albeit in the knowledge that this will lead to the underlying condition causing the patient's death (prolonged unconsciousness of any aetiology is a fatal condition unless treated).

Is the withdrawal of hydration and nutrition part of the cause of the patient's death? Yes, but the moral obligation of the doctor is to provide care, which entails the intention and prospect of benefit, and the mere prolongation of unconscious life is not a benefit. The doctor therefore has no moral obligation to provide hydration and nutrition, and his or her partial role in causing the patient's death is not of moral significance. We all have partial roles in the causation of all sorts of dire events for which we none the less bear no moral responsibility.

Does the decision in the Bland case have adverse implications for disabled people? No more than for anyone else who is unfortunate enough to become permanently unconscious and who requires a share of scarce, and therefore necessarily rationed, medical resources from the community.

Should doctors provide sedation to patients who are conscious and suffering because of withdrawal of otherwise non-beneficial life prolonging treatment? Yes. The fact that we cannot provide medical benefit to cure their condition should in no way prevent us from providing the benefit of reducing or eliminating their suffering.

Are the views of relatives relevant? Well, it depends. A patient who is unable to make autonomous decisions needs a proxy to make decisions on his or her behalf. Close relatives and, increasingly, close friends are recognised as appropriate proxies on the grounds that they are likely to know the person's views and preferences and therefore what is likely to be in the person's best interests. This presumption can always be overridden by a court if there is reason to believe that the proxy is acting against the patient's interests.

The cost of recovery from the persistent vegetative state

In his second paper 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, if the patient had not rejected in advance such treatment, and if the patient's proxies and doctor thought that such treatment was in the patient's interests, then the treatment should continue. But resources are severely limited, at least within the NHS. In the NHS we already have to withdraw or withhold life prolonging treatment from patients who would otherwise have longer conscious lives. We withdraw ventilation in certain hopeless cases of respirator dependency; we withdraw dialysis in certain hopeless cases of renal failure; we withdraw or withhold cytotoxic medications in certain hopeless cases of cancer; and we withhold cardiopulmonary resuscitation from patients who are mortally sick or severely and irremediably disabled. 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. We withdraw or withhold treatment in such cases because the treatment does not provide more benefit than harm or because, even if it provides net benefit, the patient or his or her proxies reject the treatment or because, even if the patient or proxies believe that the treatment does provide net benefit, the cost to others is too great for its provision to be just or fair.

To feel the force of the latter consideration most of us have only to imagine any clinician in an NHS hospital arguing with colleagues and with hospital finance managers that clearly beneficial life prolonging treatments should be cut back to pay for a patient who, with intensive care and the expenditure of thousands of pounds a year, might, after three years of unconsciousness, regain the ability to smile at cartoons, to be pleased when his wife was present, and to be distressed when she went away.

I write "most of us" while realising that, for some clinicians, my arguments will be morally repellent. For them the saving of human life of any quality and at any cost will always be morally desirable. Let them and their sympathisers seek sufficient support from like minded members of the public to establish privately funded hospices in which, unlike the current hospice movement, patients in the persistent vegetative state are kept alive. Let them carry out prospective research. If its results and quality are sufficiently impressive they will persuade colleagues, the public, the media, and, if necessary, parliament that such treatment should be provided by the NHS. Meanwhile I suspect that most of us believe that the year of such life support recommended by the BMA's working party[6] and by judgment of the House of Lords in the Bland case[7] is more than sufficient to reconcile the moral requirements of (possible) benefit to the patient with justice to all.

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2 Gillon R. *Philosophical medical ethics.* Chichester: Wiley, 1985.
3 Andrews K. Patients in the persistent vegetative state: problems in their long term management. *BMJ* 1993;**306**:1600-2.
4 Andrews K. Recovery of patients after four months or more in the persistent vegetative state. *BMJ* 1993;**306**:1597-600.
5 Gillon R. Persistent vegetative state and medical ethics. *St Mary's Gazette* 1993;**99**:17-20. (2 April 1993.)
6 British Medical Association. Discussion paper on treatment of patients in persistent vegetative state—medical ethics committee of the BMA. London: BMA, 1992.
7 Withdrawal of medical treatment from hopeless case not unlawful. *Times* 1993;Feb 5; p 8 (cols 1-7). (Times law report.)

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Correction

Thallium poisoning

As a result of an editorial error figures 1 and 3 in this article by Moore *et al* (5 June pp 1527-9) were transposed. The legends appeared in the correct order