the most horrendous things you can imagine.”¹¹ This leads to Borthwick’s most original points which relate to the reasons why, in the face of evidence of possible consciousness, there is such a reluctance to accept the fact that some PVS patients are indeed conscious. His first observation is closely related to the ‘denial of death’.¹²

*“We wish to believe that people in unendurable situations are unaware, and we resist evidence that would indicate otherwise. Some of us avert our eyes. Others elevate our disquiet to the status of a neurological theory and an ethical imperative.”*¹³

His second observation is even more pertinent. It focuses on medical ethicists, their need for the ‘syllogism of hard logic’,¹⁴ and their refusal to acknowledge the uncertainties inherent in real situations with their ‘inevitable ambiguities of uncertain knowledge and unclassifiable pathology’.¹⁵ The inevitable result of such simplification, argues Borthwick, is that the ‘solutions’ advocated by such ethicists are highly inappropriate.

The 1996 paper

This paper is a critical review of ‘The Multi-Society Task Force on PVS’ report. Borthwick again considers the difficulty in distinguishing theoretically between the ‘locked-in syndrome’ and PVS and suggests that:

*“The fundamental issue is not ‘Can cases of locked-in syndrome be confused with cases of PVS?’ but ‘Is it possible that PVS is the same thing as locked-in syndrome, but without purposive eye movement?’”*¹⁶

He examines the difficulty in interpreting what may be very slight signs of behavioural awareness and quotes a study showing that 92% of parents of children, diagnosed as being in a PVS did not accept the assertions by physicians that awareness was lacking in their children.¹⁷

Borthwick analyses the neurological studies used by the Multi-Society Task Force on PVS in support of their contention that PVS patients lack awareness. He points out that due to the non-existence of any tests which could independently confirm awareness, the Task Force’s use of neurological tests involves a circularity of reasoning. The Task Force had sought to draw, from the occurrence of certain results which were consistent with the absence of awareness, the conclusion that awareness was absent. He argues that such a conclusion was not justified as these results are equally consistent with alternative hypotheses - such as a diagnosis of ‘locked-in syndrome.’ He criticises the Task Force’s use of particular neurological studies:

- (i) their use of PET scan studies of PVS patients to suggest that these ‘... show levels far lower than those in patients who are aware or in a locked-in state.’ Borthwick consulted the original study used by the Task Force as justification for this and for the statement that:

*“... no overlap in metabolic impairment was noted when these patients were compared with three patients who had the locked-in syndrome.”*¹⁸

¹¹ Borthwick (1995b) p.207.

¹² which is considered in Chapter 9.

¹³ *ibid.* p.207.

¹⁴ *ibid.* p.208.

¹⁵ *ibid.* p.205.

¹⁶ Borthwick (1996) p.173 [emphasis added].

¹⁷ *ibid.* p.174.

This emphasises the relevance of the recommendation made in the Childs’ study (see Appendix A) that medical staff pay particular attention to reports by the families of patients, of changes in a patient’s behaviour.

¹⁸ *ibid.* p.176.

The original study had cited two cases of overlap.¹⁹

- (ii) their use of cerebral blood flow levels. Borthwick cites a study to show the existence of “...
normal cerebral blood flow in patients in a persistent vegetative state.”²⁰

The absence of brain activity in PVS patients similar to that found in conscious subjects who are experiencing pain is sometimes used as an argument to suggest that PVS patients do not experience pain. Borthwick counters this argument by quoting²¹ from the neurologist Oliver Sacks²² to the effect that there is some evidence that pain can relocate its functions and from other studies which show the essential malleability of the brain in regard to its functions.²³

¹⁹ McQuillen's doubts on the usefulness of PET scans in diagnosing PVS and Andrews' non-reliance on such scans, has been noted earlier (see Chapter 4).

²⁰ *ibid.* p.176.

²¹ *ibid.* p.177.

²² Oliver Sacks *Awakenings* (1990) p.331.

²³ Similar arguments have been advanced in Chapter 3.

Appendix C: Relevant Legal Judgements

The relevant legal judgements are examined in detail in this appendix. The citations for cases discussed in this appendix are listed in Table C-1 and the case details are given in Table C-2.

<u>Name of case</u>	<u>Date</u>	<u>Citation</u>
<u>IRELAND</u>		
1	<i>The Ward Case</i>	1995
		High Court: unreported judgement delivered on 5 th May 1995. Supreme Court: In the Matter of a Ward of Court [1995] 2 ILRM 401.
<u>ENGLAND</u>		
2	<i>The Bland Case</i>	1993
		Airedale N.H.S. Trust v Bland [1993] A.C. 789: (High Court at p.795 <i>et seq.</i> ; Court of Appeal at p.806 <i>et seq.</i> ; House of Lords at p. 856 <i>et seq.</i>)
3	<i>Frenchay v S</i>	Jan. 1994
		Frenchay Healthcare NHS Trust v S [1994] 2 All ER 403.
4	<i>Re G</i>	Nov.1994
		Re G (Persistent Vegetative State) [1995] 2 F.C.R. 47.
5	<i>Re D (Medical Treatment)</i>	1997
		The Times 21 st and 22 nd March 1997; subsequently reported as Re D (Medical Treatment) [1998] 1 F.L.R. 411.
6	<i>In re F. (Mental Patient: Sterilisation)</i>	1990
		In re F(Mental Patient: sterilisation) [1990] 2 A.C. 1.
7	<i>Re B (a minor) (wardship: medical treatment)</i>	1981 (reported in 1990)
		Re B. (a minor) (wardship: medical treatment) [1990] 3 All ER 927.
8	<i>McKay and another v Essex Area Health Authority and another</i>	1982
		McKay and another v Essex Area Health Authority and another (1982) 2 All ER 771.
9	<i>Re C (a minor) (wardship: medical treatment)</i>	1989
		Re C (a minor) (wardship :medical treatment) [1989] 2 All ER 782.
10	<i>Re J (a minor)(wardship: medical treatment)</i>	1990
		In re J. (A Minor) (Wardship: Medical Treatment) [1990] 3 All ER 930.
11	<i>Re R (Adult: Medical Treatment)</i>	1996
		Re R (Adult: Medical treatment) [1996] 2 FLR 99.
12	<i>T (A Minor) (Wardship: Medical treatment)</i>	1996
		The Times of 25 th October 1996; see also Current Law Year Book 1996,179.
13	<i>Re C (A Baby)</i>	1997
		Re C (A Baby) [1998] 1 F.L.R. p. 384; The Times of 20 th November 1997.
14	<i>Ex parte Glass</i>	1999
		The High Court proceedings were reported in The Times 22 nd April 1999; The Guardian 23 rd April 1999. The judgement of the Court of Appeal was reported as: R v Portsmouth Hospital NHS Trust, Ex parte Glass: The Times 26 th July 1999.
<u>CANADA AND NEW ZEALAND</u>		
15	<i>Re Superintendent of Family and Dawson</i>	1983
		Re Superintendent of Family and Child Service and Dawson (1983) 145 D.L.R. (3d) 610.
16	<i>Nancy B. v Hotel-Dieu de Quebec</i>	1992
		Nancy B. v Hotel-Dieu de Quebec 86 D.L.R. (4 th) 385.
17	<i>Auckland Area Health Board v AG</i>	1992
		Auckland Area Health Board v Attorney General [1993] 1NZLR 235.

Table C-1: Citations of cases summarised in Appendix C

Note:

- (i) Aspects of cases which are of a purely legal relevance have been omitted.
- (ii) The term 'ANH' is the acronym for 'Artificial Nutrition and Hydration'.

<u>Type of case</u>		<u>Name of case</u>	<u>Date</u>	<u>Notes</u>	<u>Page</u>
<u>IRELAND</u>					
PVS	1	The Ward Case	1995	near-PVS	431
<u>ENGLAND</u>					
PVS	2	The Bland Case	1993	PVS	434
	3	Frenchay v S.	Jan 1994	PVS - Emergency decision on treatment withdrawal without the opportunity for independent medical assessment.	439
	4	Re G	Nov. 1994	PVS - more profound vegetative state than Tony Bland; family not unanimous on the withdrawal of ANH.	440
	5	Re D (medical treatment)	March 1997	'Borderline' PVS - tube had become disconnected; whether an operation to reinsert the tube should be performed.	441
Absence of consent	6	In re F. (mental patient: sterilisation)	1990	Sterilisation of a mentally handicapped woman.	441
Disability	7	Re B (a minor) (wardship: medical treatment)	1981 [reported in 1990]	A baby born with Down Syndrome also had an intestinal blockage which could be cured without difficulty. The parents opposed the operation ; whether the parents wishes should be respected.	442
	8	McKay and another v Essex Area Health Authority and another	1982	A mother contracted rubella during pregnancy and her child was born severely disabled; whether her child had a right to claim damages because the pregnancy had not been terminated.	443
	9	Re C (a minor) (wardship: medical treatment)	1989	Discussed the appropriate treatment for a baby who was severely handicapped and terminally ill.	444
	10	Re J (a minor) (wardship: medical treatment)	1990	Withholding life-saving treatment from a 4-month old baby who was grossly handicapped but who was not dying.	444
	11	Re R (adult: medical treatment)	1996	R, a 23 year old, had malformation of the brain and cerebral palsy; his psychiatrist had signed a 'do not resuscitate order'; whether such an order was appropriate.	447
	12	T (a minor) (wardship: medical treatment)	1996	The High Court supported a mother's right to refuse consent to a life saving operation for her 18-month-old child, against the judgement of the child's doctors; 'best interests' can include non-medical factors.	448
	13	Re C (a baby)	1997	The High Court overruled parents' objections, which were on religious grounds, and permitted the withdrawal of artificial ventilation from a 16-month-old, fatally ill, child.	448
	14	Ex parte Glass	1999	Mother objected to withdrawal of ventilation from her 12-year-old severely disabled son.	449
<u>CANADA and NEW ZEALAND</u>					
Disability	15	Re Superintendent of Family and Dawson	1983	The issues to be considered when making treatment decisions for a disabled child.	450
Locked-in syndrome	16	Nancy B. v Hotel-Dieu de Quebec	1992	Patient with 'locked-in syndrome'; whether patient entitled to have life sustaining treatment discontinued.	451
Locked-in syndrome	17	Auckland Area Health Board v AG	1992	Patient with 'locked-in syndrome'; whether doctors entitled to have treatment discontinued.	451

Table C-2: Details of cases summarised in Appendix C

The cases are now examined in the order given in Table C-1.

Ireland

1. The Ward Case¹

Facts:- In 1972 a 22-year-old woman attended a Dublin hospital for a minor gynaecological operation. During the operation she suffered cardiac arrests which caused severe brain damage. As a result she was left spastic, bedridden and incontinent. She was unable to speak, her mouth was permanently clenched and she was unable to swallow. She was fed artificially, at first by a nasogastric tube - which seemed to cause her considerable distress - and, subsequently, by a gastrostomy tube. Her eyes were open and often followed people moving in her vicinity. The judgement of her doctors was that such behaviour was mainly 'reflex' with only a minimal purposive content. She was diagnosed as being in a '*near-Permanent Vegetative State*' and it was the opinion of her doctors that recovery was most unlikely.

For over twenty years her condition remained essentially unchanged and during that period she had been made a ward of court. In 1995 her family, believing that her continued medical treatment was causing her considerable distress, sought an order from the High Court that medical treatment, other than that of a purely palliative nature, be discontinued and that she be allowed to die.

The hospital authorities opposed this application.

The High Court

Held (per Lynch J.)::- Counsel for the family had argued - relying on the constitutional recognition accorded to the family - that the decision as to the future treatment of the Ward lay with her family rather than with the medical carers or with the court. The court rejected this contention and set out² and approved, what it saw as the current medical practice in relation to disputes between family and carers concerning the withdrawal of treatment from incompetent patients; it decided that, in such cases, the ultimate power of decision lay with the courts.³ The various eventualities are most easily summarised in tabular form and are set out in Table C-3:

Line	Patient terminally ill	Family want withdrawal	Medical carers want withdrawal	2 nd medical opinion required	Treatment can be withdrawn without the need for a Court application
1.	Yes	Yes	Yes	not obligatory	Yes
2.	Yes	No	Yes	obligatory	Yes
3.	Yes	Yes	No	not obligatory	Court application required
4.	No	Yes	No	not obligatory	Court application required
5.	No	No	Yes	(situation unclear)	(situation unclear)
6.	No	Yes	Yes	(situation unclear)	Yes

Table C-3: Legal requirements for treatment withdrawal as set out in the Ward case.

¹ In the Matter of a Ward of Court [1995] 2 ILRM 401.

² In the Matter of a Ward of Court; High Court, unreported judgement at p.19.

³ The judgement is not clear in relation to certain eventualities; for example, the situation (envisaged in Line 5, Table C-3) where the medical carers wish to withdraw treatment from a non-terminally ill incompetent patient against the wishes of the family, is not considered. It appears that a court application is not required in the situation envisaged in Line 6 - that is where both family and carers agree on the desirability of withdrawing treatment; had a similar procedure been in force in England, then in the circumstances set out *In re R* [1996] (Number 11 in this Appendix) the joint consent of the family and medical authorities would have been sufficient authority both for the 'Do Not Resuscitate' order, and for the withdrawal of ANH.

The situation in the Ward case is reflected in Line 4.

The court next considered the effect of the constitutional provision guaranteeing the right to life; it had been urged on the court that because this was so fundamental a right, and because the state was constitutionally obliged to defend it, a person would have no right to kill themselves irrespective of the circumstances that pertained. By considering the example of a prisoner subjected to cruel torture, the court found that such a prohibition was too widely stated and that a time would come when - in the interests of his dignity and autonomy - the prisoner would have the right to take his own life. The court held that, when expressed in a medical setting, these same interests and principles imply that a competent patient has the right to refuse burdensome medical treatment even though such a refusal results in their death. However, the court did not consider that this right of a competent patient to refuse medical treatment was unqualified: the refusal needed, in the circumstances, to be 'reasonable'.

The court then sought to apply these principles to the situation of the Ward: the hospital authorities had argued that the tube feeding of the Ward must be considered to be 'normal' for the Ward because she had been nourished in that way for many years. The court held that a state of affairs which was abnormal could not become normal simply by virtue of its continuance for an extended time; accordingly since tube feeding was, generally, not a normal means of nourishment it could not be so in the Ward's case and must be considered to be a form of medical treatment. The court held that when making a decision to withdraw treatment, the test to be applied was the 'best interests test'; the relevant question was *'What is in the best interests of the Ward?'* The court found that the benefit to the Ward of continued medical treatment was far outweighed by the burden of sustaining her life in the manner contemplated and with no hope of any improvement; accordingly it was in the Ward's best interests that treatment be terminated. The court also found support for this course of action in its finding that this would accord with the Ward's wishes. The court consented to the withdrawal of ANH and to the non-treatment of infections other than palliatively.

The court did not make an order against the hospital authorities because it accepted that the withdrawal of treatment would, in such circumstances, be contrary to their philosophy; the court gave permission to the family to move the Ward to an institution which would not find such a withdrawal of treatment objectionable.

The Supreme Court

(Hamilton, C.J., O'Flaherty, Blayney and Denham J.J., in favour of the withdrawal of ANH; Egan, J., dissenting.)

The judgement of the High Court had been appealed on the grounds⁴ that the decision to permit a withdrawal of ANH was wrongful because, *inter alia*:

- (i) it was predicated upon an assessment of the 'quality of life' of the Ward which was impermissible under the Constitution and that if the State were ever to take 'quality of life' considerations into account it would mean that the state provided less protection for the most disadvantaged, or the most vulnerable, of its citizens.
- (ii) it affected a person with cognition (even if it be extremely minimal) and was thus contrary to the Constitution.
- (iii) the decision failed to vindicate the constitutional right to life of the Ward.
- (iv) ANH was not a 'medical treatment'.

⁴ These grounds are set out in the judgement of Denham J., *In the Matter of a Ward of Court* [1995] 2 ILRM 401 at p.448; [hereafter called *'the Ward case'*]

Hamilton C.J.

Hamilton C.J. found that the right to life took precedence over all other constitutional rights but that this right had ancillary rights, one of which was *'the right to have nature take its course and to die a natural death'*.⁵ A competent adult has, if terminally ill, the right to forgo life-saving treatment. The Ward could be considered terminally ill because, in the absence of treatment, she would die within a short period of time; accordingly, she would, if competent, have the right to forgo treatment. Since the loss of mental capacity must not operate so as to diminish her constitutional rights the court must exercise these rights on her behalf; in doing so the paramount consideration must be the 'best interests' of the Ward. The withdrawal of ANH was in the 'best interests' of the Ward.

O'Flaherty J.

O'Flaherty J. held that ANH was a 'medical treatment' and that - flowing from the right to bodily integrity - there was an absolute right in a competent person to refuse medical treatment. He further accepted that the court could not step aside from making a decision, because to allow the treatment to continue is as much a decision as to stop it - a point also made in the judgement of Denham J. O'Flaherty J., found it impossible to adapt the idea of 'substituted judgement' to the facts of the case before him and held that the test to be applied was the 'best interests' test which, in this case, was best served by the withdrawal of treatment thus allowing nature to take its course.

