Withdrawal of Artificial Feeding from Patients in a Persistent Vegetative State

DAVID LANHAM*

A variety of medico-legal problems claimed the attention of the President of the Family Division, the Court of Appeal and the House of Lords in *Airedale NHS Trust v Bland.*[1] These included the relationship between law and medical ethics, medical opinion and family wishes, medical treatment and the provision of food and water, withdrawal of treatment and euthanasia, civil actions for declarations and the criminal process, and the sanctity of life and a patient's best interest. Tony Bland, then aged 17, was a victim of the Hillsborough football ground disaster on 15 April 1989. His lungs were crushed and punctured and the supply of oxygen to his brain was interrupted. From that time he suffered from a condition known as a persistent vegetative state, in which the brain stem remains alive but the brain cortex is irreversibly damaged. In this condition the patient's breathing and digestive system continue unaided but the patient has no cognitive function, is incapable of voluntary movement and cannot taste or smell, speak or communicate or feel emotion.[2] By August 1989 two hospital consultants came to the conclusion that there was no hope of any improvement. One of the consultants discussed with the coroner concerned with the deaths arising from the Hillsborough disaster the possibility of withdrawing the artificial feeding (a nasogastric tube) which was keeping Tony Bland alive. The coroner warned the consultant of the risk of criminal proceedings if the patient were allowed to starve to death. As a result of this warning the hospital trust sought a declaration in the Family Division of the High Court that the responsible doctors could lawfully withdraw life sustaining treatment including artificial nutrition and hydration. Mr Bland's parents supported the application but the application was opposed by the Official Solicitor who was appointed as his guardian *ad litem.* Because of the importance of the case, the court invited the Attorney General to take part and he instructed counsel to appear as amicus curiae.

The case was heard by Sir Stephen Brown P who granted the declaration. The official solicitor appealed to the Court of Appeal. That court, composed of Sir Thomas Bingham MR and Butler-Sloss and Hoffmann LJJ unanimously dismissed the appeal. A further appeal to the House of Lords, composed of Lords Keith, Goff, Lowry, Browne-Wilkinson and Mustill was also dismissed unanimously. The result is that all the judges at all three levels recognised that it is lawful to withdraw artificial feeding from a patient in a persistent vegetative state.

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* Kenneth Bailey Professor of Law, University of Melbourne.

1 [1993] AC 789.

2 See id at 860 per Lord Goff adopting the description given by Sir Thomas Bingham MR.

The line of reasoning by which this result was reached involved consideration of the issues set out at the beginning of this article. Though there was much common ground there were also several points of difference. These and other features of the case will be brought out in the discussion of the various points below. At the House of Lords level the principal judgment was given by Lord Goff with whom the other members of the House of Lords were in general agreement, though with varying degrees of endorsement or confidence on specific points. In these circumstances Lord Goff's judgment will be taken, where appropriate, as the starting point in the discussion which follows.

1. *Sanctity of Life, Self-Determination and Best Interests*

No declaration of the kind approved by the House of Lords could have been made if the law's recognition of the sanctity of life were absolute. Lord Goff[3] saw the sanctity of life as a fundamental principle recognised by most, if not all, civilised societies and also by European and international treaties. That right, though fundamental, is not absolute. Lord Goff recognised that one limitation to the sanctity of life is the right to self-determination. This means that an adult of sound mind has the right to refuse life-saving medical treatment even if others regard the refusal as unreasonable and against the best interests of the patient.

Lord Goff recognised not only the right of patients to refuse imminent medical treatment but also the right to express refusal at an earlier date.[4] This provides support for the idea of a common law right to make what is frequently called a living will.[5] This possibility was endorsed by Lord Keith[6] and referred to with some caution by Lord Mustill.[7] In the Court of Appeal, Sir Thomas Bingham MR held that if Mr Bland had given prior instructions that he should not be fed or treated with antibiotics if he became a PVS patient, doctors would be acting lawfully if they complied with his directions and unlawfully if they did not.[8] Butler-Sloss LJ recorded that counsel all agreed that the right to reject treatment extended to advance directives or living wills and gave as an example of an advance directive[9] the situation in the Canadian case *Malette v Shulman*[10] where a Jehovah's witness gave prior instructions refusing a blood transfusion. Hoffmann LJ said that advance wishes should be respected and noted that different jurisdictions had varying requirements about how clearly such wishes should be expressed.[11]

These opinions show that the right to self-determination constitutes a very considerable inroad into the notion of the sanctity of human life. The problem however was that Tony Bland had not given instructions or any other indication that artificial feeding should not be maintained should he fall into a persistent vegetative state. The appeal to self-determination as a limitation on the sanctity of human life was accordingly more problematic.

