

## Book reviews

### ABC of Brain Stem Death

Christopher Pallis. London, British Medical Journal, 1983. Paperback £5.50. USA \$16.25

Ten years ago when I lectured on brain death, the audience reaction was often hostile. Most of the criticisms were based on conceptual grounds and emotional anxieties. Over the years the audiences have become quieter and the questions fewer, until now if there are doubts, they are generally about some minor technical detail. The ethical and physiological concepts of brain death, its diagnosis and what follows are now widely accepted. The process leading up to this milestone in medical practice has been long, controversial, sometimes ill-tempered, and once even tainted with deceit. But the outcome has been worth the struggle and the final chapter has almost been written.

Everything about brain death is contained in the brilliant little book *ABC of Brain Stem Death*, by Dr Christopher Pallis. This excellent work traces the history of brain death in a simple yet non-condescending way. It deals with the concepts involved, lays out the practicalities of the diagnosis and finally looks at some of the controversies. It is a text which for its simplicity and clarity alone is a masterpiece, and which will become a historical document on the bookshelves not only of doctors, but also of many others.

As it is such an important milestone in medical practice, rather than simply review the book, I have taken this opportunity also to reflect on some of the other matters involved: our relationships with the media (and, complementary to that, our relationship with the public); what the controversy tells us about our 'medical method', and finally some of the issues of brain death itself.

### MEDICINE'S RELATIONSHIP WITH THE MEDIA

This reached a nadir with the *Panorama* programme on brain death which suggested that doctors had got things wrong. The medical reaction was a mixture of anger, paternalism and arrogance, surely a response we must learn to avoid. It is not given to doctors always to be right nor to hand down dictates which may not be questioned by others. We have to accept society's right to question our actions. And when they do, we must be ready to explain our position in a calm and reasonable manner.

Doctors cannot unilaterally decide when a person is 'dead'. The question of when a person is 'dead' is conceptual and in this area doctors have no more right, nor expertise in deciding, than any other member of society. We may wish to propose that certain concepts be accepted, but that is all we are entitled to do. Our specific role is to ensure that any concept of death, once accepted, can be made operational, and to lay out the criteria for doing this.

*Panorama*, although it was not appreciated at the time, was not questioning the concept of brain death. Rather surprisingly, it was questioning how to diagnose it. This is the area in which doctors do have special expertise, and we were therefore entitled to give an authoritative opinion. Unfortunately once our diagnostic methods had been questioned, the very concept of brain death was also anxiously questioned and, as usual, the picture became confused. In future we will have to ensure that we separate value judgements from purely technical matters.

Once we answered the technical questions in the brain-death debate the conceptual disagreements abated. As a result of the *Panorama* programme, therefore, public acceptance of brain death was strengthened. Provided we have agreed our position and we argue it reasonably the press and other media are our allies, and we have nothing to

fear from them.

### THE 'MEDICAL METHOD' IN THE BRAIN DEATH CONTROVERSY

By 'medical method' I mean our 'scientific method'. Although the two are similar I desist from saying they are the same. As medicine involves value judgements which cannot be falsified it is not 'scientific' in the true 'Popperian' sense. I have heard it suggested that the publication of the criteria for diagnosing brain death was premature and that this was the cause of the controversy: that the normal scientific method was not used. This is not true.

If (*a la* Kuhn) we examine what actually happened rather than what we theoretically think should have happened we readily discover that the science and the value judgements got mixed up. That mix is impossible to predict and we can only discover it by publishing and awaiting the response. There is no short cut.

In the brain death controversy it was the scientific aspects that were first questioned. Anxieties on this ground led to doubts about the concept. The purely technical criticisms of the criteria were answered in a true scientific manner, but this was not enough to allay the doubts that had been generated about the concept. This required a behavioural response: two consultants, each carrying out the brain-stem-function tests twice. It is because we are dealing with a mix of human behaviour, value judgements and science that our 'medical method' (however much we refine it) will always lead to controversy.