Egan J.

Egan J. found that the method of providing sustenance to the Ward was intrusive and would - if she were competent - require her consent; but he found that there was little useful evidence as to what her wishes might be. He rejected the suggestion that she was terminally ill. He held that the inevitable result of the removal of the tube would be to kill a human being and accordingly it must be rejected. Furthermore, pointing out that the Ward had *some* cognition, he posed the rhetorical questions *"If slightly more cognitive function existed, would a right to withdraw sustenance still be claimed? Where would the line be drawn?"*⁶

Blayney J.

Blayney J. held that the trial judge clearly complied with the constitutional obligation to respect the Ward's life by addressing very fully the question of whether it was of any benefit to her to prolong her life. He also accepted that not only was the ANH a 'medical treatment', but that it was also abnormal; though the relevance of this latter point is not developed. He agreed to the withdrawal of ANH.

Denham J.

Denham J. held that medical treatment may not be given to a competent person without their consent; this right flows from the constitutional rights to privacy and to be treated with dignity. She held that ANH was a 'medical treatment'; that the constitutional rights of the Ward were equal to those of any other citizen; and that the question before the court was whether these rights could be exercised by anyone else on her behalf.

⁵ *ibid.* p.426.

⁶ *ibid.* p.437.

Denham J., held that the question was to be decided as one of personal rights rather than of family rights, and accordingly the making of the decision rested with the court (as the guardian of the rights of the ward) though they would be influenced in their decision by the views of the family. The test to be applied by the court is: *'Is it in the best interests of the Ward that the court consent to continued treatment?'* A list of the factors to be taken into account by the court in making its decision was provided. A consideration of these factors - in particular the invasive nature of the treatment - make clear that it is in the best interests of the Ward that treatment be withdrawn.

England

PVS Cases

2. *The Bland Case*⁷

Facts:- Tony Bland who was then aged 17, was seriously injured in the Hillsborough football disaster. He suffered severe brain damage and was subsequently diagnosed as being in a PVS and was fed by a nasogastric tube. At the time of the court application he had been in this condition for three and a half years; the medical prognosis was to the effect that there was no hope of any recovery. At no time before the disaster had he made his wishes known as to how in such an eventuality, he wished to be treated, though his father was of the opinion that his son would not want to be left to remain in his present condition.

The court application was for a declaration that the withdrawal of medical treatment (including ANH) was lawful; it was made by the health authority in charge of the hospital wherein the patient was being treated with the concurrence of the family and the support of the consultant physicians involved in the case and also that of independent physicians.

The court application was made because the medical team had been advised that a withdrawal of ANH could lead to a criminal prosecution for murder.

The application was heard:

- (i) at first instance in the High Court: by Sir Stephen Brown.
- (ii) on appeal to the Court of Appeal: before Bingham M.R., Butler-Sloss and Hoffman L.JJ..
- (iii) on appeal to the House of Lords: before Lords Keith, Goff, Lowry, Browne-Wilkinson and Mustill.

The High Court

Sir Stephen Brown

Dr Andrews had given evidence against regarding ANH as a 'medical treatment' and against resolving the problem by withdrawal of treatment as *'he would find the means of death worrying'*.⁸ However, the preponderance of the medical evidence was that ANH was a 'medical treatment' and it was accepted to be so by Sir Stephen Brown who forthrightly acknowledged that the process would be one of *'starvation'*.⁹

⁷ *Airedale N.H.S. Trust v Bland* [1993] A.C. 789; [hereafter called *'the Bland case'*]

⁸ *ibid.* p.800.

⁹ *ibid.* p.796.

This case was the first English case to consider such matters and the court placed reliance on the case of *In re J*¹⁰ which concerned a severely brain damaged child and in which the court had stated that:

“... account has to be taken of the pain and suffering and the quality of life which the child will experience if life is prolonged.”¹¹

The official solicitor had argued that as Tony Bland was incapable of feeling or awareness - this was conceded by all sides - such consideration could not apply. However, the court held that the interests of Tony Bland were best served by the withdrawal of ANH.

The court directed that in similar cases before treatment be withdrawn, application be made to the High Court and be based on the testimony of at least two medical experts¹² and that such a procedure was essential¹³ in cases where there was of a division of opinion amongst family members. This recommendation was endorsed by both the Court of Appeal and the House of Lords.

The Court of Appeal

(The judgement that ANH be withdrawn, was unanimous.)

Bingham, M.R.

Sir Thomas Bingham first set out certain principles which he held had been accepted by all parties. These were that:

- (i) Medical treatment may not be imposed on a competent person without their consent; this is so even if the reasons given for the refusal are irrational.
- (ii) In the case of an incompetent adult, no one (and this includes the court) can give consent on his behalf; however, treatment may be provided by a doctor where the treatment is in the best interests of the patient.¹⁴
- (iii) In cases where the patient is a child or a ward of court, the court will itself decide when treatment is in the best interests of the patient.

Accordingly, had Tony Bland given instructions concerning artificial feeding these would be binding. Had he been a child or a ward of court, the court could give consent. This case is novel because it falls outside these situations.

[Note:- The *parens patriae* jurisdiction¹⁵ of the court over an incompetent adult was implicitly removed by statute and as a result, the English courts had lost the power to consent to invasive treatment of incompetents other than those who were children or wards of court. However, the court (in the case *In re F*) laid down the principle - based on the law of necessity - that a doctor can lawfully treat an incompetent adult if it is in the patient's best interests that he do so. The result is that although the courts could not make a decision on treatment withdrawal for Tony Bland, they could lay down the criteria to be used by the doctor in making this decision. This issue was much discussed in the various judgements in the Court of Appeal and in the House of Lords.

¹⁰ Number 10 in Appendix C.

¹¹ *ibid.* p.801.

¹² The application in the instant case had been based on the testimony of just one medical expert.

¹³ *ibid.* p.805:

“Because of the gravity of the decision and the likely possible variation in the facts in individual cases I consider that the approval of the court should be sought in cases of a similar nature ... and the Official Solicitor ... be invited to act as the guardian ad litem of the patient.”

¹⁴ The point is not that the doctor can give or dispense with the need for consent but rather that the doctor will have a valid defence - based on the legal doctrine of necessity - to a charge of assault if he acts in the best interests of the patient provided the circumstances were such that it was not possible to seek, and obtain, consent.

In the Ward case, the Irish courts made their judgement by explicitly invoking the *parens patriae* jurisdiction, thus their decision is not restricted to cases of wardship.]

Sir Thomas Bingham held that it is not crucial to decide as to whether ANH is 'medical treatment' as it is undoubtedly 'medical care' and the answer to the problem before the Court should not depend on such fine distinctions. The indefinite prolonging of the life of an insensate patient is not one of the objects of medical care. The assessment of the patient's best interests is, in the first instance, for the doctors but is subject to a review by the courts. In the present case there was no reason for not accepting the doctors' assessment. Indeed, if one endeavours to look at the matter through Mr. Bland's eyes, it is difficult to conceive of any benefit his continued existence could give him.

Application to the court was required in similar cases until such time as a body of experience and practice in dealing with these cases has been established.

Butler-Sloss L.J.

Lady Butler-Sloss noted that the starting point for an analysis of this case is the right of self-determination; this right implies the right to refuse medical treatment irrespective of whether the reasons given are rational or irrational. As Tony Bland is incompetent, no one can consent to treatment on his behalf; however, treatment may be lawfully given if it is in his best interests. The judgement of best interests involves a balancing exercise and although the severity of pain is an important consideration it is not the only one; issues of human dignity and the intrusiveness must be considered. Because of the gravity of the case, the medical assessment of best interests requires some degree of monitoring and in subsequent cases applications to discontinue treatment should be made to the High Court.

The provision of ANH has been considered as medical treatment by courts and medical authorities worldwide; the Mental Health Act 1983 includes nursing care in its definition of 'medical treatment'. However, by considering ANH as 'medical care' - rather than 'medical treatment' - the necessity for over-subtle distinctions can be avoided.

The distinction between an 'act' and an 'omission' is not helpful. The case of *R v Cox* (1992)¹⁶ - where a doctor had given his patient an injection and used a lethal dosage designed to cause death - was distinguished because, in that case, Dr. Cox had introduced an '*external agency of death*.'

Hoffman L.J.

Lord Hoffman noted that appeal is often made to the principle of the 'sanctity of life' when discussing cases such as this; it explains why we think it almost always wrong to cause the death of another. However, in deciding how we should live our lives, other principles are also required - rights of autonomy, self-determination and human dignity. The problem is that in many situations these rights are not compatible - the patient who refuses life-saving medical treatment is exercising the right to self-determination but, in the eyes of some, committing an offence against the sanctity of life.

In this case a decision has to be made between conflicting rights - that of the sanctity of life and that to human dignity. In choosing human dignity it may be thought by some that a lethal injection would be more preferable than treatment withdrawal; this ignores the fact that the sanctity of life

¹⁵ In a *parens patriae* jurisdiction the court makes the decision on whether treatment should be given, whereas in the Bland case the court is considering the criteria that should be used by the doctors in their making the decision.

¹⁶ *R v Cox*, 18th September 1992; Ognall J. (cited the Bland case at p.823)

involves an added '*principle of inviolability*' against intrusion by an outsider, so that, even if requested, we would not be entitled to end a patient's life by lethal injection.

This distinction is complicated somewhat by a further ethical principle that we should show kindness to another. This principle is manifested in the most basic way, in the obligation to provide food and shelter to the helpless; so that if someone starves a child or invalid in his care, to death we treat him as *if* he had introduced an external agency. In normal cases there is no moral difference between the prohibition on violating the person and the positive obligation to act with humanity towards the helpless but there are two exceptions. Unlike the prohibition on violating the person which is absolute - it was this principle which was violated by Dr. Cox¹⁷ - the duty to provide care ceases when such care can provide for no humane purpose. The duty to provide care is also restricted to what one can *reasonably* provide; health resources are not limitless and choices must be made; this aspect of the case was not argued but may be of importance for future cases. The important distinction is not the barren one between 'act' and 'omission', nor that between 'medical treatment' and 'medical care', but between introducing an external agency to cause death and not doing so.

It was suggested that because Tony Bland was unconscious, he had no interests to be protected but this shows a lack of understanding of how people intuitively perceive interests as is shown, for example, by how we respect the wishes of the dead even though they would never know that their wishes had been ignored. The interests of a patient also embrace having a peaceful and dignified death.

The High Court laid some emphasis on the fact that its decision was in accord with the views of the BMA and with good medical practice; Lord Hoffman stated, however, that '*I would expect medical ethics to be formed by the law rather than the reverse*';¹⁸ the decision before the court is a purely legal or moral one which does not require any medical expertise and is therefore appropriate to the court.

The House of Lords

(The judgement that ANH be withdrawn, was unanimous.)

Lord Keith

Lord Keith first reviewed the cases *In re F*¹⁹ and *In re J*.²⁰

In *In re F*, the House of Lords held that it would be lawful to sterilise a female mental patient who was incapable of giving consent to the procedure on the grounds that such would be in the patient's best interests as it would enable her life to 'be fuller and more agreeable'.

In *In re J*, the House of Lords held that it would be lawful to withhold lifesaving treatment from a young child in circumstances where the child's life, if saved, would be racked by pain and suffering.

In both these cases it was possible to make a judgement as to the best interests of the patient; the difficulty in the present case is because Tony Bland, being insensate, must be completely indifferent as to whether he lives or dies. The decision as to whether the treatment confers any benefit is essentially one for the medical practitioners in this case.

¹⁷ in *R v Cox (supra)*.

¹⁸ The Bland case p.834.

¹⁹ No. 6 in this Appendix.

²⁰ No. 10 in this Appendix.

As to whether the continued feeding is 'medical treatment'; regard should be had to the whole regime, including the artificial feeding, which keeps Tony Bland alive and that is undoubtedly a 'medical treatment'.

Lord Goff

Lord Goff held that in certain circumstances the principle of the sanctity of human life must yield to the principle of self-determination; an example of such is when a patient refuses consent to life-sustaining medical treatment; one consequence of this is that there is no absolute obligation on a doctor to prolong the life of his patient regardless of the circumstances.

The question at the heart of the present case is whether what is being suggested is in the best interests of the patient; the question is not whether it is in his best interests that he should die but rather whether it is in his best interest that his life should be prolonged by this form of medical treatment. A further distinction can be drawn between cases where - as in *In re J* - a balancing operation can be performed, and cases where the patient is totally and permanently unconscious; in these latter cases it is the futility of the treatment that justifies its withdrawal.

In US courts, the 'substituted judgement' test has gained favour and it generally involves a detailed investigation into the patient's views and preferences; this test does not form part of English law and the 'best interests' test should be the appropriate guide.

Lord Lowry

Lord Lowry held that the real nub of this case lies in the suggestion that the duty to feed a helpless person is something which exists independently of all questions of treatment; against this, it can be argued that the overwhelming verdict of medical opinion worldwide is that these questions cannot be separated. The suggestion is based on a faulty premise namely that feeding in order to sustain life is *necessarily* for the benefit of the patient so the theory of a 'duty to feed' is based on a misapprehension. ANH should be withdrawn and - even though there is an intention to bring about the patient's death - there is no guilty act; this is because were the doctor to *continue* to give ANH, he would be guilty of an unlawful act as he would not be acting in the best interests of the patient.

Lord Lowry considered that this judgement may rely on a 'distinction without a difference' and legislation is required to resolve this question and help bring 'old law' and 'new medicine' again into harmony.

Lord Browne-Wilkinson

Lord Browne-Wilkinson held that the law in this area must, to be acceptable, reflect the moral attitudes of society; but this is a task for parliament, not for the courts. It is for parliament to decide the broader issues, such as the limited nature of resources and the fact that the precise time of death may have serious implications for others *e.g.* as to the amount of damages recoverable or the rights to succession or criminal liability.²¹ Accordingly it is imperative that legislation to resolve

²¹ A recent US case highlights the urgency of resolving these questions: a daughter was attempting to place her aged mother in a nursing home; the mother shot and severely wounded her daughter leaving the daughter severely incapacitated. The daughter sought, and received, court approval to have her own life support system discontinued. The precise date of discontinuing the life support would determine whether the mother could, or could not, be charged with murder. (The Irish Times 20-5-1999)

Speaking generally, if the original brain damage which resulted in PVS was caused by medical negligence (as happened in the Ward case), then not only the timing of the decision to withdraw ANH but especially the decision itself - in that damages for future care are no longer an issue - are highly relevant and raise the possibility of there being a conflict of interests.

these issues, be introduced. The only solution open to the court in the present case is to apply the existing law even though the result may be both legally and morally unsatisfactory.

Lord Browne-Wilkinson asked whether - since the whole purpose of stopping artificial feeding is to bring about the death of Anthony Bland - this constitutes murder? He answered this question by placing reliance on the distinction between an act and an omission: if the withdrawal of ANH is an *act* it is murder; if it is an *omission*, and the doctors are under a duty to provide ANH, it is murder; but if they are not under such a duty, then it is not murder. The removal of ANH, although it wears the appearance of an act, is in reality an omission. It is not in the best interests of Tony Bland to provide ANH, therefore the doctors are under a duty *not* to provide it; therefore, they are not in breach of the law in refusing to continue to provide ANH.

Lord Mustill.

Lord Mustill held that the conclusion that ANH can be withdrawn depends crucially on the legal distinction between an act and an omission. Using this distinction as the strategy to enable a resolution of the problem occasions an acute sense of unease because it may accentuate the distortions of a legal structure which is already both morally and intellectually misshapen. There have been attempts to suggest that if ANH is withdrawn, Tony Bland's death will not have been *caused* by the doctors but by the Hillsborough disaster. This is a manipulation of the doctrine of causation and is misplaced; the resolution of the issue is to be found - not in an analysis of the doctrine of causation - but in deciding whether the withdrawal of ANH is itself lawful.

Lord Mustill held that the proposed course of action is not in Tony Bland's best interest because, in fact he has no interests of any kind. Thus, although the termination of his life is not in his best interests, his best interests in being kept alive - which originally justified the initiation of treatment - have also disappeared, taking with them the justification for the continuance of the non-consensual treatment. Absent a duty, the omission to perform what had been a duty, is not unlawful.

Lord Mustill noted the suggestion that the duty of the state to preserve life may be overridden in situations where the 'quality' of life is diminished by disease or incapacity; this should be firmly rejected: "*This is the first step on a very dangerous road indeed, and one which I am not willing to take.*"²²

3. Frenchay v S²³

Facts:- In 1991 a young man took a drug overdose which resulted in him sustaining severe brain damage; he was diagnosed as being in a PVS and tube feeding was necessitated. Subsequently his gastrostomy tube had become disconnected and an operation to insert a new tube was required. The patient's doctor believed that such an operation would not be in the patient's best interest. Other medical opinion was given to the effect that the patient's quality of life was nil and that there was no hope of recovery. The judge granted the declaration sought.