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3 Id at 863.
4 Id at 864.
5 For discussion of this possibility see Lanham, D, *Taming Death By Law* (1993) ch 8.
6 Above n1 at 857.
7 Id at 894.
8 Id at 809.
9 Id at 816.
10 72 OR (2d) 417 (1990).
11 Above n1 at 828. For Australian models of living wills legislation see above n5 at ch 6; Lanham, D and Fehlberg, B, "Living Wills and the Right to Die with Dignity" (1991) 18 *MULR* 329.

American courts have wrestled with this problem for about two decades and have in broad terms come up with three solutions, one fictitious and the second dangerous, and the third pure but oppressive. The third solution is to maintain that, since there can be no exercise of the right to self-determination, where the patient is unconscious and there has been no (or no sufficient) prior indication of the patient's wishes, the principle of the sanctity of life remains absolute and so treatment must continue. That such an approach was constitutionally permissible was the view of a majority of the judges of the Supreme Court of the United States in *Cruzan v Director Missouri Dept of Health.*[12] Even so the majority of American jurisdictions reject this approach. That rejection is also constitutionally permissible. The *Bland* case at all three levels expressly or implicitly also rejects this third approach. At first instance Sir Stephen Brown P noted that the *Cruzan* decision turned on a constitutional point[13] and preferred the dissenting judgments which he held went to the substantive merits and allowed the removal of artificial feeding in a case of a persistent vegetative state. All the other judgments in the *Bland* case are consistent with this position.

That leaves the two other solutions. The one which involves a large dose of fiction is the substituted judgment approach. That which eschews fiction but flirts with danger is the best interests test.

Under the substituted judgment test, the decision maker has to try to work out what the patient would have decided if he or she had been capable of making a decision. In some cases there may be evidence which assists the decision maker but in others, for example babies or people with a very low mental age, there may be nothing to go on. The decision then becomes pure guesswork or the implementation of a fiction. For this reason some American courts reject this approach.[14] The House of Lords in the *Bland* case also seem largely unimpressed with it. Lord Goff[15] said that the test formed no part of English Law, but his treatment of the best interest test, which he favours, softens this position a little. The other members of the House of Lords, in addition to agreeing generally with Lord Goff, favoured some form of best interests test.[16]

Best interests then seems to be the test most favoured by English law. But it is a test which must be treated with some caution. American courts which have been prepared to live with the fiction inherent in the substituted judgment test take that position because of the danger presented by a best interest approach. In *Re Estate of Longeway*[17] the Illinois Supreme Court rejected the best interests test because it allowed a second party to make a decision on the patient's quality of life. There is certainly a danger, if such a test is allowed free rein, that judgments may be made that a given person is on balance better off dead or that a given life is a life not worth living.

The truth is that neither test is sufficiently focussed to provide anything like a solution to the multitude of problems which are likely to emerge. Either test is capable of serving two important but limited purposes. First, the very suggestion that such tests could in some circumstances result in the withdrawal or withholding of treatment on behalf of incompetent

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12 110 SCt 2841 (1990).

13 Above n1 at 803.

14 For example *Re Drabic* 245 Cal Rptr 840 (1988).

15 Above n1 at 872.

16 Above n1 at 859 per Lord Keith; 876 per Lord Lowry; 883 per Lord Browne-Wilkinson; 896–9 per Lord Mustill.

17 549 NE 2d 292 (1989).

patients indicates that the law does not take a life-at-all-costs approach to these cases. Secondly, either test can stand as a peg on which to hang a set of more specific principles, substantive and if necessary procedural, which are capable of reasonably confident application. But whichever test is adopted it will need supplementation by those more specific principles.

