**Commentary on Derick Wade’s Back to the bedside? Making clinical decisions in patients with prolonged unconsciousness**

**and**

**Zoe Fritz’ Can ‘Best Interests’ derail the trolley? Examining withdrawal of Clinically Assisted Nutrition and Hydration in patients in the Permanent Vegetative State**

Wade describes diagnostic and prognostic uncertainties encountered in trying to categorise patients with a prolonged disorder of consciousness (DOC). That DOCs are diagnostically controversial is well documented.[1] Nonetheless, Wade’s paper provides informative details and a neurologist’s insights. But exactly what follows from difficulties in reliably diagnosing DOCs? Wade ‘concludes that this arises because consciousness forms a spectrum, so that no single test will ever define someone’s state with certainty’. In other words, DOCs are impossible to diagnose because consciousness is a spectrum of awareness along which everyone is moving.

This is highly questionable. Although it is clearly true that ‘awareness … covers a range from heightened awareness to complete unresponsiveness’, it does not follow that everyone’s level of awareness is in a constant state of flux. Colours form a spectrum, but it does not follow that everything is constantly changing colour. Likewise, the position on a spectrum of consciousness occupied by some DOC patients could now be fixed.

Not only is this possible, it is highly probable. For one thing, it is *a priori* feasible for a human brain to be malformed or damaged in such a way that consciousness is permanently either lacking or minimal. And there are real world instances: an anencephalic infant lacking a cerebrum and cerebellum does not have a fluctuating level of awareness; nor does a permanently vegetative (PermsVS) patient such as Tony Bland ‘whose higher brain had effectively liquefied’.[2]

In fact, Wade apparently concurs with this view when he ‘acknowledges that some people are so severely damaged that they can be considered as being permanently totally unaware’. But he immediately goes on to say, ‘they are at an extreme end of the spectrum, and not otherwise different’. This seems incoherent: how can a ‘permanently totally unaware’ patient be on a spectrum characterised by fluctuating levels of awareness?

More generally, there seems to be a slide from the fact that the level of awareness of *some* DOC patients fluctuates, to saying that the level of awareness of *all* DOC patients fluctuates; and of incorrectly inferring from the fact that *some* DOC patients have been misdiagnosed as being permanently vegetative or minimally conscious, that *no one* is. Hence the implausible claim that consciousness is a spectrum along which everyone is moving.

We should resist this and accept that the level of awareness of some patients is in fact now permanent. Crucially, this is compatible with Wade’s major premise, namely, that DOC diagnoses are unreliable. The key is to distinguish two claims: first, no one is permanently vegetative or minimally conscious; second, we have no current or foreseeable prospect of developing the diagnostic sophistication to identify reliably patients whose level of awareness is in fact now permanent.

At a couple of points Wade makes this distinction: ‘There is no separate vegetative state … Even if there were such a state, it cannot be identified’. But he emphasises the former, whereas the latter is an entirely plausible epistemic claim. It avoids questionable suggestions such as that everyone’s level of awareness is in flux, or that we could never develop diagnostic tools to identify the permanently vegetative or minimally conscious; and it is well supported by Wade’s detailed discussion of diagnostic and prognostic difficulties.

The upshot is that the level of awareness of some DOC patients is now fixed, but current and foreseeable diagnostic tests to identify them are unreliable. What follows? Wade advocates that treatment decisions – notably, to withdraw clinically assisted nutrition and hydration (CANH) – should not mandatorily involve the court; rather, clinical management should be undertaken by the clinical team, in accordance with the Best Interests framework set out in the Mental Capacity Act. But there is no straightforward entailment from epistemic uncertainty to removing mandatory court involvement.

For one thing, there might be countervailing reasons for requiring a court ruling. Halliday et al. thoroughly evaluate the declaratory relief afforded by the court, including numerous benefits not fully considered by Wade.[3] Most strikingly, Halliday et al. consider whether diagnostic difficulties of just the sort Wade details provide an argument *for* mandatorily involving the court. Specifically, given diagnostic uncertainties, the requirement to go through the courts provides reassurance to family members and protects patients. Halliday et al. ‘conclude that declaratory relief offers greater confidence in PVS diagnoses’, a conclusion to which they adhere even after considering whether the benefits of declaratory relief could be achieved other than by a court ruling.

Evidently, Halliday et al. and Wade have diametrically opposed views about the significance of diagnostic uncertainty for mandatory court involvement. Nonetheless, they are in broad agreement in advocating for ‘reform to the declaratory relief requirement’.[3] So the important point is that the call for legal reform cannot, as in Wade’s paper, be based solely on the unreliability of DOC diagnoses. A broader discussion of the value of declaratory relief, of the sort undertaken by Halliday et al., is required. The upshot may well be that mandatory court involvement in treatment decisions should be removed; but not because – and certainly not solely because – DOCs are hard to diagnose.

Fritz also considers the management of DOC patients, imaginatively enlisting best interests and organ donation to bolster the case for actively ending life as opposed to withdrawing CANH. But Fritz is very quick with the slippery slope objection, including a brief comment which is rhetorical as opposed to a counter-argument. And ironically, his presentation demonstrates the strength of the objection. The paper focuses on the permanent vegetative state, until the very last page:

The current practice of withdrawing CANH from patients in Permanent Vegetative *or Minimally Conscious States* – with the inevitable consequence of death – is ethically inferior to actively ending life with a drug that would stop the heart [emphasis added]

It is just this sort of slide – from the killing of PermVS patients to MCS patients – that suggests slippery slopes.

So the case for active euthanasia requires a more compelling response to the slippery slope objection. Specifically, we need grounds for restricting active killing to PermVS patients. One approach is based on the ontological status of the permanently vegetative.[4] A PermVS patient is in a distinctive ontological state, being neither straightforwardly alive nor yet dead; as opposed to other DOC patients, who are clearly alive. This helps establish a break on any putative slippery slope: actively euthanasia is being considered only for those in this distinctive ontological state.

Of course, this argument requires that at least some DOC patients are permanently vegetative; which explains the resistance earlier in this Commentary to Wade’s suggestion that everyone’s level of awareness is moving along a spectrum of consciousness.

[1] Nettleton S. Kitzinger J. Kitzinger C. A diagnostic illusory? The case of distinguishing between “vegetative” and “minimally conscious” states. *Soc Sci Med* 2014;116:134–41.

[2] Huxtable R. Euthanasia, ethics and the law: From conflict to compromise. London: Routledge 2007:2.

[3] Halliday S. Formby A. Cookson R. An assessment of the court’s role in the withdrawal of clinically assisted nutrition and hydration from patients in the permanent vegetative state. *Med Law Rev* 2015;23:556–87.

[4] Holland S. Kitzinger C. Kitzinger J. Death, treatment decisions and the permanent vegetative state: Evidence from families and experts. *Med Health Care Philos* 2014;17:413–23.