The guardian *ad litem*²⁴ appealed on the grounds that:

- (i) the legal procedure adopted had deprived him (the guardian) of sufficient time to explore the patient's situation;
- (ii) the judge had placed too great a reliance on the doctor's assessment of the patient's 'best interests',

²² The Bland case at p.894

²³ *Frenchay Healthcare NHS Trust v S* [1994] 2 All ER 403

(iii) there was reason to question the diagnosis of PVS.

Held:- Sir Thomas Bingham held that the issue to be determined in cases of treatment withdrawal was the best interests of the patient; that, although the court had the ultimate power to determine the patient's best interests, it would be slow to interfere with the medical assessment of these unless a substantial doubt had been established. In the instant case, there was no reason to doubt the doctor's assessment; it was, however, important that it not be automatically assumed that what was said by the doctor to be in the patient's best interest, *is* in the patient's best interest.

When a hospital makes an application to the courts seeking permission to withdraw treatment, time should - except in cases of emergency where such was not possible - be afforded to the Official Solicitor to obtain independent medical opinion.

Sir Thomas Bingham held that the Bland decision - as that court was at pains to emphasise - applied *only* to the facts which were before it; hence, it was important to ensure that this was a case of true PVS and not one of those where 'glimmerings of awareness' - as mentioned in the Bland judgements - might be present. He held, that though the evidence in the present case was not as unanimous or emphatic as in the Bland case - particularly in that one professor's report stated that the patient *'appears to suffer pain but it is not obvious where this is originating'*,²⁵ which was a view shared by the nurses - the weight of the evidence, particularly that of the doctors who had cared for the patient longest, was that he was in a PVS.

Waite LJ., Gibson LJ., concurred.

4. Re G²⁶

Facts:- In 1991 G, a married man then aged 24, had a serious motorcycle accident; he never regained consciousness and was diagnosed as being in a PVS. This diagnosis had been confirmed by four leading consultant neurologists including Professor Jennett and Dr. Andrews. Dr Andrews' report, which had been commissioned by the Official Solicitor, concluded that G was in a more profound PVS than was Tony Bland. Although the patient's wife reluctantly agreed to a withdrawal of ANH, his mother - believing that her son had some awareness - did not. The judge at first instance permitted the withdrawal of feeding.

This decision was appealed by the mother.

Held:- (per Bingham, M.R.) The patient's mother had based her belief that her son had some awareness on the fact that he became distressed by discomforts such as chest infections and that he could be calmed by the presence and care of his family. Sir Thomas Bingham, relying on Dr. Andrew's report, considered that these responses were reflex in nature and not evidence of any underlying consciousness; this had also been the view of Professor Jennett who had examined G at the insistence of G's mother.

The court accepted the unanimous medical evidence that G had no awareness and held that a right of veto on the decision to withdraw ANH would place an appalling burden on any relative and that accordingly G's mother could not have such a veto. It was decreed that ANH should be withdrawn.

²⁴ i.e. the Official Solicitor charged with legally representing the patient's interests.

²⁵ *ibid.* p.407.

²⁶ *Re G (Persistent Vegetative State)* [1995] 2 F.C.R. 47.

5. *Re D (Medical Treatment)*²⁷

Facts:- Miss D, a 29 year old university student, had as a child suffered from hydrocephalus; in 1995 she had been involved in a car accident leaving her paralysed and with severe mental problems. She was cared for by her parents but suffered a seizure and was hospitalised where she was again treated for hydrocephalus.

She finally recovered wakefulness but there was a dispute as to whether she fulfilled the criteria for the diagnosis of PVS because she appeared to track moving objects with her eyes, she flinched in response to gestures and reacted to the feeling of ice on her body. The Official Solicitor argued that Miss D's responses showed that she was not in a PVS; Professor Chadwick, a medical expert, was of the opinion that these movements were simply 'primitive reflexes' showing no evidence of consciousness.

Her feeding tube had become disconnected and application was made to the court for directions as to whether an operation should be performed to reinsert the tube. She was at present being given fluids intravenously. Her mother and her carers were of the opinion that the operation should not be performed.

Sir Stephen Browne gave judgement in the High Court.

Held:- That, as all the medical consultants and family agreed, Miss D had no awareness and as there was '*no possibility for a meaningful life whatever*',²⁸ that Miss D was in reality in a PVS and it was in the patient's best interests not to operate.

Sir Stephen stressed that he was not extending the list of cases where a declaration for the withdrawal of ANH could be considered: "*The court recognises that no declaration to permit or sanction so extreme a step could be granted where there is any real possibility of a meaningful life continuing to exist.*"²⁹

The non-PVS cases

6. *In re F. (mental patient: sterilisation)*³⁰

N.B. :- The judgements in the Bland case relied on *In re F* as authority for the proposition that the criterion to be used in the medical treatment of incompetents was their 'best interests'.

Facts:- A 36 year old mentally handicapped woman 'F' with the mental age of a child, lived in a mental hospital where she had formed a sexual relationship with a male patient. The hospital staff considered that she would not be able to cope with the demand of pregnancy and of giving birth and that - because it was not desirable to further restrict her liberty and because all other forms of contraception were unsuitable - it was in her best interests that she be sterilised. F's mother agreed with the proposed course of action.

The application was granted.

The Official Solicitor appealed to the House of Lords.

Held:- that the *parens patriae* jurisdiction of the English courts over incompetent adults had been implicitly removed by statute. The court laid down the principle, based on the law of necessity,

²⁷ The Times 21st and 22nd March 1997; subsequently reported as *Re D (Medical Treatment)* [1998] 1 F.L.R. 411

²⁸ The Times 22nd March 1997.

²⁹ *ibid.*

³⁰ *In re F (Mental Patient: sterilisation)* [1990] 2 A.C. 1

that a doctor can lawfully treat an incompetent adult if it is in the patient's best interests that he do so.

The court stated that it was highly desirable that in similar cases an application be made to the High Court for a declaration as to the legality of such proposed procedures.

7. *Re B (a minor)(wardship: medical treatment)*³¹

N.B.:- In the Ward case counsel for the Attorney General, referring to *Re B*, submitted that "... the case uniquely illustrates why the quality of life should not be adopted as a test." ³² None of the judgements in the Ward Case gave any detailed consideration to the decision in *Re B*.

Facts:- The case concerned a week old baby girl who had been born with Down Syndrome. The child had an intestinal blockage which could be cured without difficulty by a simple operation; her life expectancy would then be 20 to 30 years. The child would die in a matter of days without the operation. The child's parents refused consent for the operation believing it not to be in the child's best interests that she should survive because she would be handicapped both mentally and physically.

There was a difference of medical views as to whether the parents' wishes should be respected. The judge at first instance gave consent for the operation but subsequently³³ a further difference of medical opinion developed and the matter again came before the judge; he then refused consent for the operation.

This decision was appealed to the Court of Appeal.

Held:- That the correct question to be determined by the judge was not whether the parents' wishes should be respected but whether what was proposed was in the child's best interests. Because the proposed operation was in the child's best interests, it should be performed.

Templeman LJ.

Templeman LJ, held that the interests of the child were paramount and that the issue before the court was:

*"... to decide whether the life of this child is demonstrably going to be so awful that in effect the child must be condemned to die ³⁴ ... There may be cases ... of severe proved damage ... where the life of the child is so bound to be full of pain and suffering that the court might be driven to a different conclusion, but in the present case ... I have no doubt that it is the duty of this court to decide that the child must live."*³⁵

He appeared to draw a distinction between 'cabbage cases' - where people's faculties are entirely destroyed - and those of other severely mentally and physically handicapped with the suggestion that a different rule applied to these cases.³⁶ In *Re J*³⁷ Lord Donaldson also accepted that special consideration might apply to such cases but Lord Balcombe strongly disagreed, stating:

³¹ *Re B. (a minor) (wardship: medical treatment)* [1990] 3 All ER 927 The case was decided in 1981 but not reported until 1990

³² The Ward case at 401

³³ This change of mind is mentioned by Lord Donaldson MR in *In re J. (A Minor) (Wardship: Medical Treatment)* [1990] 3 All E R 930 at p. 937; the circumstances which caused it are noted in the judgement in *Re B*.

³⁴ *ibid.* p.929. The judge appears to give short shrift to the distinction between act and omission. One wonders if the case had been decided differently, whether the language would have been so stark or whether solace would have been found in the euphemism 'allowed to die'.

³⁵ *ibid.* at p.929.

³⁶ *ibid.*

"... I would not accept that the so-called 'cabbage' cases could be treated as an exception to this suggested rule,"³⁸ since in deciding that a child whose faculties have been destroyed is a 'cabbage' of itself involves making a judgement about the quality of that child's life."³⁹

Dunn LJ.

Dunn LJ, noted that no reliable prognosis as to the child's future could be made until she was two years old and that:

"... because there is no evidence that this child's short life is likely to be an intolerable one. There is no evidence at all as to the quality of life which the child may expect ... the child should be put into the same position as any other mongol child and must be given the chance to live an existence."⁴⁰

8. McKay v Essex Health Authority⁴¹

Facts:- A mother contracted rubella during pregnancy and, as a result, her child was born severely disabled. The rubella had not been diagnosed and, arguing that this was due to the negligence of the Health Authority, both the mother and child sought damages. Counsel for the child based his claim on a number of grounds one of which was that *"of being allowed to enter life damaged"*; he argued - on the authority of *Re B* - that where a child's disabilities are so severe that it can be properly stated that she would be 'better off dead', the duty of care involves the duty to terminate its life.

The question before the court was whether the child had a right to claim damages because of the non-termination of his mother's pregnancy.

Held:- The unanimous opinion of the court was that the child's claim for what has been called a 'wrongful life', disclosed no reasonable cause of action.

Stephenson LJ.

Stephenson LJ., held that the child's real complaint was not that she had been born but that she had not been born whole; a ground of action could only arise if there was a right to be born whole. To impose a duty on others to ensure such a right would be contrary to public policy. It would mean that the life of a handicapped child should be regarded not only as less valuable than that of a normal child but so much less valuable that it was not worth preserving. It would also entail the possibility of a child having a ground of action against her mother for not having had an abortion.

The claim also failed on the ground that the damages were not only difficult but impossible to assess in that the damages sought under this head were necessarily based on a comparison between the child's actual condition and her condition if she had not been born at all.

In considering the submission based on *Re B*, he stated:

"Like this court ... in Re B ... I would not answer until it is necessary to do so the question whether the life of a child could be so certainly 'awful' and 'intolerable' that it would be in its best interests to end it and it might be considered that it had a right to be put to death. But that is not this case. We have no exact information about the extent of this child's serious and highly debilitating

³⁷ *ibid.* 938.

³⁸ *i.e.* that the interests of the child are paramount.

³⁹ *Re J* at p.942.

⁴⁰ *Re B* at p.930.

congenital injuries; the judge was told that she is partly blind and deaf, but it is not and could not be suggested that the quality of her life is such that she is certainly better dead ... " ⁴²

Ackner and Griffiths LJJ.

Ackner and Griffiths LJJ, held that the issue of damages was impossible to assess and accordingly, the claim should fail. *Re B* was an urgent application made in vacation, and the judgements were *ex tempore*; in his judgement in that case Templeman LJ. was saying no more than that the court could, in certain circumstances, refuse to sanction an operation to prolong life. The case provides no support for the contentions raised in the present case.

9. *Re C (a minor)(wardship: medical treatment)* ⁴³

Facts:- C had, at birth, been taken into care and made a ward of court. It was subsequently discovered that she had seriously brain damage and was terminally ill. The court directed that the aim of treatment should be to "... *treat the ward to die, to die with the greatest dignity and the least of pain, suffering and distress.*" ⁴⁴ rather than to seek to achieve a short prolongation of life. Accordingly, the court decreed that intravenous feeding and the treatment of serious infections was unnecessary.

The Official Solicitor appealed to the Court of Appeal.

Held:- That the one inescapable fact is that baby C was dying and nothing the court, or the doctors, can do could alter that fact. The essential problem was what treatment should be given and the resolution of this was to be found in determining the 'best interests' of C. The best interests of the child require that she be treated in such a manner as to ease her suffering and so as to permit her life to come to an end peacefully and with dignity, rather than in attempting to prolong her life; however, the phrase '*treat to die*' was misleading.

The court held that it was inappropriate for it to issue specific instructions as to how this be achieved.

10. *In re J (a minor) (wardship: medical treatment)* ⁴⁵

Facts:- 'J' was an 18 week old baby who had been born prematurely with very severe and irreparable brain damage. He was epileptic and was likely to develop serious spastic quadriplegia ⁴⁶ and to be blind and deaf. Though he may have become able to make sounds to reflect his mood and to smile and cry, he was unlikely ever to speak or develop even limited intellectual abilities. It was likely that he would feel pain similar to a normal baby. He was not terminally ill. His life expectancy was uncertain but he was expected to die before late adolescence. He had been ventilated twice for long periods, and the prognosis was that, in the absence of ventilation, any further collapse would be fatal.

The court had decided that, in the event of his ceasing to breath, he should not be reventilated.

The Official Solicitor appealed on the ground that lifesaving treatment should only be withheld in cases of terminal illness.

⁴¹ *McKay and another v Essex Area Health Authority and another* (1982) 2 All E R 771.

⁴² *ibid.* p.781.

⁴³ *Re C (a minor) (wardship: medical treatment)* [1989] 2 All E R 782.

⁴⁴ *ibid.* p.787.

⁴⁵ *In re J. (A Minor) (Wardship: Medical Treatment)* [1990] 3 All E R 930.

⁴⁶ *i.e.* paralysis of both his arms and legs.

Held:- The court first summarised the arguments of the Official Solicitor. He had contended, firstly, that guidance on the approach to adopt in relation to treatment decisions for children had been given:

- (i) in *Re C*, in relation to children who were dying,
- (ii) in *Re B*, in relation to children who were severely, but not grossly, handicapped but with a substantial expectation of life.

The present case fell between these two and required guidance.

Secondly, he had contended that a court is only entitled to withhold consent to lifesaving treatment either:

- (i) in cases of terminal illness - called the '*Absolutist Submission*'; or,
- (ii) where the quality of the child's subsequent life would be intolerable to that child and '*bound to be full of pain and suffering*' - called the '*Qualified Submission*'.

Donaldson MR.

Lord Donaldson first clarified the respective roles of the court, the parents and the doctors: neither the parents, nor the court, nor the doctors, can *dictate* the treatment to be given. The doctors can suggest; the court, or parents, can refuse to consent to what is suggested; it is therefore, in some measure, a joint decision.

Turning to the 'absolutist submission' - and exempting the so-called "*cabbage case*" to which *special considerations may well apply*"⁴⁷ - Lord Donaldson held that where a child is dying there is no balancing of life against death; what is being balanced is a marginally longer life of pain against a marginally shorter life free from pain and ending in death with dignity.

As to the 'qualified submission'; he held that although the terms 'intolerable' and 'demonstrably so awful' were used in the judgements in *Re B*, they should not be taken as a judicial yardstick. *Re B* should be understood as asserting that a balancing operation is to be adopted between the pain and suffering which the child will experience if life is prolonged, and the pain and suffering of the proposed treatment itself. He cited the judgement of McKenzie J. in *Re Superintendent of family and Dawson D*⁴⁸ saying: "*This gives effect, as it should, to the fact that even very severely handicapped people find a quality of life rewarding which to the unhandicapped may seem manifestly intolerable*".⁴⁹ A particular decision as to medical treatment could be taken which as a *side effect* will render death more or less likely. This is not a matter of semantics it is fundamental. Thus, the use of drugs to reduce pain will often be fully justified notwithstanding that they will hasten the moment of death.

In J's situation the balancing operation implied that authority for the reventilation should be withheld as to do so was in his best interests.

Balcombe LJ.

Balcombe LJ., summarised the arguments offered for the 'absolute submission'; these were:

- (i) the court is unable to evaluate the consequences of death and can thus not apply a balancing operation

⁴⁷ *ibid.* p.938.

⁴⁸ number 15 in this appendix.

⁴⁹ *ibid.* p.938.

- (ii) respect for the sanctity of human life preclude attempts by the court to evaluate the quality of a disabled person's life,
- (iii) the 'slippery slope' argument.