Despite the recognition by the House of Lord's in *Bland* that the appropriate test was that of best interests, the danger inherent in this test is implicitly acknowledged and met by a procedural requirement that, for the time being, the approval of a court should be sought whenever life saving treatment is withdrawn from incompetent patients who have expressed no prior wishes.[18] This provides for content to be given to the best interests test on a case by case basis so that the test does not become a safe guide for decision until it is released from its procedural bonds and given its own determinative authority.

2. *Futility*

As the best interests test seems the dominant one it is worth considering whether any further guidance is available on the nature of this test. It is clear from this case itself that one important principle in applying the test is that futile treatment is not in the best interests of the patient. Is this principle so strong as to outweigh all other factors? Having considered a number of factors including invasiveness of the treatment, the indignity to the patient and the distress to the family, Lord Goff said that in the end it was the futility of the treatment which justified its termination.[19] He distinguished cases where treatment might lead to a poor quality of life as in the case of severely disabled infants and those where the patient is totally unconscious with no prospect of improvement. In the former case there were considerations to be weighed on each side. In the latter there was no weighing operation to be performed.[20] This seems to suggest that, once a condition like a persistent vegetative state is established without doubt, treatment can, and possibly should be discontinued. In the *Bland case*, apart from whatever weight might have been accorded to the sanctity of life, all the other factors supported a decision based on futility. The medical authorities, the family and the appropriate use of scarce resources were all in favour of withdrawing the treatment. What if all or any of these had presented themselves as opponents rather than supporters? The effect of this kind of opposition will be considered in the next few sections.

3. *Medical Opinion*

There has been some variety in the significance given to medical opinion in making this kind of life and death decision. On one point medical opinion must be of the greatest weight and, if uncontradicted, conclusive. That is the clinical question whether the patient is in a persistent vegetative state. If there is a realistic hope of recovery the state is not persistent and the treatment is not futile. Quite different considerations would then apply. But if medical opinion is that the patient is truly in a persistent vegetative state, it seems to

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18 Above n1 at 874. For further discussion of the role of the court see Section 5 below.

19 Id at 869.

20 Ibid.

have no further part to play on whether the treatment should be withdrawn. The question has then passed from a medical to a moral, ethical or legal one.

There is potential for conflict at two broad levels. First, the whole or a dominant segment of the medical profession might take a different view from the law on the appropriateness of giving or withholding treatment in a given type of case. While both professions will no doubt strive to avoid such a conflict, the courts would have little choice but to apply the law rather than medical ethics. In *Airedale NHS Trust v Bland*,[21] Lord Goff held that it was the function of the judges to state the legal principles on which the lawfulness of the actions of doctors depend, but acknowledged that the evolution of sensible and sensitive legal framework called for a mutual understanding between doctors and judges. Happily, the British Medical Association had produced guidance in a discussion paper[22] which stated a number of rules for discontinuing life support for patients in a persistent vegetative state. With one major procedural reservation,[23] the House of Lords appears to have approved those rules.[24] The rules require rehabilitative efforts for six months before diagnosis of PVS is confirmed, confirmation by two other independent doctors and great weight to be given to the wishes of the family. While there is no doubt room for flexibility in the application of those rules to particular cases, the *Bland* case reveals a large measure of concurrence between the law and medical ethics on the question of the treatment of patients in a persistent vegetative state.

The second level at which there may be a potential conflict between doctors and the law is at the individual or single institutional level. Despite the view of the BMA, there may for example be some doctors or hospital authorities who hold the opinion that it is unethical to withhold food and water from those in a persistent vegetative state. This problem did not emerge in the *Bland* case, but Lord Goff suggested that the difficulty could be met by providing for a change of medical practitioner and by allowing doctors a right to abstain from involvement in such work on the ground of conscientious objection.[25] Lord Keith appears to have delegated a little more authority to doctors. He suggested that the question whether the continued treatment and care of a PVS patient confers benefit upon him is essentially for the practitioners but that any decision that it does not should be brought before the Family Division of the High Court for endorsement or the reverse.[26] This suggests that a decision in favour of continuing treatment would be for the doctor rather than the court. This may, however, mean no more than that no court order is necessary to continue the treatment and that the court would become involved only if someone sought an order to withdraw the treatment. In such a case the court rather than the doctor would have to consider the question of best interests. Both Lord Keith[27] and Lord Goff[28] took the view that their reasoning was substantially similar and so the more specific treatment of the subject by Lord Goff would seem to represent the views of both judges. The remaining members of the House of Lords also appear to have agreed with Lord Goff on this point[29] except for Lord Browne-Wilkinson who was prepared to confer a consider-

