Reviewer's report

Title: DYING TOO SOON OR LIVING TOO LONG? WITHDRAWING TREATMENT FROM PATIENTS WITH PROLONGED DISORDERS OF CONSCIOUSNESS AFTER RE Y

Version: 0 Date: 28 Aug 2019

Reviewer: Alexandra Mullock

Reviewer's report:

This is an excellent article that I very much enjoyed and which I think should be accepted for publication. I have two observations that I think would improve the paper, which the author might want to consider.

At the start of the article, there is a discussion about the nature of the pre Y requirement to seek court approval and since this question has now only been resolved regarding patients whose relatives are in agreement with clinicians, it would be good if there was a little more focus on the crucial question regarding the nature of the requirement post Y. Thus, on this subject and at p.7, 'Leaving such legal niceties aside..' seemed slightly inapt, as I think the points raised in the previous paragraph are very important. As the author points out, the sloppy use of 'should' etc simply continues the very problem that the case was supposed to resolve. For me, this is a really crucial point so I would not park this as a 'legal nicety'. This issue is also one that links to some of the subsequent concerns raised in the article. For example, in a 'dying too soon' case where clinicians are erroneously assuming a patient has no interests, would family opposition to withdrawal compel the clinicians to seek court approval, or might they construe Re Y to mean that it is a soft obligation without legal force? While this uncertainty is briefly identified, it deserves more attention in my view.

I agree that the two opposing dangers, which seem to represent conflicting default positions, are real and important and any conflict between these concerns is generally managed well, but I wonder whether it would be good to briefly address this inherent conflict more directly. This could be done at the start and/or perhaps when it arises. The second main point in the 'living too long' section suggests that families are generally the driver for withdrawal because the professional clinical default is to treat. This obviously conflicts with the main thrust of the earlier point made about the (dying too soon) danger that clinicians might wrongly assume that people in VS, and perhaps also those in a MCS, have no interests. A critical reader might ask 'which is it then?' because while both possibilities are possible, if we are to be persuaded that we should worry about both, the conflicting arguments and evidence (that clinicians will be too keen to withdraw/that, according to the Kitzingers, clinicians don't instigate or attempt to drive withdrawal) need to be addressed.
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