Lord Balcombe held that because public policy interests cannot be allowed to prevail over the interests of the individual - whose interests are paramount - and because grounds (ii) and (iii) "... depend on the assertion that public policy precludes any inroad on the sanctity of human life."⁵⁰ these grounds must fail. *McKay*⁵¹ was offered as authority for (i) but this is mistaken, *McKay* is authority only for the proposition that "... the court could not evaluate non-existence for the purpose of awarding damages for the denial of it."⁵²

Accordingly "... there is no warrant, either on principle or authority for the absolute submission."⁵³

As to the 'qualified submission' Balcombe LJ. stated that the argument offered for this was the statement in *Re B* that:

"... the court can only approve the withholding of lifesaving treatment if it is certain that the life of the child is going to be so intolerable that, on the facts of the case, the court was justified in reaching so drastic a conclusion."⁵⁴

This was treating the language used in *Re B* as if it had been intended to lay down a test applicable to all circumstances, which was clearly not the case. The only test required is that the 'interests of the ward are the first and paramount consideration'.⁵⁵ Adopting a more objective standpoint than Donaldson LJ, he stated that:

"... in determining where those interests lie the court adopts the standpoint of the reasonable and responsible parent who has his or her child's best interest at heart."⁵⁶

Mechanical ventilation is itself an invasive procedure which would cause the child distress; these procedures carry their own hazards, not only to life but they may cause even greater brain damage. This has to be balanced against what could possibly be achieved: the chances of preserving the child's life might be improved, although this was not certain, and account had to be taken of the extremely poor 'quality of life' at present enjoyed by the child. He dismissed the appeal.

Taylor LJ.

Taylor LJ. considered that the phrases 'condemned to die'⁵⁷ and 'put to death'⁵⁸ were unfortunate. He considered, however, that there are extreme cases in which the court is entitled to say "The life which this treatment would prolong would be so cruel as to be intolerable."⁵⁹ The present case is such a case.

⁵⁰ *ibid.* p.942.

⁵¹ Number 8 in this appendix.

⁵² *ibid.* p.942.

⁵³ *ibid.*

⁵⁴ *ibid.* p.941

⁵⁵ *ibid.* p.942

⁵⁶ *ibid.*

⁵⁷ used by Templeman LJ, in *Re B*.

⁵⁸ used by Stephenson LJ, in *McKay* in speaking of the possibility of a child being 'put to death'.

⁵⁹ *ibid.* p.944.

11. *Re R (adult : medical treatment)*⁶⁰

Facts:- R was born with a serious malformation of the brain and with cerebral palsy; he subsequently developed severe epilepsy. At the time of the court application he was 23 years old, had profound learning difficulties and had not developed any formal means of communication; he was believed to be both blind and deaf. He was unable to chew and his food had to be syringed to the back of his mouth. The only response to touch appeared when he was cuddled and he then gave an indication of pleasure. Dr. Andrews gave evidence that R existed 'in a low awareness state.' R appeared to respond to pain and suffered from recurrent chest infections. R's consultant was of the view that, when the next life threatening crisis occurred, treatment should be withheld to allow R to die with some comfort and dignity.

A 'Do Not Resuscitate' (DNR) order had been made by his medical carers with the consent of his family. R's carers at the day centre which he attended did not agree that his quality of life was 'unacceptable' - a term used in the BMA guidelines on DNR orders - and sought the assistance of the Disability Law Service in seeking a judicial review.

In response, the hospital authorities sought not only a declaration as to the lawfulness of the DNR order, but in addition a declaration that it was lawful to withdraw ANH; this latter application was later withdrawn and permission was sought to conduct a gastrostomy.⁶¹

The question before the court was whether the DNR order was appropriate.

Evidence was given by Dr. Andrews that, in a hospital setting, CPR was effective for only 13% of patients; in a nursing home situation the chances of a successful resuscitation would be almost nil; in addition there was the danger of causing either broken ribs or further brain damage.

Held:- Sir Stephen Browne held that there was no question of the court being asked to approve a course aimed at terminating life or accelerating death; there should be no global 'do not treat' policy. However, the facts of this case were very different from the Bland Case.⁶²

The principle of law to be applied is the 'best interests' of the patient as laid down in *Re J*. That case held that the court might in appropriate circumstances withhold consent to life-saving treatment. Taylor LJ, said, in *Re J*, that "... the correct approach is for the court to judge the quality of life ... and decide whether such a life would be so afflicted as to be intolerable ... "⁶³ The operative words are 'so afflicted as to be intolerable'.

The court judged the DNR order to be in the patient's best interests (medical opinion being unanimous); it left the decision on the withholding of antibiotics to the judgement of the attending clinician and subject to the consent of R's parents. The Court consented to the gastrostomy procedure.

⁶⁰ *Re R (Adult: Medical treatment)* [1996] 2 FLR 99.

⁶¹ The joint BMA and RCN guidelines considered that a DNR order would be appropriate inter alia "... where successful CPR [cardio-pulmonary resuscitation] is likely to be followed by a lengthened quality of life which would not be acceptable to the patient." *Re R (Adult: Medical treatment)* at p.102.

⁶² The original summons had asked for permission to withhold life sustaining treatment including ANH; the summons was subsequently amended to seek only permission to withhold cardio-pulmonary resuscitation and antibiotics from R in the event of him developing a potentially life threatening infection. It was agreed by all parties that it was in R's interest to have a gastrostomy tube inserted and that accordingly it would be premature to consider withdrawal of ANH at this stage. It seems that this procedure was adopted because the case was not comparable to the Bland case in that it was not a case of PVS.

⁶³ *ibid.* p.108.

12. *T (a minor) (wardship: medical treatment)* ⁶⁴

Facts:- An 18-month-old child, who was not retarded but who suffered from a blockage of the bowel ducts, required a liver transplant. The liver transplant had a 'good prospect of success' and would, if successful, have enabled the child to survive into adulthood. Such surgery was successful in about 80% of cases. Without this operation the child would die within a year.

The child's parents, who were both health professionals experienced in the care of sick children and who were living abroad, had decided against such surgery. It would have been necessary for the child to return to England for surgery as there were no facilities for such operations in the country in which the family now lived. The child's mother had judged that the operation, in so far as it might only marginally increase her son's life expectancy and since it could lead to pain and suffering and since it would lead to disruption in the child's life, was not in the child's 'best interests'. The parents' decision not to proceed with the operation was influenced by the outcome of earlier surgery on the child, which had been a failure.

The mother had been urged by two of the child's consultants to consent to the operation; one of the consultants had precipitated the legal action as he felt that the mother was not acting in the child's 'best interests'. The High Court decided that the operation should proceed.

This decision was appealed to the Court of Appeal.

Held:- that the judge should not have restricted himself solely to medical factors when judging the child's 'best interests'; he "... *should have considered whether it was in the child's 'best interests' that the mother should be forced to take on the commitment of caring for a child after surgery with which she did not agree.*" ⁶⁵ The decision should be taken by the child's parents as the child had been 'entrusted by nature' to their care.

N.B.:- The medical correspondent of The Times noted that the court's decision might well have the effect of reinforcing the prejudice of parents who often find congenital disease and disability in children very hard to accept.

13. *Re C (a baby)* ⁶⁶

Facts:- 'C' was a 16-month-old baby girl who was suffering from a fatal degenerative disease and was unable to move her arms or legs; she was conscious and recognised and smiled at her parents when they visited. Medical opinion was to the effect that the disease was fatal, that death usually comes at 18 months in such cases and that the baby's suffering would increase before death. The doctors wished to withdraw artificial ventilation.

The baby's parents, who were strict Orthodox Jews, refused permission to withdraw the artificial ventilation, as to do so would contravene their religious views.

Held:- Sir Stephen Browne decreed that, as there was no dispute as to the medical evidence - which was that disease was fatal and the child was approaching death - it was in the child's best interests to withdraw artificial ventilation.

⁶⁴ The Times of 25th October 1996; see also note in Current Law Year Book 1996 at p.179.

⁶⁵ Current Law Year Book 1996 at p.179.

⁶⁶ The Times 20th November 1997; see also *Re C (A Baby)* [1998] 1 F.L.R. p. 384

*"Whilst the sanctity of life is vitally important, it is not the paramount consideration ... that paramount consideration is the best interests of little C ... She has a desperately tragic existence. She is emaciated. Although she is conscious, there is the prospect of increased suffering as the days go by."*⁶⁷

14. Ex Parte Glass⁶⁸

Facts:- This case concerned a 12 year old boy, David Glass, who had been born with hydrocephalus and was profoundly disabled though not to the extent of requiring tube feeding. Though normally living at home, he had been admitted to a local hospital suffering from breathing difficulties. He had been kept on artificial ventilation for 23 days and the hospital authorities were of the opinion that resuscitation should not be provided if these difficulties reoccurred. His mother disagreed with this assessment.

Subsequently, David's mother had been told that her son was dying and that he had been given diamorphine on the instructions of the hospital authorities. She forcibly attempted to stimulate her son's breathing; this was against the wishes of the hospital authorities who believed that this was extremely cruel and that he should have been allowed to pass away peacefully.⁶⁹

David Glass recovered and now lives at home.

The boy's mother sought a declaration from the High Court that:

- (i) her son was entitled to resuscitation if similar circumstances reoccurred; or that
- (ii) the hospital had no authority to withhold treatment against her wishes; or that
- (iii) the doctors must, in the absence of her consent, seek court approval before withholding treatment.

The High Court

Held:- Scott Baker J. refused the declaration ruling that such a sensitive problem was not susceptible to the 'blunt tool' of judicial review, particularly when the issues related to a problem which was passed. He intimated that if difficulties arose in the future it would be desirable, and indeed in everyone's interest, that the issue should be referred to the High Court before the situation became acute. The mother appealed this decision.

The Court of Appeal

Additional Facts:- The court found that David was not terminally ill; some studies suggested a 50:50 chance of living for more than a few years. Morphine, which depressed respiratory function, had been administered to David against the mother's wishes and on the instructions of the chief executive of the hospital without having first obtained the sanction of the court.⁷⁰

⁶⁷ The Times 20th November 1997.

⁶⁸ The High Court proceedings were reported in The Times 22nd April 1999 and The Guardian 23rd April 1999. The judgement of the Court of Appeal before Lord Woolf MR, Butler-Sloss and Walker, was reported as: *R v Portsmouth Hospital NHS Trust, Ex parte Glass*: The Times 26th July 1999.

⁶⁹ A criminal prosecution had been taken against the child's parents, following allegations against them of assault on members of the hospital staff arising out of a fracas which occurred when the parents attempted to forcibly stimulate their sons breathing. A different hospital has agreed to treat David Glass in future emergencies. Subsequently, David Glass' uncle and his aunts were convicted of causing violent disorder and assault; the uncle was imprisoned for one year and the aunts for nine months each. [see BBC 'Online News Service' 14th July 2000, under the title: 'Medical row family jailed']

⁷⁰ The court accepted for the purposes of judgement that the mother's statement of the facts was correct, though some were disputed by the hospital authorities. On an initial consideration, the possible reasons for administering morphine and the fact that it was authorised by an executive of the hospital rather than by David's medical team are disquieting; these questions were not pursued in the judgements.

Held:- The court reiterated that the appropriate criterion was the best interests of the child; however, in cases where the patient's family did not agree that a course of action proposed by the patient's medical team was in fact in the patient best interests, then application must be made to the courts. Faced with a particular problem the court would answer that problem; however, no decision as to what was a proper course of action would be made in advance of the actual circumstances arising. The court upheld the judgement of the High Court.

Some cases from other jurisdictions

Canada

15. Re Superintendent of Family ⁷¹

Facts:- This case concerned a seven year old boy with severe brain damage which had been caused by meningitis. The boy suffered from hydrocephalus and had had two operations to unblock a plastic tube which drained excess fluid from his brain.⁷²

The boy's parents opposed the operation on the grounds that he should be allowed to die with dignity rather than endure a life of suffering. The evidence was that, without the operation, the boy might not necessarily die but might live for years and with a real possibility that he would endure a state of progressive disability and pain. The boy, although severely handicapped, was not as severely handicapped as some in his class at the hospital school. If the operation was performed he would probably continue to live as he had done before and would do so for some years more.

Held:- (per McKenzie J.) That this was not a 'right to die' situation where the courts are concerned with the terminally ill but rather raised the question of whether the boy has a right to receive appropriate medical care of a simple kind which would assure to him the continuation of his life. The operation should proceed because the presumption must be in favour of life but also because the court could not sanction the withholding of treatment when such a withholding could result not necessarily in death but in a more impoverished and agonising form of life. Judge McKenzie added:

"I do not think that it lies within the prerogative of any parent or of this court to look down upon a disadvantaged person and judge the quality of that person's life to be so low as not to be deserving of continuance. The matter was well put in an American decision - Re Weberlist ⁷³ where Justice Ashe said:

'There is a strident cry in America to terminate the lives of other people - deemed physically or mentally defective ... Assuredly one test of civilization is its concern with the survival of the 'unfittest', a reversal of Darwin's formulation ... In this case the court must decide what its ward would choose, if he were in a position to make a sound judgement.'

This last sentence puts it right. It is not appropriate for an external decision maker to apply his standards of what constitutes a liveable life and exercise the right to impose death if that standard is not met in his estimation. The decision can only be made in the context of the disabled person viewing the worthwhileness or otherwise of his life in its own context as a disabled person - and in

⁷¹ *Re Superintendent of Family and Child Service and Dawson* (1983) 145 D.L.R. (3d) 610

⁷² This procedure is called 'revising a shunt'.

⁷³ ((1974) 360 NYS 2d 783 at 787.

that context he would not compare his life with that of a person enjoying normal advantages. He would know nothing of a normal person's life never having experienced it." ⁷⁴

N.B.:-This case was mentioned and distinguished in *Re C* by both Donaldson and Balcombe L JJ. In *Re J*, Donaldson J. quoted with approval the extract from the judgement of McKenzie J. (*supra*)

16. Nancy B. v Hotel-Dieu de Quebec ⁷⁵

Facts:- Nancy B. who was aged 25, had suffered from locked-in syndrome for two and a half years. She could breathe only with the assistance of a respirator; her intellectual capacity and mental competence were unaffected. She had been informed that her condition was irreversible. She applied to the court seeking to establish her right to refuse any further treatment.

Held:- That the technique of putting a person on a respirator is 'medical treatment'. That, as no medical treatment may be given to a competent person without their consent, Nancy B. has the right to refuse any further use of a respirator.

New Zealand

17. Auckland Area Health Board v AG ⁷⁶

Facts:- The case involved an application by doctors concerning the withdrawal of a ventilatory support system from a patient 'Mr. L' who was diagnosed as being in an extreme form of locked-in syndrome. The patient was totally unable to move and there was no prospect of recovery. There was no possibility of communication with the patient even by using primitive means; his eyeball muscles were inert and his pupils were fixed and dilated. It was not known whether Mr L could see, the nerves involving hearing no longer functioned. As best as could be ascertained Mr. L's brain was in a drowsy, semi-working, state, but this was probably due to sensory deprivation rather than to any brain damage. It was the unanimous opinion of the eight specialists, who had examined Mr. L, that ventilation should be withdrawn as not being medically justified; this was also the opinion of the hospital ethics committee; the patient's family agreed with this proposal. In the event of ventilation being withdrawn death would be instantaneous and painless.

The doctors sought a declaration from the court that the removal of ventilation would not be unlawful. ⁷⁷

Held:- (*per* Thomas J.) Counsel for the doctors and for the Attorney General had both argued that decisions such as contemplated in the present case were essentially clinical decisions and best resolved as such without recourse to the courts. The judge agreed with this submission, suggesting that such cases do not lend themselves to the 'close analysis and refinements which are the stock in trade of lawyers'; in a furtherance of this approach he declined to consider the case as an exercise of his *parens patriae* jurisdiction, preferring to resolve the case by analysing the proposed course of action in terms of its 'lawfulness'.

⁷⁴ *Re Superintendent of Family and Child Service and Dawson* (1983) 145 D.L.R. (3d) 610 at p.620

⁷⁵ *Nancy B. v Hotel-Dieu de Quebec* 86 D.L.R. (4th) 385.

⁷⁶ *Auckland Area Health Board v Attorney General* [1993] 1NZLR 235.

⁷⁷ New Zealand had a statutory provision to the effect that, in certain circumstances, there was a 'duty to provide the necessities of life' and any breach of this duty, 'without lawful excuse', constituted a criminal act. There was a further statutory provision to the effect that any hastening of the death of another was legally murder.

The judge discussed recent advances in the definition of death, in particular the criteria for brain death; he attempted to draw out 'the essence' of these criteria and apply it to the instant case. He concluded that a person - if they are brain dead - is considered to be 'dead' because the brain has, at that point of time, irretrievably lost both the ability to regenerate and to provide the route by which messages to and from the body are transmitted. He posed the question: "*How different is Mr. L?*" He suggested that the situations of Mr L and of those who are brain dead could both be described by the phrase '*the living dead*':

*"Whether a body devoid of a mind or, as in the case of Mr L, a brain destitute of a body, does not matter in any sensible way. In their chronic persistent vegetative condition⁷⁸ they lack self-awareness or awareness of their surroundings in any cognitive sense. They are 'the living dead'."*⁷⁹

Next turning to the question of causation; counsel had urged that the proposed course of action could not be considered as *causing* the death of Mr. L, the judge however, found such an analysis to be unhelpful. He considered the example of a polio victim unable to breathe and being ventilated, but desirous of remaining alive; it is not acceptable to say of a doctor, who in such a case did in fact remove ventilation, that he did not cause the death of the patient. The question must be resolved, not by an analysis of cause but by an analysis of the lawfulness of the proposed course of action.