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21 Above n1 at 879.
22 British Medical Association, *Treatment of Patients in Persistent Vegetative State* (1992).
23 Relating to the need for judicial approval.
24 Above n1 at 871.
25 Id at 874.
26 Id at 859.
27 Ibid.
28 Id at 875.
29 Ibid per Lord Lowry and at 895 per Lord Mustill.

able amount of power on the doctor in charge of a PVS patient. Lord Browne-Wilkinson held that it is not for the court, in declaration proceedings, to decide on best interests but for the responsible doctor to do so. He recognised that different doctors might come to different views on the same medical facts whether intrusive medical care should be continued. All that would be required is that the doctor's decision to discontinue was in accordance with a respectable body of medical opinion and was reasonable.[30] His Lordship thought that it would be different if the matter came before the court under its parens patriae jurisdiction.

Lord Browne-Wilkinson's approach casts too much power and responsibility on doctors. It also does so in a haphazard way. The role of the court depends on this view on whether it has parens patriae jurisdiction and whether that jurisdiction is involved. The court's role should not turn on such considerations. The question is whether it is more appropriate for a doctor or a court to have the final say whether in a given state of medical facts the continuation of treatment is in the best interests of the patient. If the doctor is the more appropriate decision maker, this should be recognised even where the parens patriae jurisdiction is involved. If the court is better the court should decide both in cases of parens patriae and where a declaration or other remedy is being sought. Lord Browne Wilkinson's solution comes close to setting the doctor up on a kind of independent tribunal with an independent discretion. The majority recognise the question of best interests as one of ethics or law rather than of discretionary power, and that is the better view.

4. *The Role of the Family*

Where the question of the patient's best interests arises, the views of the family will be highly relevant but not conclusive. The British Medical Association's *Discussion Paper*,[31] states that generally, the wishes of the patient's immediate family will be given great weight but cannot be determinative of the treatment. Lord Goff[32] endorsed this position both in relation to the desirability of consultation and the inability of relatives to dictate to doctors what is in the best interests of the patient.

A more influential role for the family is suggested by Thomas J in a New Zealand case *Auckland Health Board v Attorney General*.[33] There the patient was suffering from Guillain Barre syndrome. His condition had become hopeless and he was unable to communicate. Thomas J did not find it necessary to decide whether the correct test for discontinuing treatment was best interests or substituted judgment but held that in either event the patient's family or guardian had to be fully informed and had freely to concur in the discontinuation of the treatment.[34] The position taken by the House of Lords may not be very far removed from that of Thomas J because the former court held that it was highly desirable that all decisions to discontinue treatment in such cases should be brought to court. Thomas J did not regard judicial proceedings as so necessary. If however the family or guardian should object to the discontinuation of treatment the matter could no doubt come before the court which in appropriate cases could overrule the objection.

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30 Id at 884.
31 Above n22.
32 Above n1 at 871.
33 [1993] 1 *NZLR* 235.
34 Id at 251.

Where the question is not one of best interests, the position of family members, guardians or even relative strangers may become more crucial. The best interest test comes into play only where there is insufficient evidence of what the patient's own wishes were. A wide range of factors may need to be taken into account, but if there is strong evidence that a competent, adult, informed, prospective patient foresaw the possibility that he or she would suffer a condition like a persistent vegetative state, and freely gave directions that once the condition was confirmed as hopeless no further treatment, nutrition or hydration was to be given, that should be sufficient to justify discontinuation without reference to a determination of best interests. The role of relatives and other people with knowledge of the patient would be to provide evidence not of their own wishes or opinions but of the directions, desires or values of the patient. The weight of that evidence may vary from the virtually conclusive to the almost worthless, but the recognition by the House of Lords of the living will technique[35] may give the family a central position of influence on the decision.