Thomas J., next considered the meaning of the term '*necessities*'. Medical treatment is undoubtedly included in the phrase '*necessities*'; however, in the present case - in that the only function of the treatment is to defer death - it could not be considered a '*necessary of life*'. However, even if it must be so considered, then its withdrawal in the present case is done with '*lawful excuse*'. This is so because it is unacceptable to suggest that a doctor adhering to what is considered '*good medical practice*' should not at the same time be provided with a '*lawful excuse*'; thus, the fact that, in Mr. L's case, the medical consensus is that ventilation should be withdrawn, is itself evidence that what is being proposed is '*with lawful excuse*'. Introducing a distinction between '*cause*' and '*legal cause*', he concluded that although the doctors in embarking on the proposed course of action may be held to '*cause*' death, they did not '*legally cause*' death.⁸⁰

⁷⁸ Note how the phrases 'locked-in syndrome' and 'persistent vegetative condition' are used interchangeably.

⁷⁹ *ibid.* p.245.

⁸⁰ *ibid.* p.254.

Appendix D: Phillipa Foot's analysis of the ethics of euthanasia¹

Introduction

Phillipa Foot defines euthanasia not only by its *manner*² but also by the requirement that it be 'for the sake of' the one who dies. She takes the example of a dying torture victim who is revived so that the torture might continue, to show that there are situations where life is not a good; she then attempts to establish the grounds on which it could be judged that, for a particular individual, '*Life is an evil*'.³

Her analysis falls into two parts: firstly, the search for the criteria underlying the judgement '*Life is a good*' [summarised here in Section 1] and secondly, an examination of the conditions under which a judgement that for someone 'Life is an evil' (or 'Death is a good') implies, if not a moral *obligation* to act on the basis of this judgement, at least a *justification* for so acting [summarised here in Section 2].⁴

Section 1: The criteria required for the judgement '*Life is a good*'

To Foot, the question '*Is life a good for X?*' is equivalent to the question '*If I were to save X's life, would I be his benefactor?*' For example, because in reviving the torture victim so that he could be further tortured I would not be his benefactor, consequently life would not be a good for him. What are the grounds underlying the making of such a judgement?

Foot considers and rejects various possibilities:

- * '*the balance of good and evil in a life*'.

This is rejected in the recognition that to refuse to rescue a person from death on the grounds that there was more evil than good in their lives, would be generally considered to be unjustified. To overcome this difficulty Foot considers a suggestion by Thomas Nagel that:

- * '*the experience of life is itself a good*' which must be brought into the equation.

This is shown not to advance the problem, as is a third suggestion that:

- * '*man's desire for life makes it a good*'.

The search for criteria to enable a judgement that '*life is a good*' being unsuccessful, Foot then approaches the question from a different direction. She asks whether the conceptual connection between '*life*' and '*good*' is *necessary* or *contingent* and she seeks to elucidate the connection. Rather than seeking to tackle this problem as it applies to the human situation, she considers the relationship between the concepts of '*life*' and '*good*'⁵ as we apply them to animals and plants suggesting that, in them, the relationship is more easily analysed without the added complication

¹ This discussion is based on Foot's essay 'Euthanasia' included in her Virtues and Vices and Other Essays in Moral Philosophy, (1978).

² i.e. as being '*gentle and easy*'.

³ The assumption that life being an evil for someone implies that death is a good for them has been criticised in Chapter 9 (Section 2 Subsection 3) where its distorting effect on Foot's argument has been noted. Those criticism will not be repeated here where the intention is simply to summarise Foot's argument and conclusions.

⁴ It should be noted that, for Foot, the determination that '*X is a good for Y*' does not, of itself, imply the moral obligation to provide X for Y; the explanation for this lies in Foot's distinction between the obligations that flow from Justice and those that flow from Charity.

⁵ More accurately '*benefit*'.

caused by considerations of the *'balance of pain and pleasure'*.⁶ Notwithstanding Foot's belief that to speak of such balances is *'absurd in the case of animals'*,⁷ the redirection of focus does permit a more fruitful analysis. In the case of animals we would not feel that we had done anything for the animal simply by keeping it alive; this, she argues, is because such an animal would not be able to *'operate in the normal way'*.⁸ Taking this criterion of *'normal functioning'* and returning to the human situation, Foot notes the complication added by the necessity of including the human's view of their own situation. Should a subject's wish for death be conclusive evidence of his life being an evil? A man might wish for death out of revenge or out of love of another even though his life was not an evil; conversely, a man's life may be a burden to him and yet he may not wish for death. Thus, a man's wish for death is not determinative of his life being an evil and it unclear how a man's wishes as to his death can be incorporated into the analysis.

To summarise: Foot's attempts to explicate the grounds for the judgement *'Death is a good'*:

- * *firstly*, by considering some reasons often suggested as to why life is a good, and
- * *secondly*, by attempting to widen the results of her earlier analysis of the nature of the relationship between the concepts 'life' and 'good' as applied to animals and plants, to include humans and their wishes;

were unsuccessful; her analysis faltered and she was forced to reassess her position.

A reassessment

Foot forsakes the abstract direction taken by her earlier analysis in favour of a more concrete study of those borderline cases where the normal consensus that life is a good begins to waiver. She enumerates these cases and attempts to find the principles that govern the judgements that people normally make in these matters.⁹

The consensus that *'life can be a good'* extends:

- * to those who suffers much pain,
- * to those who are severely physically handicapped,
- * to those who are *'fairly severely'* mentally handicapped such as those with Down Syndrome.¹⁰

However, the consensus appears to disappear when senility and severe mental disability enter the picture:

*"There are some in geriatric wards who are barely conscious, though they can move a little or swallow food put into their mouths. To prolong such a state, whether in the old or in the very severely mentally handicapped is not to do them a service or confer a benefit."*¹¹

Thus, merely being alive is not a good, a distinction must be made similar to that made in the case of animals where *'ability to operate in an ordinary way'* was the criterion. In an attempt to

⁶ *ibid.* p.38 (presumably based on the belief that animals cannot feel pain or pleasure though a contrary view is suggested on p.40.)

⁷ *ibid.* p.38.

⁸ Foot does not use the concept of *'thriving'* but it is helpful in this discussion: a plant, or animal, would be killed if it was considered that it was unlikely to thrive ever again. In certain cases - for example, a household pet - such a judgement would be made *'for the sake of the animal'*. The concept of *'thriving'* may have an applicability to the human situation with the proviso that the judgement the individual makes of his own *'thriving'* takes precedence over all others.

⁹ [*ibid.* p.40]:

"We are not trying to make new judgements possible, but rather to find the principle of the ones we do make."

¹⁰ [*ibid.* p.41]:

"There are many fairly severely handicapped people - such as those with Down's Syndrome (Mongolism) - for whom a simple affectionate life is possible. What about senility? Does this break the normal connection between life and good? Here we must surely distinguish between forms of senility."

clarify this criterion Foot next considers the example of prisoners of war living in unmerciful conditions who despite this *'were determined to hold on'* but yet for whom *'a bullet would have been a merciful release'*.¹² These prisoners worked every day so that the condition that is being sought cannot be found in terms of ability to operate in the normal way; Foot is lead to the conclusion that what makes 'life not a good' for these prisoners is the *lack of a minimum of basic human goods*.¹³ Foot then uses this criterion to reformulate her proposals.

Foot's conclusion is that a necessary and sufficient condition for life being a good is that it contains a minimum of 'basic human goods'. Once this basic level is achieved then life is a good, questions of the balance of pain and pleasure are irrelevant. Conversely, if this minimum is not achieved then life is not a good and questions of the balance of pleasure and pain will not reverse this judgement. However, if suffering enters into a life which is not a good then death would be a good. Thus, for example, if consciousness has sunk to such a low level as to destroy the possibility of basic human goods then such a life is - in itself - neither good nor evil; once suffering sets in then death would be a good.

Section 2: The pre-conditions required for the judgement that *'Death is a good'* to become a justification for action.

Foot separates the questions of whether acts of euthanasia can ever be morally justified and whether such acts should ever be legalised; the first being the simpler question in that it involves consideration of the rights, interests and obligations of only the individuals concerned; the second question requires consideration of the effects on the wider society of the legalising of those acts of euthanasia which are morally justified (if such exist).

Are acts of euthanasia ever morally justified?

The key that Foot uses to unravel this problem is the question: *'When one man opts for the death of another what are the grounds on which objection may be raised?'*

The grounds, she suggests, are *'Justice'* and *'Charity'* and these are distinct grounds.

Justice has to do with what men owe each other in the way of non-interference and positive service, it is concerned with what a man has *'a right to'*.

Charity in contrast, is a virtue which attaches to the good of others, it is concerned with what a man has *'a need of'*.

Foot offers some points in clarification of the relationship between *'Justice'* and *'Charity'*:

- (i) It is possible to have an action which offends both Charity and Justice as, for example, when a man is denied what he has both *'a right to'* and *'a need of'*.
- (ii) It is possible to have an offence against Justice but not against Charity, as in the refusal to repay a debt to an alcoholic whilst he is still drinking.

¹¹ *ibid.* p.42.

¹² *ibid.* p.37. This is an unsettling aspects of Foot's analysis in that she appears to allow the judgement of an impartial bystander *'that a life is an evil'* to overrule the judgement of the possessor of that life; the testimony of Victor Frankl on his life in a concentration camp, and the writings of Jean-Dominique Bauby who suffered from locked-in syndrome (both discussed in Chapter 7) is a reminder of an alternative perspective. (Foot's subsequent discussion of the obligations imposed by Justice does much to restore the balance.)

Judgements such as those contemplated by Foot, are *'absolute quality of life'* judgements, and one of the conclusion of Chapter 7 was that such judgements should not be used:

Conclusion 7.5: There are at least two reasons why 'absolute quality of life' judgements should be rejected: they are unreliable and they are incompatible with the egalitarian principle that all persons be treated as equal. Furthermore 'absolute quality of life' judgements often function as a mechanism of denial so that situations which are unacceptable to the decision-maker are not permitted to continue.

(iii) It is possible to have an offence against Charity but not against Justice, as when one refuses to rescue another if not legally obliged to do so.

(iv) Injustice may involve an act or an omission as can an offence against Charity.

Because 'Justice' is so intimately connected with rights and their infringement, Foot - in her attempt to clarify the concept of 'Justice' - is first led to clarify the concept of a '*right*'. Foot distinguishes between:

- * a '*liberty*' - where no one else can demand that a person not do what he has a liberty to do e.g. to park in a public parking zone; and
- * a '*claim right*' - where in addition to the liberty to do something there is also the obligation (i.e. the '*duty*') on others not to interfere, e.g. in parking in my private car space.

She next seeks to analyse the, so-called, '*right to life*' by asking: "*Is the 'right to life' a liberty, or a claim right, or a bundle of these?*" Foot notes that the '*right to life*' not only encompasses '*right*' in the sense of '*liberty*' but also '*claim rights*'; these latter are of considerable importance as they establish duties on others. The most fundamental of the claim rights implicit in the '*right to life*' is the '*right to be let alone*' and to be free from any threat by others to one's life; this '*right to be let alone*' is essentially a negative duty placed on others to refrain from interference in one's life.

In addition to the '*right to be let alone*', the '*right to life*' also encompasses the right to assistance from doctors and others flowing from contract¹⁴ - these are the essentially positive duties on doctors and others to provide that which they contracted to provide.

Foot's analysis yields the most important conclusion that '*Justice*' takes precedence over '*Charity*'; her argument for this is that otherwise the existence of the right to be let alone would be rendered null. This conclusion implies that, in discussing rights, it is a man's *wishes* that are of importance not his *welfare*; the opinions of others as to what will be to his benefit are not relevant. So long as a man wants to live, we are not justified in killing him nor, perhaps,¹⁵ in deliberately allowing him to die; in particular, the duties which flow from the '*right to life*' are not affected by the judgements of others as to the man's '*absolute quality of life*'.¹⁶

Foot concludes that the duty of non-interference prohibits active¹⁷ euthanasia. James Rachels had argued that the distinction between '*active*' and '*passive*' in such a context was invalid; he used the example of a child drowning in a bath and suggested that no sensible moral distinction could be drawn between the one who holds the child's head under water and the one who refuses to rescue it. Foot's response is that, in this example, it is not that the '*killing*' is worse than the '*allowing to drown*'. Both are immoral but they offend against *different* virtues. '*Killing*' offends against Justice, '*allowing to drown*' against Charity.

Taking the analysis further she considers the example of a wounded soldier left by a retreating army; the soldier does not wish to be killed; however, his comrades know that he will be tortured when found by the advancing enemy. Charity requires that he be killed but Justice prohibits this;

¹³ The '*goods*' she has in mind are family support and companionship, freedom from hunger, hopes for the future etc.

¹⁴ either an explicit or implicit contract.

¹⁵ If, say, as a doctor we have a contractual duty to keep him alive; Foot suggests (*op.cit.* p.51) that if the procedures are part of normal medical practice the patient is entitled to them however much it may be against his interest to do so.

¹⁶ Unless of course this has been provided for by a '*living will*' or otherwise.

¹⁷ The distinction made by Foot between active and passive euthanasia is not that between act and omission with which it is often confused. Active euthanasia is the positive choice of a behavioural strategy - whether act or omission - which is sufficient to result in death. Thus, the killing of a man by a lethal injection and the refusal to give him a life saving drug when under a duty to do so, are both examples of active euthanasia.

however, the withholding a life-sustaining drug would not conflict with Justice¹⁸ and would be in accord with Charity.¹⁹

Foot concludes:

*"It is important to emphasise that a man's rights may stand between us and the action we would dearly like to take for his sake"*²⁰

Foot meets Rachels' second argument against the distinction between 'active' and 'passive' - that it is often more humane to kill than to allow to die - by acknowledging that even though an active killing may be more humane it may infringe against Justice.

Foot concludes that when someone's wish to die is beyond doubt then the duties of non-interference lapse and an act of euthanasia, whether active or passive, would not be contrary to Justice. However, this is not a sufficient condition; the requirements of Charity must still be considered and they may, on occasion, imply that the death which is asked for, should not be conceded as it would not be *'for the sake of'* that individual; such circumstances might occur if the person who was asked to assist in the euthanasia was strongly of the belief that the life in question was still a good.²¹

Should morally justified acts of euthanasia be legalised?

Though there are circumstances where active euthanasia is morally permissible, Foot argues that the calls for the legalisation of active euthanasia should be resisted principally because of the risk of creating a 'slippery slope'. She cites the difficulty in devising procedures to ensure the consent is truly voluntary, the openness to abuse by those eager to get rid of elderly relatives and the necessity to keep intact a psychological barrier against killing, particularly so as at present, *"... when people so readily assume that the life of a handicapped baby is of no value ..."*²²

¹⁸ in that it is a non-interference and provided also that there was no duty implied by contract to provide it.

¹⁹ [*ibid.* p.54]:

"So, in spite of a very proper resistance to refusing to go along with the man's own wishes in the matter of life and death, someone might justifiably refuse to prolong the life even of someone who asked him to prolong it, ..."

²⁰ *ibid.* p.49.

²¹ As might happen, for example, when the individual requesting death - though rational and thus, competent - was severely depressed.

²² *ibid.* p.58.

Appendix E: The development of euthanasia in pre-war Germany

Leo Alexander¹ has noted that euthanasia programmes were widely discussed in German medical circles prior to the Nazi rise to power:²

*"Sterilization and euthanasia of persons with chronic mental illnesses was discussed at a meeting of Bavarian psychiatrists in 1931. By 1936 extermination of the socially unfit was so openly accepted that its practice was mentioned incidentally in an article in an official German medical journal."*³

Edmund Pellegrino confirms Alexander's perception and says (of the role played by the German medical establishment in such policies):

*"German academics, especially psychiatrists, were leaders in theories of racial superiority, ... before Hitler came to power. They even urged the Hitler regime to adopt these nefarious ideals. ... The German medical profession eagerly supported Hitler's Third Reich and made itself the Reich's willing agent."*⁴

However, the German debate on euthanasia and 'mercy killing' did not originate in the 1930's; the intellectual foundations were laid⁵ in a book written by two distinguished professors Karl Binding (a jurist) and Alfred Hoche (a psychiatrist) and entitled Die Freigabe der Vernichtung lebensunwerten Lebens,⁶ which was published in 1920. In this book Binding posed the question as to whether the legally permissible taking of life should be restricted to suicide (as was then the law). Binding argued that there should be three further exceptions:

- (i) *"The first group is composed of those irretrievably lost as a result of illness or injury, who, fully understanding their situation, possess and have somehow expressed their urgent wish for release."*⁷
- (ii) *"The second group consists of incurable idiots, no matter whether they are so congenitally or have (like paralytics) become so in the final stage of suffering. They have the will neither to live nor to die. ... Their life is completely without purpose, but they do not experience it as unbearable. They are a fearfully heavy burden both for their*

¹ Leo Alexander MD, was Chief Medical Consultant for the Office of the United States Chief of Counsel for War Crimes of the Nuremberg War Crimes Tribunal.

² Leo Alexander, 'Medical science under dictatorship' New England Journal of Medicine, (1949) at p.45.

³ *ibid.* p.39.

⁴ Edmund Pellegrino, 'The Nazi Doctors and Nuremberg: Some Moral Lessons Revisited', editorial, Annals of Internal Medicine, (1997), at p.308.

⁵ See, for example:

* Mark Rothe, *Amicus Curiae* brief to the US Supreme Court in the case of *Vacco v Quill* (1996).
[Internet source: <http://wings.buffalo.edu/faculty/research/bioethics/brf-rot2.html> 20 pp]

* Henry Friedlander, (The Origins of Nazi Genocide, p.14) also gives examples showing that eminent German scientists of the 1920's urged that the law should permit the mercy killing of the disabled.

* Dr. William Reville - reviewing Robert Proctor's Racial Hygiene: Medicine under the Nazis - summarises Proctor's argument as being that "... the development of Nazism was much less the imposition of the will of a fanatical minority on a majority, and much more an organic growth of ideas, trends and movements already present in mainstreams Germany than is commonly supposed." [The Irish Times; 14-6-96].

⁶ Published in translation under the title 'Permission for the destruction of Life Not Worth Living' in 8 Issues in Law & Medicine, 221 (1992); 231-265. This book comprises two essays: the first by Professor Karl Binding and the second by Professor Hoche.

⁷ *ibid.* p.247.

families and for society. ... Again I find no grounds - legally, socially, ethically, or religiously - for not permitting the killing of these people, ..."⁸

- (iii) "I have mentioned a middle group, and I find it in those mentally sound people who, through some event like a very severe, doubtlessly fatal wound, have become unconscious and who, if they should ever again rouse from their comatose state, would waken to nameless suffering."⁹

Hoche, building on Binding's analysis, posed a somewhat different question:

"The primary purpose of my medical commentary on the foregoing legal considerations should be to answer the question: Is there human life which has so utterly forfeited its claim to worth that its continuation has forever lost all value both for the bearer of that life and for society?"¹⁰

Hoche counselled against a purely utilitarian approach, but concluded that:

"We will never cease giving the best possible care to the physically and mentally ill, so long as there is any prospect of improvement in their condition. But perhaps we will eventually come to the conclusion that eliminating those who are completely mentally dead is no crime, no immoral act, no emotional cruelty, but is rather a permissible and useful act."¹¹

To Hoche, an individual could be described as being 'mentally dead' if :

- * (with respect to external relationships) "... [he] lacks any productive accomplishments and lives in a condition of total helplessness, requiring care by another."¹²
- * (with respect to his inner state) "... clear ideas, feelings, or acts of will cannot arise; ... no emotional links to the environment can arise (even though they may naturally be the object of the inclinations of someone else). But the most essential thing is ... the absence of self-consciousness. ... Just as he is incapable of any other mental process, a mentally dead person is thus inwardly unable to make a subjective claim to life."¹³

Binding and Hoche advocated a carefully controlled process of decision-making with evaluation by a government board composed of a physician, a psychiatrist and a lawyer; unanimity being required. Consent, which was to be required in all cases (with the exception of categories 2 and 3 above), could be withdrawn by the patient at any time.¹⁴ "The decree [of permission] itself may only say that, after thorough investigation on the basis of current scientific opinion, the patient seems beyond help; that there is no reason to doubt the sincerity of his consent; that accordingly no impediment stands in the way of killing the patient; ..."¹⁵

The proposals of Binding and Hoche drew considerable support from within Germany and from the international community - including many in the American Psychiatric Association¹⁶ - though

⁸ *ibid.* p.248-9. [emphasis in the original]

⁹ *ibid.* p.249. [emphasis in the original] This category is reminiscent of those who, in current terminology, would be described as having a 'null quality of life'; such a description being, of course, an 'absolute quality of life' judgement.

¹⁰ *ibid.* p. 258. [emphasis in the original]

¹¹ *ibid.* p. 262. [emphasis in the original]

¹² *ibid.* [emphasis in the original]

¹³ *ibid.* [emphasis in the original]

¹⁴ *ibid.* p.252.

¹⁵ Rothe *op.cit.* p.7.

¹⁶ Until the late 1930's when news of the German experience started to spread; see Rothe *op.cit.* p.6.

Bryan Magee (*Confessions of a Philosopher*, p.338) notes that:

there were some who suggested that it would lead to a 'slippery slope'. By 1933 a sufficient social momentum had developed in favour of euthanasia to enable the German Ministry of Justice to propose that it "... *be made possible for physicians to end the tortures of incurable patients, upon request, in the interests of humanity.*"¹⁷ These proposals, though not enacted into law, were put into practice¹⁸ first in relation to child euthanasia, which was permitted for disabled and 'defective' infants and children; subsequently an adult program for the 'easy death' of mentally ill and incurably sick Germans was instituted on grounds of compassion. Later, Jews and other 'undesirables' were included in the euthanasia programme but this was for racial and eugenic reasons.¹⁹

Child euthanasia developed²⁰ initially not by bureaucratic *fiat*, but as a response to a groundswell of public demand. In 1938 a father wrote to the German Government asking that his mentally retarded daughter who had been born without an arm and a leg, be granted a '*mercy death*'; he was not alone in his demands. Many parents sought such deaths for their disabled children and many '*wrote to hospitals to ask if their child could be relieved of his or her misery and be granted euthanasia.*'²¹ Thereafter, the mercy killing of children became commonplace; shortening their lives was considered to be a humane measure.²²

Pellegrino argues that many of the doctors involved in the Nazi euthanasia programmes believed that :

*"... they were doing the right thing ... The German physicians indicted at Nuremberg had been taught by some of the world's best historians of medicine and ethics. They could not plead ignorance of ethics and, in fact, made constant allusions to medical ethics and the Hippocratic tradition in their testimony. ... they justified their actions by what they considered to be moral reasons that have received insufficient attention."*²³

This, rather than the belief that all the Nazi doctors were ogres and sadistic killers, is the perspective that best allows the lessons of the Nazi experience to be learned.²⁴

"Early in the twentieth century it was common for writers who were then or later of international reputation to advocate the mass killing of ordinary people in order to raise the standards of those remaining."

Magee cites D. H. Lawrence, Bernard Shaw and H. G. Wells as having such views, adding:

"I once spent a morning in rancorous argument with Robert Graves because of his attachment to the same sentiment."

¹⁷ Rothe *op.cit.* p.9.

¹⁸ The guidelines authorised a doctor to perform certain procedures if he was satisfied that they were appropriate, they did not direct that he do so; see Rothe *op.cit.* p.11.

See also Patrick G. Derr. '*Hadamard, Hippocrates, and the Future of Medicine: Reflections on Euthanasia and the History of German Medicine.*' 4 *Issues in Law and Medicine*, (1989), at p.488:

"The tragedy is that the psychiatrists acted on their own. They were not carrying out a death sentence pronounced by somebody else. They laid down the rules for deciding who was to die; ... they were the executioners who carried out the sentence ..."

[Patrick Derr is Associate Professor of Philosophy at Clarke University and was the editor of the translation of Binding and Hoche mentioned above.]

¹⁹ Rothe *op.cit.* p.8-9.

Rothe quotes (*op.cit.* p.13) Simon Wiesenthal as saying:

"The Nazis considered euthanasia a quasi-ethical sort of murder, and reserved it for members of their own kind."

See also Derr *op.cit.* p. 488:

"We know, for example, that the moral collapse of German medicine was not caused by antisemitism. Ironically, as Wertham has noted: 'Jewish mental patients, old and young, were strictly spared and excluded. The reason given was that they did not deserve the 'benefit' of psychiatric euthanasia. This lasted up to the second half of 1940.'"

²⁰ Rothe *op.cit.* p.10.

²¹ Rothe (*op.cit.* p.10) cites authorities for this assertion.

'*The Nazis: a Warning from History*' Part 2 (shown on BBC2 29-7-00) described how thousands of letters arrived each week petitioning Hitler for favours; in late 1938 a father of a mentally disabled child wrote and asked the Fuhrer's permission to have the child killed; the letter was shown to Hitler and he agreed.

This programme made no mention of the proposals by Binding and Hoche dating from 1920 or the subsequent debate amongst medical practitioners; it left viewers under the impression that the mercy killing debate *originated* with Nazism.

²² Rothe (*op.cit.* p.10) cites evidence given to the Nuremberg Military Tribunal for this assertion.

²³ Pellegrino *op.cit.* p.307-8.

²⁴ Rothe (*op.cit.* p.11) quotes the testimony of a doctor (who had been involved in the euthanasia programme) to the Nuremberg hearings:

The Nazi child euthanasia programme involved little overt killing. The actions - increasing doses of painkillers and withdrawal of food - could even find a tentative accommodation within some variants of the 'double effect' argument. Friedlander shows that the euthanasia programme for disabled children was effected either by slow starvation or by the use of increasing doses of morphine, sedatives or sleeping tablets.²⁵ The physicians described such a process as '*treatment*', they reported a 'natural death' and subsequently argued that such death occurred indirectly by virtue of complications such as pneumonia, and that, accordingly, the death was not a direct killing. Furthermore, the belief that these practices were motivated solely by the interests of the wider society and were unconcerned with the perceived 'quality of life' of the children involved is simplistic; that this is so is evident from, for example, the fact that Jews were excluded from the euthanasia programme; and from the controversy over whether 'mongoloid' children should be included in the programme, some of those involved in directing the programme arguing - ultimately unsuccessfully - that 'mongoloid' children should be *excluded* because they had a special appreciation for music and love of life.²⁶

The development of adult euthanasia was, to some extent, also fuelled by the demands of some citizens that their handicapped relatives be '*released from their suffering*'²⁷ though the programme was widened considerably to include both psychiatric patients and those who were not 'racially pure'. According to Friedlander the fiction of a natural death was officially maintained as was the suggestion that only '*brain dead patients*' were included, although he notes that expert testimony in the post-war courts was to the effect that at most 7% could be so classified.²⁸ The adult euthanasia programme was to a large extent suspended due to public controversy; however, the child euthanasia programme continued.

The development of the euthanasia programme to include the killing of Jews and others is well documented but such ideas were only first developed in 1941²⁹ long after the child and adult euthanasia programmes had commenced. It is important to recognise that the development of the 'final solution' for the Jews was not fuelled by ideas of 'mercy death' - Jews were wholly forbidden from participation in either the adult or child euthanasia programme - but by ideas of racial purity; Rothe quotes Simon Wiesenthal as saying:

*"The Nazis considered euthanasia a quasi-ethical sort of murder, and reserved it for members of their own kind."*³⁰

Some Conclusions

- * Though the euthanasia programme undoubtedly set the stage for the anti-Jewish holocaust and is crucial for its understanding, the converse is not so. Neither racism nor antisemitism

"I was motivated by absolutely humane feelings. I never had any other intention. I never had any other belief than that those poor miserable creatures - that the painful lives of these creatures were to be shortened."

See also Binding *op.cit.* p.252:

"The act of euthanasia must be a consequence of free sympathy for the patient." [emphasis in the original]

²⁵ Friedlander (*op.cit.* p.61) suggests that the best estimate of the total number of children involved in these programmes is 5,000.

see also Rothe *op.cit.* p.15 who notes that the techniques used in the adult euthanasia programme (subsequent to 1942) were lethal injections and the 'withholding of nutrition and hydration'.

²⁶ Friedlander *op.cit.* p.58.

²⁷ Friedlander *op.cit.* p.171.

²⁸ Friedlander *op.cit.* p.170.

²⁹ Rothe *op.cit.* p.14.

³⁰ Rothe *op.cit.* p.13.

was a factor in the development of euthanasia in Germany; the full development of the child euthanasia³¹ programmes could have occurred even in the absence of Nazi racial policies.

- * Many involved in the euthanasia programmes were motivated, however misguided, by compassion. Friedlander mentions³² that the doctors involved in the euthanasia programmes occasionally gave lethal injections to severely injured German soldiers, suggesting that any attempt to assert that the doctors were motivated solely by ill-will is untenable. The exemption of Jews from the 'mercy death' programmes - in the context of considerable anti-Jewish sentiment - is further evidence that these programmes were not perceived in terms of punishment or conferring disadvantage, but rather as conferring advantage.
- * Though euthanasia - as advocated by Binding and Hoche - had some societal, or 'statist', aspect to it that might serve to distinguish it from current definitions of the 'right-to-die'- which stress personal autonomy and individual rights - this is more apparent than real.³³

These conclusions show that arguments to the effect that the development of euthanasia in Nazi Germany were *sui generis* and, accordingly, of no relevance to modern bioethical debates, cannot be sustained; indeed, a clear lesson can be drawn in relation to the ease with which 'slippery slopes' can develop from small, seemingly innocuous, beginnings:

*"Whatever proportions these crimes finally assumed, it became evident to all who investigated them that they all started from small beginnings ... it is important to realise that the infinitely small wedged-in lever from which this entire trend of mind received its impetus was the attitude towards the nonrehabitable sick."*³⁴

Derr believes that the most important lessons to be drawn are:

"Lesson 1: What has happened, can happen. ..."

*Lesson 2: If a culture adopts the practice of active euthanasia ... the killing should be done by nonphysicians and without physician involvement. ... It was Hippocrates' genius to realise that if medicine is to avoid playing the role of society's executioner, it must renounce killing utterly and without exception. The fatal error of German medicine ... was to think it could accept a little killing ..."*³⁵

³¹ The development of the adult euthanasia programme is more problematic in that it was, to some extent, justified in terms of 'racial purity'.

³² Friedlander *op.cit.* p.297.

³³ Rothe (*op.cit.* p.7) comments:

"The distinction, however, may not be that sharp. Contemporary proponents of the 'right to die' do not rely exclusively on the autonomy, but on the perceived worthlessness of the lives in question, and the economic costs of sustaining them."

See also Derr *op.cit.* p.494:

"Still, it is worth remembering that the engine which drove the early moral transformation of German medicine was not the ideology of racial discrimination, but medical economics."

³⁴ Alexander *op.cit.* p.46.

³⁵ Derr *op.cit.* p. 491-4.

Appendix F: Some modern definitions of personhood

Introduction

This Appendix considers the definitions of personhood proposed by some modern philosophers. As has been mentioned earlier¹ the various definitions focus mainly on the possible *denotations* of the term 'person'; its *connotation* - as a 'bearer of rights' - being usually regarded as uncontroversial.² The focus of the discussion is:

- * *firstly*, to state these definitions simply and without elaboration or without any attempt to summarise the arguments offered in their favour,
- * *secondly*, to examine whether these definitions imply:
(T): *'the ability to communicate to some minimal extent is a necessary condition for the ascription of personhood'*.

The definitions to be discussed are those of:

1. Alan Turing (1950) and Justin Leiber (1991)
2. R. S. Downie (1969)
3. John Rawls (1971)
4. Michael Tooley (1972)
5. Eike-Henner W. Kluge (1975)
6. Daniel Dennett (1978)
7. Joseph Fletcher (1979)
8. Owen Flanagan (1991)
9. James F. Drane (1994)
10. John Harris (1994)

Some conclusions are drawn in the final Section.

1. Turing and Leiber

Justin Leiber³ approaches the question of what is meant by the term '*person*' from quite a different direction than do the other philosophers discussed in this Appendix; his approach is of especial interest because of the prominence it accords to the ability to communicate; Leiber, in fact, takes 'being able to communicate' as the criterion for personhood. His argument depends crucially on the work of Alan Turing.⁴

Turing had been attempting to resolve the problem of whether machines could be said to 'think'. He had argued that if the problem was to be resolved by examining how the words '*think*' and '*machine*' are commonly used then this would imply that:

¹ Chapter 10, Introduction.

² See, however, the discussion of Harris's definition below.

³ Justin Leiber, *An Invitation to Cognitive Science*.

⁴ Though Leiber also argues that whereas Aristotle had used '*race*' (in the sense of distinguishing between Greek and non-Greek) as the criterion for being a '*person*' (in the sense of one deemed worthy of respect) [*"Aristotle ... claimed that Persians and other non-Greeks were incapable of rationality and, therefore, were natural slaves."* (Leiber *op.cit.* p.13)] Plato had, in contrast, used '*ability to communicate*' (in the sense of being able to speak Greek) [in *Meno*, Plato - in describing the efforts of Socrates to explain the theorem of Pythagoras to a young boy - has Socrates ask not whether the boy is Persian or Greek but only "*... whether the slave can speak Greek*". (Leiber *op.cit.* p.14)].

“... the answer to the question, ‘Can machines think?’ is to be sought in a statistical survey such as a Gallup Poll. But this is absurd.”⁵

Furthermore, attempts to resolve the problem by proffering a definition of the term ‘think’ left Turing open to the charge that such a definition either is not what is normally meant by the term or had been tailored to suit his conclusions. However, a remark of Descartes’ offered a way out of the impasse.