5. *The Role of the Court*

After some initial doubt whether a civil court should involve itself in what Lord Mustill called a kind of proleptic criminal trial,[36] the House of Lords held that such intervention was not only proper but, at least for the time being, obligatory, or at least desirable.[37] Lord Goff adopted this position in preference to one where reference to a court would be required only in certain specific cases: where there was medical disagreement on diagnosis or prognosis or disputes within the family or conflict of interest.[38] Lord Goff rejected this more limited role for the court despite the high cost in obtaining judicial guidance. He adopted Sir Thomas Bingham's view that judicial approval was needed for the protection of patients and doctors and the reassurance of patients' families and the public. These are important concerns but they must be appropriately offset against the cost of requiring applications to court. Lord Goff himself recognised that the protection of a court order would not be required in perpetuity and that a time would come when the President of the Family Division could relax the requirement.[39] It is important then to identify the basis on which the participation of a court is, at present, desirable in a way that outweighs the costs involved. The concern to protect patients and doctors and reassure the family and the public can be reanalysed under three heads: medical doubt, family or other disagreement, and moral judgment.

So far as medical doubt is concerned this can be resolved by medical guidelines which make it clear that there is no hope of reversal of the persistent vegetative state. That is essentially a medical decision and there seems no reason why the approval of the court should be involved in every case. A diagnosis of brain death or even traditionally defined death could conceivably be wrong in exceptional circumstances but society does not demand a court order to justify acting on such diagnoses.

So far as family or other disagreement is concerned this can be met by requiring application to the court where there is such disagreement but making no such requirement

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35 See above nn 5 and 6.

36 Above n1 at 888. See also 862–3 per Lord Goff; 881 per Lord Browne-Wilkinson.

37 American cases are divided on this issue, see above n5 at 36–39.

38 Above n1 at 873.

39 Id at 873.

where all relevant parties are agreed that withdrawal of treatment is appropriate. Brain death and organ donation might provide an appropriate analogy. If a patient signed a consent form as a potential organ donor and the spouse or relative disagree with it, it may be that a court order would be desirable if the patient's request were sought to be fulfilled. But that would be no reason for seeking a court order in cases where the family agreed with the patient's decision. There would be greater reassurance for the family and the public if a court order were required as a matter of course whenever it was proposed to withdraw a life support system and take the patient's organs for transplant purposes, but that reassurance would be bought at too high a cost.

That leaves the moral or ethical dimension. Whether treatment should be withdrawn even if it is certain that there will be no recovery and even if all the family and all the health workers agree that withdrawal is the right action, there is still the question whether the law will recognise the legality of withdrawal. I have called this the moral or ethical judgment to distinguish it from other legal questions which could emerge. But it is both a moral and a legal question and the law must make its own mind up about it. Now the question whether life preserving treatment should ever be withdrawn from a patient in a persistent vegetative state is merely one example of a more general question whether life saving treatment should ever be withdrawn from an incompetent patient, which in its turn is a species of a wider question still, whether life preserving treatment should ever be withdrawn and if so under what conditions.

The decision in *Bland* does not come anywhere near to answering all these broader questions. Even within the situation of a patient in a persistent vegetative state there may arise a set of variations which make it unsafe to rely on the substantive principle in the *Bland* case. What for instance would the position be if there was evidence that the patient wanted to be kept alive but the hospital wished to withdraw treatment because it was needed for other patients? And where the patient's condition is different from a persistent vegetative state all sorts of other considerations may be brought into play. As we have seen the broad test of best interests is nowhere near sufficiently developed to stand as a secure principle on which to answer the questions which might arise. So much is left uncovered. But not everything. There must be cases where the moral or ethical position is covered by the *Bland* decision. If all the material facts are the same as in the *Bland* case or are even more in favour of withdrawal there seems no point in expending resources to get confirmation that the withdrawal is moral, ethical and lawful. While the best interests test is too vague to provide answers without more detailed content, some of that content is provided by the *Bland* decision. It may be some time before the best interests test is sufficiently detailed to provide secure guidance in all cases of incompetent patients. But the sub-principle in the *Bland* case should be regarded as sufficient authority for action in similar cases without further judicial proceedings.