Descartes had asserted that it is impossible to make a robot that ‘would reply appropriately to whatever was said in its presence’⁶ and Turing seized on this as a criterion for determining whether an actual computer can be said to ‘think’.⁷ It is now widely regarded as the fundamental test for this question and is called ‘The Turing Test’.

Turing argued that instead of attempting to resolve the problem of whether machines can think through a search for definitions, the problem could be resolved by recasting it in the form of a game - the ‘imitation game’. To best explain this idea, Turing described an imaginary experiment involving three people - a man (A), a woman (B) and an interrogator (C) who may be of either sex; the interrogator is placed in a room different to the others (so that he is unable to see their physical appearance) and his task is to determine, by question and answer, which is the man; in this game the woman co-operates but not so the man. Turing argues that if the man succeeds in impersonating the woman then we can conclude that ‘he can think like a woman’. Turing next suggests that, in the game, a machine take the part of the man; this then gives him the test for deciding whether a machine can think:

“... being able to perform indistinguishably from a human thinker is to be able to think, period.”⁸

Leiber⁹ deduces that:

“The reason that you and I have for thinking that other human beings think is that they pass the Turing test. Of course, we assume that something that looks human and healthy and awake can think because the two often go together, but proof positive, both psychological and legal, requires and requires no more than linguistic performance, some approximation of Descartes ‘reply appropriately to whatever is said in its presence’.”¹⁰

Leiber considers the concept of ‘personhood’ as being:

⁵ Quoted by Leiber *op.cit.* p.109.

⁶ This was discussed earlier. (Chapter 1 Section 4 under the heading ‘Animal Consciousness from a Cartesian standpoint’) see also Descartes, Chavez-Arviso (trans.), *Discourse on Method*, p.107.

⁷ Leiber *op.cit.* p.23, p.46.

⁸ Leiber *op.cit.* p.110. Leiber compares modern objections to this test to the attitude of the Victorian male who - convinced that women could not reason - were enraged to find that the novelist George Eliot was a woman who had, to them, successfully impersonated the intellectual qualities of a man.

⁹ Leiber concludes his book *An Invitation to Cognitive Science* with a discussion (p.116) on consciousness in which he draws on the work on Roger Sperry and his successors (notably Michael Gazzaniga) on split brain patients; this research led to the discovery of the phenomenon of ‘blindsight’ (Discussed earlier in Chapter 2, Section 2). Leiber quotes Gazzaniga as stating that:

“The mind is not a psychological entity but a sociological entity ... The uniqueness of man is his ability to verbalise and, in so doing, create a personal sense of conscious reality out of the multiple mental systems present.” (*op.cit.* p.148).

And also that:

“... our verbal module supports, indeed is, our consciousness and personhood.” (*op.cit.* p.150)

These observations embed not only personhood, but consciousness itself, within a social context. Others have also argued for the thesis that consciousness cannot be a property of an isolated brain - vide a recent discussion in the *Journal of Consciousness Studies* [JCS Vol 5-3 p.375].

¹⁰ *ibid.* p.116. [emphasis in the original].

“... a set of tools for characterising - ‘personating’ one might call it - fellow humans and our self.”¹¹

The ‘Turing Test’ is such a tool and requiring, as it does, the ability to communicate, it implies (T).

2. Downie

R. S. Downie¹² notes that, traditionally, it has been asserted that the ‘*distinctive endowment of a human being is his ability to reason*’; Downie, however, conceives of ‘rationality’ as encompassing more than simply the ability to *reason*; to him it also requires the ability to *act* in a rational manner.¹³ To Downie, it is ‘*rational will*’ rather than simply ‘rationality’ that is of importance in delineating the term ‘person’; it is the ability to formulate plans and goals and to carry them into effect that is crucial. In an attempt to determine whether Downie’s definition implies (T), the question to be asked is:

‘Is it possible to adjudge an individual to be acting rationally without being able to communicate with him?’

If one sees a dog who has some bones and who buries some of them so that they might be retrieved in times of scarcity, might one say that he had a purpose which he was effecting and thus conclude that the dog was acting rationally? Certainly one might speak of ‘instinct’ but (as noted earlier¹⁴) this is perhaps nothing other than a device designed to mask a problem rather than help resolve it and does not further the discussion.¹⁵ Imputing an intention to a system and seeing it executed does not imply the ability to communicate and thus (T) would not be implied in such circumstances.¹⁶ This problem is, however, tangential to Downie’s discussion of the term ‘person’ which is conducted explicitly within the context of *human* individuals. This suggests that the appropriate question to ask is whether we could judge, of a human, that they were acting rationally if they were unable to communicate. An equivalent, but more easily resolvable, question is ‘*Could we judge a human to be irrational if we could not communicate with him?*’

Consider an individual who is considered to be acting irrationally. Does the irrationality reside in the *act*, or in something deeper? A little reflection will show that the irrationality cannot be manifest *solely* in the act - to suggest such would be to imply that reality itself, which contains that very act, was somehow irrational - but must reside in the disparity between the act and the intention. The madman who believes that he is Napoleon is mad not because he acts like Napoleon acted - he might after all be an actor pretending to be Napoleon - but because his beliefs, and the common consensus of what is ‘real’, are out of kilter. However, an individual’s beliefs are not accessible if he lacks the ability to communicate. We can therefore *conclude* that an individual cannot be judged to be irrational - nor rational (in Downie’s sense) - unless that individual has the ability to communicate. Thus, Downie’s definition of a person implies (T).

Downie also addresses the *connotation* of the term ‘person’:

¹¹ *ibid.* p.108.

¹² R. S. Downie and Elizabeth Telfer, *Respect for Persons*, p.20 *et seq.*

¹³ In terms of the dichotomy ‘*being* / *doing*’ as sources for value, Downie sides unambiguously with ‘*doing*’. The distinction between ‘*being*’ and ‘*doing*’ as sources for value was discussed earlier (Chapter 9 Section 2 Subsection 2) where it was argued that death denial is one consequence of the positing of value solely in ‘*doing*’.

¹⁴ In a footnote to the discussion of Strawson’s solution in Chapter 10, Section 3.

¹⁵ Though Dennett, for example, distinguishes such instinctual responses from other behaviour in that: (speaking of birds feigning a broken wing)

“... all birds of a species do it; they do it even when circumstances aren’t entirely appropriate.” (*Brainstorms* p.276)

¹⁶ The problem is reminiscent of Dennett’s analysis of ‘*intention*’ discussed in Chapter 2, Section 4, and Chapter 10, Section 3.

“... the concept of a person is already an evaluative concept with something of the force of ‘that which makes a human being valuable’ implied in it ...”¹⁷

He argues that that which is of value is ‘the exercise of rational will’.¹⁸ It was suggested earlier¹⁹ that the precondition for our valuing and respecting other persons lies in the possibility of our achieving empathy with them, this receives some support from Downie’s conclusion that:

“To respect such a person is to make his ends one’s own (show sympathy with him) and to take into account in all one’s dealings with him that he too is self-determining and rule-following.”²⁰

3. Rawls

John Rawls, in his A Theory of Justice, states:

“Here I adapt Royce’s thought that a person may be regarded as a human life lived according to a plan.”²¹ For Royce an individual says who he is by describing his purposes and causes, what he intends to do in his life.”²²

Rawls considers how such a plan relates to a person’s concept of ‘good’. He then defines what is meant by calling such a plan a ‘rational plan’ of life and this permits him to examine whether, in any particular case a ‘person’s conception of his good is likewise rational.’ For our purposes it is not necessary to pursue the question of rationality because before such issues can be discussed, Rawls first requires that the individual *describe* his purposes. This clearly implies an ability to communicate *i.e.*(T).

¹⁷ Downie *op.cit.* p.19 [emphasis in the original].

¹⁸ *ibid.* p.23:

“... that what is of value in persons can be characterised roughly as the exercise of rational will ... ”

¹⁹ When discussing Strawson and Wittgenstein in Section 3 Chapter 10.

²⁰ Downie *op.cit.* p.37.

²¹ The definition of a ‘person’ in terms of possession of a life plan is also found amongst some existentialist writers; for example, Jose Ortega y Gasset:

“If the reader reflects a little upon the meaning of the entity he calls his life, he will find that it is the attempt to carry out a definite program or project of existence. And his self - each man’s self - is nothing but this devised program. All we do we do in the service of this program. Thus man begins by being something that has no reality, neither corporeal nor spiritual; he is a project as such, something which is not yet but aspires to be.” (Walter Kaufmann (ed.) Existentialism from Dostoevsky to Sartre, p 154).

y Gasset contrast the possession of a life plan (*i.e.* being a ‘person’) with being a ‘thing’:

“The stone is given its existence; it need not fight for being what it is - a stone in the field. ... An entity whose mode of being consists in what it is already, whose potentiality coincides at once with his reality, we call a ‘thing’. Things are given their being ready-made.” (*ibid.* p.153-4).

y Gasset’s argument suggests a conclusion (similar to that in Dennett’s theory of stances discussed below) that the determination of personhood is essentially a choice of attitude resting on a *decision*, rather than being a *conclusion* implied by the results of some internal examination. See also, Wittgenstein:

“My attitude to him is an attitude to a soul. I am not of the opinion that he has a soul.”

[Wittgenstein, PI-II (iv) p. 178e] and the comment by Guy Robinson on this passage:

“My attitude is a matter of my whole demeanour toward him involving the rights and duties and customs of my culture. Not something that is simply true or false like an opinion, a matter for argument and proof. Paradigms, attitudes, and ways of looking are not matters of proof and disproof.”

[Guy Robinson, Philosophy and Mystification p.198]

²² John Rawls, A Theory Of Justice p.408; adding in a footnote:

“Royce uses the notion of a plan to characterise the coherent, systematic purposes of the individual, what makes him a conscious, unified moral person.”

4. Tooley

Michael Tooley²³ - in contrast to the other philosophers discussed in this section - sets the link²⁴ between 'personhood' and 'ownership of rights' centre stage. Whilst noting that most philosophers treat '*X is a person*' as synonymous with '*X has rights*', Tooley disagrees:

*"Specifically, in my usage the sentence 'X is a person' will be synonymous with the sentence 'X has a (serious) moral right to life'."*²⁵

The reason offered by Tooley for dissenting from the consensus, is that he believes a distinction can be drawn between '*having rights*' and '*having the right to life*'; the former not necessarily implying the latter. He offers for consideration the example that although, for humans, being killed is a greater infringement on their rights than being tortured, this may not be so for animals:

*"... it seems to me that while it is not seriously wrong to kill a newborn kitten, it is seriously wrong to torture one for an hour. This suggests that newborn kittens may have a right not to be tortured without having a serious right to life."*²⁶

I suggest that a better solution lies in the use of the concept of '*Objects of Intrinsic Moral Worth*'; this would permit Tooley's distinction to be made but would allow the connotation of personhood - i.e. as a 'bearer of rights' - to be preserved.²⁷

Turning next to consider the *denotation* of the term 'person', Tooley states:

*"Let us turn now to the first and most fundamental question: What properties must something have in order to be a person, i.e. to have a serious right to life? The claim I wish to defend is this: An organism possesses a serious right to life only if it possesses the concept of a self as a continuing subject of experiences and other mental states, and believes that it is itself such a continuing entity."*²⁸

Tooley calls this the '*self-consciousness requirement*'; he argues that the rights accorded to a person flow out of the existence of 'desires' in that person; furthermore:

*"... the desires a thing can have are limited by the concepts it possesses."*²⁹

From this Tooley concludes that for something to have a 'serious right to life' it is a necessary condition that:

"... it possess the concept of a self as a continuing subject of experiences, ..." ³⁰

In order to derive (T) from Tooley's definition of a person, reliance must again be placed in Wittgenstein's '*Private Language Argument*' with its implication that concept formation cannot take

²³ Michael Tooley '*Abortion and Infanticide*' *Philosophy & Public Affairs* 2, (1972), included in Peter Singer (ed.) *Applied Ethics*, (1986), 57-85.

²⁴ What has been termed the *connotation* of the term 'person' (see Chapter 10).

²⁵ Singer (1986) p.60.

²⁶ *ibid.* p.60. [emphasis in the original].

²⁷ The use of the concept of '*Objects of Intrinsic Moral Worth*' (i.e. entities, effects on which are to be considered relevant in assessing the morality of any proposed action) and distinguishing it from that of '*Persons*' (i.e. entities to whom rights are ascribed) would assist the discussion. It would then be possible to say that kittens are not 'persons' hence no rights are to be ascribed to them; they are, however, '*OMW*'s and so are part of the moral discourse. It would then possible to argue, without any inconsistency, that - although kittens have no rights - it is morally wrong to torture them but not to (painlessly) kill them.

²⁸ *ibid.* p.64.

²⁹ *ibid.* p.66.

³⁰ *ibid.* p.67.

place in the absence of social interaction and in particular the ability to communicate. Once the 'PLA' is conceded, (T) readily follows.

5. Kluge

Eike-Henner W. Kluge considers³¹ that 'persons' are characterised by the fact that they are rational beings and as such, he argues, they have absolute value. Kluge elaborates on the meaning of the term 'rational being' and in doing so offers the following definition of a person:

*"A person is an entity that is a rational being: that is to say, it is an entity that has the present capabilities of symbolic awareness in the manner characteristic of rational beings ... A person is an entity - any entity, irrespective of the precise nature of its constitution - that is either presently aware in a manner characteristic of rational beings, or can become thus aware without any change in the constitutive nature of its composition."*³²

Dolores Dooley-Clarke, in analysing this definition, notes that Kluge further characterises the concept of symbolic awareness as follows:

"1) The capability of symbolic awareness of reality is the capacity to respond to external reality by means of symbolic categorization processes that permit whatever it is that has this sort of awareness to apprehend the world as subsumed under certain more or less conventional categories of classification.

2) The capability of symbolic awareness of reality is the ability to form judgements.

3) To count as a rational being something must also have the capability of self-awareness.

*4) Overlapping with 2 and 3 above, the entity in question must be capable of internalising and using a language."*³³

The ability to use a language is explicitly assumed as a criterion. In attempting to apply Kluge's criteria it would seem that, in all but the most extreme of circumstances, this would require an ability to communicate. One could, perhaps, imagine such extreme circumstance as where an individual would, for example, 'dispatch missives' to others but not reply to or communicate in any reciprocal sense, with them. It is possible to argue that such 'language production' would not be a language use, no more than would the activity of a computer printer or a tape machine.³⁴ Descartes' criterion of 'ability to reply appropriately to what was said in its presence' would seem an adequate test of language use and this is, in essence, the ability to communicate. A further argument could be constructed from Kluge's criterion that a person show 'present awareness', this condition implies a responsiveness to the present environment which the 'dispatching of missives' would not satisfy.

In conclusion an individual without the ability to communicate would fail Kluges test (as it were by default) simply because his test could not be applied; Kluge's definition would thus imply (T).

³¹ Kluge's criteria are taken from:
Dolores Dooley-Clarke, 'A review of *The Practice of Death* by Eike-Henner W Kluge [1975]' in *Philosophical Studies* 25, 1977, 300-308.

³² Dooley-Clarke *op.cit.* p.301.

³³ *ibid.* p.301.

³⁴ Furthermore the *knowledge* of a language - in conjunction with Wittgenstein's 'Private Language Argument' - implies an ability to communicate, albeit at some earlier time.

6. Dennett

Daniel Dennett sets out the *necessary* conditions³⁵ for ascribing personhood as follows:

- 1) Persons are rational beings.³⁶
- 2) Persons are beings to whom intentional predicates are ascribed.
- 3) Ascribing personhood to an individual is dependent on the stance adopted towards that individual. Dennett explains this more fully as:

“... it is not the case that once we have established the objective fact that something is a person, we treat him or her or it in a certain way, but that our treating him or her or it in this certain way is somehow and to some extent constitutive of its being a person.”³⁷

- 4) The object toward which this personal stance is taken must be capable of reciprocating in some way.
- 5) Persons must be capable of verbal communication.
- 6) Persons are conscious in a special way often described as ‘self-consciousness’. In attempting to describe this special consciousness Dennett considers the concept of ‘second-order intentional systems’ - i.e. those systems which not only have simple beliefs, intentions and desires but also beliefs about these other beliefs, intentions and desires. On examination, however, second-order intentional systems can be found in certain animal behaviour - such as when animals feign to be dead, or injured, in order to mislead predators. Dennett is forced to use ‘third-order intentions’ to adequately characterise persons.

Dennett’s condition (5) is more than sufficient to imply (T).

Dennett argues that there are two distinct notions intertwined in the concept of ‘person’, a ‘metaphysical notion’ and a ‘moral notion’. He asks:

“Does the metaphysical notion - roughly, the notion of an intelligent, conscious, feeling agent - coincide with the moral notion - roughly, the notion of an agent who is accountable, who has both rights and responsibilities?”³⁸

He concludes that metaphysical personhood is a necessary condition³⁹ for moral personhood.

³⁵ Dennett *Brainstorms*, Chapter 14 ‘Conditions of Personhood’. Dennett believes that it is not possible to give *sufficient* conditions. (*op.cit.* p.285)

³⁶ Dennett considers that conditions 1, 2 and 3 are mutually interdependent.

³⁷ *ibid.* p.270.

³⁸ *ibid.* p.268.

³⁹ In Chapter 10 I have described Dennett’s ‘metaphysical notion’ as the ‘denotation’ of the term person and his ‘moral notion’ as its ‘connotation’. This description has as a consequence, that they are necessary and sufficient conditions for each other. Dennett’s analysis is more subtle in that it does not necessarily imply such identity.

Dennett does not argue for metaphysical personhood being a sufficient condition of moral personhood - though he does accept it as a necessary condition - because, for example, in considering an insane man, he is treated as a person even though deprived as his rights:

“... when we declare a man insane we cease treating him as accountable, and we deny him most rights, but still our actions with him are virtually indistinguishable from normal personal interactions unless he is very far gone in madness indeed.” [*Brainstorms* p.269]

Perhaps, if Dennett distinguished between the concepts of ‘Objects of Intrinsic Moral Worth’ and ‘Personhood’ (as outlined in Chapter 10, Introduction) then the case of the insane man could be understood as being one to whom moral obligations are due even though his rights - and consequently his personhood - have been lost. Arguing in this fashion would allow the conclusion to be drawn that ‘metaphysical personhood’ was a necessary *and sufficient* condition for ‘moral personhood’.

The concept of ‘stickiness’ [discussed in Section 5, Chapter 10] would permit a similar conclusion; this concept would imply that whilst an insane patient may lose rights he does not lose *all* his rights; this is because the (even remote) possibility that he may recover is sufficient to make some rights persist - in particular the right to life; as such, the insane person would have an attenuated personhood.

7. Fletcher

Joseph Fletcher sets out⁴⁰ the following criteria as '*attributes of personhood*':

- 1) Minimum Intelligence
- 2) Self-awareness
- 3) Self-control
- 4) A sense of time
- 5) A sense of futurity
- 6) A sense of the past
- 7) The capability to relate to others
- 8) Concern for others
- 9) Communication, of which he says:

*"Utter alienation or disconnection from others, if it is irreparable, is de-humanization."*⁴¹

- 10) Control of Existence, of which he says:

*"It is of the nature of man that he is not helplessly subject to the blind workings of physical or physiological nature."*⁴²

- 11) Curiosity, of which he says:

*"To be without affect, sunk in anomie, is to be not a person."*⁴³

- 12) Change and changeability
- 13) Balance of rationality and feeling
- 14) Idiosyncrasy
- 15) Neocortical function, of which he says:

*"In a way, this is the cardinal indicator, the one all others are hinged upon."*⁴⁴

Criterion (9), which requires an ability to communicate with others, obviously implies (T).

8. Flanagan

Owen Flanagan's concept of personhood has been discussed earlier⁴⁵ where it was noted that he considered personhood to reside in the possession of a reasonably viable '*story of the self*' which permits the individual and the world to interrelate. The earlier discussion drew on Flanagan's Consciousness Reconsidered; however, Flanagan elaborates on these ideas in his later Varieties of Moral Personality⁴⁶ where he attempts to incorporate the research findings of modern psychology into what is, normally, a purely philosophical discussion. His hope is that the resulting concept of 'person' will be less dependent on purely Western ideas⁴⁷ and will be enriched by the insights of other disciplines.

Flanagan first considers whether the possession of '*life plans*' - in Rawls' sense - can be taken as a criterion of personhood; he asks whether we must:

⁴⁰ Joseph Fletcher, 'Humanness' in Humanhood: Essays in Biomedical Ethics (1979) pp 12-16; reproduced in Furrow, Johnson, Jost and Schwartz Bioethics: Health Care Law and Ethics p.38 et seq.

⁴¹ *ibid.* p.39.

⁴² *ibid.* p.40.

⁴³ *ibid.* p.40.

⁴⁴ *ibid.* p.40.

⁴⁵ In chapter 10 when discussing Locke's concept of '*personal identity*'.

⁴⁶ Owen Flanagan, Varieties of Moral Personality p.56 et seq.

⁴⁷ *ibid.* p.62:

"I mean what I say here to be fully compatible with anthropological work on cross-cultural differences in the conception and constitution of persons."

*"... accept the idea that all persons will have life plans in Rawls's sense? Possibly not. ... Children do not have life plans. ... Do most adults have life plans? I am not sure. ... men tend to have them and women do not."*⁴⁸

In recognising that perception of personhood common in the West is not shared by many other cultures,⁴⁹ Flanagan is led to consider the concept of a '*minimal person*'. Elaborating on this concept, Flanagan states that minimal persons:

*"... consciously bear the information about themselves that they are continuous subjects of experience. They possess some sort of self-representation. But this self-representation can be extremely dim and inchoate. ... Minimal persons care how their lives go, and this involves caring about the satisfaction of their desires over time, ..."*⁵⁰

Flanagan concludes that the possession of a unitary 'life plan' is too onerous to be a criterion of personhood and that:

*"The picture of persons whose lives consist of a nexus of plans, perhaps none of which plays a foundational role, is therefore the best way to capture the usual nature of persons and their plans."*⁵¹

Does Flanagan's concept of a person imply (T)?

'Life plans' are of a considerably higher order of complexity than purposeful actions and whilst an examination of behaviour is in some cases sufficient to permit conclusions to be drawn with regard to the existence of intentions or purposes, it would be wholly inappropriate in the case of 'life plans'. This is especially so if the life plans were not of the unitary type but consisted of a 'nexus of plans'; the existence of such a nexus of plans could only be determined through communication, thus implying (T).

9. Drane

James F. Drane, in his Clinical Bioethics, aims to 'objectify' the quality of life concept⁵² by:

*"... deciding on a basic human anthropology and then identifying the experiences which are associated with each essential component of human life."*⁵³

To this end he analyses that which he considers to be, the most valuable aspects of our humanness. The results of this analysis are set out in a number of '*levels*' and are shown in Table F-1:

⁴⁸ *ibid.* p.65-6.

⁴⁹ Flanagan mentions (*ibid.* p.62) that '*Western, Javanese, Balinese and Moroccan*' conceptions of personhood differ.

⁵⁰ *ibid.* p. 63-4.

⁵¹ *ibid.* p.68.

⁵² James F. Drane Clinical Bioethics, p.177 *et seq.*

⁵³ *op.cit.* p.176.

Levels of Life		Quality of life
A philosophical anthropology: (a third person perspective)		Subjective life experiences: (a first person perspective)
Biological	1. Somatic / Sensory	Pleasure and pain, and recognisable human form.
	2. Physiological / Behavioural	Physical functioning and associated feelings.
Psychological	3. Cognitive / Rational	Consciousness, self-awareness, curiosity, insight, and associated feelings.
	4. Conative / Ethical	Autonomy, independence, moral agency, self, choice, conscience, and associated feeling states.
Socio-	5. Social	Relationship (personal, family, religious), love, care, support.
	6. Economic	A sense of financial adequacy for maintaining life.

Table F-1: Drane's Levels of Life.⁵⁴

Of these levels, Drane states:

*"Although the levels are listed in such a way as to suggest layers of being, this would be a faulty analogy. The levels are not separate strata but conceptually different dimensions of a complex human totality. Each dimension of the human person is critical to personhood, and the total and definitive loss of any one feature or capacity destroys the unity that we call a human person."*⁵⁵

Speaking of level 5, Drane says:

*"Social function refers to ability to engage in meaningful interaction with other people. ... Experience of relatedness is critical to humanness."*⁵⁶

This obviously implies that ability to communicate is a necessary condition for personhood thus establishing (T).

Before leaving Drane's account of personhood, it is necessary to note that his use of language and argument is loose and imprecise⁵⁷ and is so to such an extent that - in view of its possible implications - it amounts to irresponsibility. His criteria - the loss of any one of which he claims destroys personhood - have quite startling implications; the personhood of the disabled would be questioned under levels 2 and 4, that of autistic children at level 5, the poor at level 6. Drane's apologia - the term 'argument' is inappropriate - is an attempt to hijack the term 'person' and thus claim a specious universality for what is little other than a description of American economic

⁵⁴ Adapted from Drane *op.cit.* p.177.

⁵⁵ *op.cit.* p.177 [emphasis added].

⁵⁶ *op.cit.* p.178.

see also (*op.cit.* p.177):

"To think about the human person as an isolated and detached atom is to use a defective metaphor."

⁵⁷ For example:

* *"The anthropology which follows is one which enjoys widespread acceptance across cultural and religious lines. A bio-psycho-social anthropology is familiar to physicians who spend some time during their training practising psychiatry, which uses this background paradigm."* [*op.cit.* p.176]

* *"The notion of unqualified and continuing support to preserve all human life is obviously irrational."* [*op.cit.* p.165]

* *"A patient in PVS has a 'meaningful' life in the sense that his or her purely vegetative functions could be the object of meaningful scientific studies. Human cells are biological 'miracles' which are meaningful and valuable and worthwhile for research, but they do not have rights."* [*op.cit.* p.184]

Drane conflates the wider interests of society including the scarcity of its resources with the interests of the patient into one overarching term misleadingly called the 'quality of life' of the patient. This has quite a corporatist tinge in that it precludes the possibility that the interests of the patient and that of the wider society may on occasion diverge. It permits him, for example, to conclude that:

"Treatments that are too costly for either the patient or community or are environmentally ruinous are not in a patient's best interest when the patient is considered in totality." [*op.cit.* p.185]

individualism. This must be abhorred particularly in what purports to be a textbook on medical ethics.

10. Harris

John Harris's discussion of personhood⁵⁸ is the very antithesis of Drane's; Harris is lucid and insightful, his analysis draws distinctions which are of considerable assistance in delineating the scope of the term person. Harris uses the term 'person':

*"... to stand for any being who has what it takes to be valuable in the sense described, whatever they are otherwise like."*⁵⁹

By 'valuable', he means:

*"... features which have moral relevance, which justify our preference for ourselves and our belief that it is right to treat people as the equal of one another and as the superiors of other creatures."*⁶⁰

What do these terms denote? Harris has two strategies that can be used to discover 'just what it is that entitles an individual to be considered a person';⁶¹ firstly, to ask 'What is a person?' and secondly, 'What is valuable?'. His analysis of the term 'person' is based on Locke's definition and Harris concludes that the term is best understood as meaning 'a combination of rationality and self-consciousness.'⁶²

He finds any analysis of the term 'valuable' to be:

*"... so difficult and so profound as to be almost absurd."*⁶³

This leads him to a type of 'second order analysis' and he concludes that individuals have value if, and only if, they 'value their own lives'.

The conclusion he draws is that:

*"... it is the capacity to value one's own life that is crucial ..."*⁶⁴

The necessary condition for this capacity is awareness and self-consciousness; his two approaches thus coincide. However, given a specific individual, how do we determine whether it possesses this awareness or self-consciousness? Harris sees the ability to use language as crucial:

*"... language is the hallmark of self-consciousness. ... Moreover, language is the only vehicle we know of for self-consciousness."*⁶⁵

However, strictly speaking, the problem is not whether the individual has self consciousness but whether he can value his own life. Could an individual value his own life without language? Harris considers some experiments which sought to determine whether monkeys and chimpanzees had

⁵⁸ John Harris *The Value of Life*, especially p.19 *et seq.*

⁵⁹ *op.cit.* p.9.

⁶⁰ *op.cit.* p.9.

⁶¹ *op.cit.* p.14.

⁶² *op.cit.* p.15. He continues:

"The rationality required is of a fairly low order, just sufficient for the individual to 'consider itself the same thinking thing in different times and places'; and for Locke self-consciousness is simply the awareness of that reasoning process."

This is a fundamental misunderstanding of Locke's position: Locke required a level of awareness sufficient to ground a sense of personal identity and moral responsibility.

⁶³ *op.cit.* p.15.

⁶⁴ *op.cit.* p.17 [emphasis in the original].

⁶⁵ *op.cit.* p.19.

self-awareness⁶⁶ or could use language.⁶⁷ Harris believes that the latter experiment was successful and concludes that the chimpanzee in question was therefore *'clearly a person'*.⁶⁸ Harris's conclusion is that:

*"... the presence of language is definitive evidence that the beings who possess it are persons."*⁶⁹

However, Harris also believes that we should *'err on the safe side'* and that if a being normally capable of being a person can exhibit rudimentary self-awareness, this should be taken as the *'first signs of personhood'*.

Does this conclusion imply (T)? Strictly speaking it does not; there is a slight gap between Harris's conclusion and (T); this gap is occasioned by those individuals who have rudimentary self awareness but not the (present) ability to communicate. This gap can, I believe, be closed by using the idea of *'precociousness'*.⁷⁰ Once 'personhood' is considered to be a precocious attribute then rudimentary signs of self awareness (in Harris's sense) can raise the possibility that language use may be possible in the further and thus allow the *present* ascription of personhood.

Harris raises a further problem⁷¹ when he asks *"Once a person always a person?"*⁷² Harris considers that if the capacities for personhood are permanently⁷³ lost then personhood ceases. If there is:

*"... zero probability of my ever regaining consciousness, it seems fair to say that I have ceased to be a person, for there can be no self-consciousness and so no ability to value my existence if I am permanently unaware of my existence."*⁷⁴

What, however, of the conscious patient⁷⁵ unable to communicate and with zero probability of ever being able to do so? To Harris, such a patient could indeed continue to value their lives and so must be considered a 'person'.

In conclusion: Harris's analysis supports (T) as a test for the ascription of personhood but not for its removal.

⁶⁶ *op.cit.* p.20. The experiment had sought to establish whether monkeys recognised that a mirror image of themselves, was indeed themselves; however, the very limited nature of the experiment does not appear sufficient to support the purported conclusion that the monkeys had self-consciousness.

⁶⁷ The so-called Washoe experiment.

A recent article (The Sunday Times 13-8-00) discusses the work of Dr Savage-Rumbaugh of the Language Research Center in Georgia State University on measuring the ability of chimpanzees to communicate; it cites the example of one chimpanzee - who had been brought up in the company of humans since birth - as being *'cognitively at the level of a 4 to 5 year old and having the linguistic ability of a 2 year old.'* One of the researchers is quoted as believing that the vocalisations of a parrot - parrots having the same linguistic abilities as chimpanzees - *"... are the result of him expressing his thoughts, not mere mimicry."*

⁶⁸ *op.cit.* p.20.

⁶⁹ *op.cit.* p.21.

⁷⁰ The idea of *'precociousness'* in relation to an attribute is introduced in Chapter 10, Section 5; it means that if it is believed that at some future time the attribute will be applicable, then it is considered to be applicable at present but in an attenuated form; it is there argued that personhood is precocious in that, for example, it is this *'precociousness'* which enables a baby, and in some cases a foetus, to be considered to be a 'person'.

'Precociousness' should be distinguished from *'potential'*: an individual who is a potential person is no more a person that is an acorn, a tree; consequently, a potential person (being not a person) has no rights; in contrast - if personhood is accepted to be a precocious attribute - an individual who will become a person is deemed to possess an attenuated personhood and thus *presently* partakes of personhood and presently possesses (limited) rights.

⁷¹ Which is specifically addressed in Chapter 10, Section 5.

⁷² *op.cit.* p.25.

⁷³ *op.cit.* p.26.

⁷⁴ *"... where 'permanently' means zero probability of my ever regaining consciousness ... "*

⁷⁵ *ibid.*

⁷⁵ This (as discussed earlier in Part 1) is the situation of some PVS patients.

Conclusions

All the definitions given imply (T) though - in the case of Tooley's and Harris's definitions - reliance must be placed on Wittgenstein '*Private Language Argument*'.

The distinction between those definitions which require the application of the '*PLA*' and those that do not, is of importance when the conditions required for the ascription of personhood are distinguished from those required for the removal of personhood. These sets of conditions differ because if personhood was once ascribed to an individual then that individual had, at one time, language capacities and the ability to think conceptually. If this individual, at a later time, loses the ability to communicate then Wittgenstein '*Private Language Argument*' is of no relevance as the ability to think conceptually may still persist.

In conclusion, both Tooley and Harris accept (T) for the ascription of personhood but not for its removal; all of the others accept (T) as a test both for the ascription of personhood and, presumably, for its removal. This question is discussed further in Chapters 10 and 11.

Conclusion_{F-1} : *Definitions of personhood given by 11 modern philosophers are considered in Appendix F. All of these definitions imply (T); however, in two cases - Tooley and Harris - it is necessary to rely on Wittgenstein's 'Private Language Argument'. A corollary is that Harris and Tooley accept (T) for the ascription of personhood but not for its removal; all others accept (T) as a criterion both for the ascription, and removal, of personhood. All of the definitions, with the exception of Harris's, assume (U).*

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