### THE CONCEPT OF BRAIN DEATH

One of the positive things to emerge from the discussion of the philosophical concepts involved in brain death was the demonstration of the value of philosophy in medicine. I know many doctors ignore ethical concepts, unless they are to their own, often materialistic, advantage. But this era is coming to an end and I think the analysis of the

philosophical issues involved in the diagnosis of death is the start of an important process.

Establishing the concept of brain death was the most important aspect of the whole controversy. How we decided whether or not it had occurred was of less significance. The first step in this debate was the realisation that definitions were not immutable. Some things may be the same 'yesterday, today and forever', but with developments in medical technology this can no longer be the case with death. It was not that it was necessary to re-define death, but rather that it was necessary to specify which concept of death we thought appropriate and why.

We were quick to realise that physiological criteria alone could not determine when life had ceased. We had learned our lesson from the abortion debate where initially it was thought that physiological criteria could establish when life had started. Eventually we grasped that this was a philosophical issue. So it is with death; physiological criteria alone cannot establish when life ceases. They can only establish when a given concept of death has been fulfilled.

The analysis of death, and the final elucidation of the concept contained in Dr Pallis's book, is a work of major philosophical significance. The key here is to get people to grasp the difference between the 'death of the organism as a whole' and the 'death of the whole organism'. I think it is this idea, more than any other, which has taken us forward. It has made all of us face up to what we mean by death.

**THE TESTS FOR BRAIN STEM DEATH**  
As was expected, this proved to be the area in which doctors felt most at ease, and as a result it generated a lot of discussion. I don't want to get into the controversy surrounding electroencephalographs (EEGs) and cerebral angiograms other than to say that I believe them to be of little consequence. I want to do nothing more than leave this area with a few thoughts.

First of all, is it necessary to carry out all the tests of brain stem function? If the response to one test is absent will not responses to all the other tests also be absent? It seems surprising that we do not know this.

Secondly, why is it necessary for each doctor to do the tests twice? According to the published evidence there has never been a mistake when the tests have been done once. Why then assess the criteria twice? I think that here we may have given up science for purposes

of psychological reassurance. (But who is to say that this is wrong?)

#### THE BEHAVIOURAL RESPONSES WHICH FOLLOW

I wish here to deal only with the doctors' response. In this area our actions and emotions lag behind our intellectual convictions. Once the patient has been diagnosed as dead, and even after the relatives have agreed to organ donation, many doctors still balk at the concept of 'beating heart' donors and at the use of muscle relaxants to inhibit spasms of spinal origin. But if the patient is really dead what is wrong with muscle relaxants? If the concept of brain death is accepted, the concept of 'beating heart' donors and the use of muscle relaxants are surely both logical and legitimate. We have a long way to go on this. Patients' relatives rarely have such problems.

#### CONCLUSION

As someone intimately involved over a number of years in the diagnosis of brain death I have tried to reflect my feelings and those of others in what has been a piece of medical history in the making. I have only touched superficially on a few areas, and have not dealt at all with many others. For a full analysis of the subject I would once again recommend very highly Dr Pallis's excellent little book *ABC of Brain Stem Death*. It is not given to many to make a major contribution to medicine and when it does happen it is generally in the field of therapeutics; a successful challenge at the conceptual level rarely achieves recognition. Dr Pallis's book, which is the culmination of many years work by many people, represents such a conceptual challenge. It should not go unnoticed.

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### Annual Report of the Health Service Commissioner 1982-83

London, HMSO, 1983. £3.75

### Report of the Health Service Commissioner: Selected Investigations

London, HMSO, 1983. £9.95

It was fortunate for the public face of the Health Service Commissioner for Great Britain that he was able to be dubbed in popular parlance the 'health ombudsman', appropriating the Scandinavian name for the comparable office in those countries. Fortunate, because

it has given the holder of the office here a more human-sounding personality than the official title, and to some extent the procedures surrounding his operations, convey.

The annual report and the twice-yearly reports of selected (anonymised) investigations are perhaps rather dry reading, but they contain a lot of human interest stories which moreover should be studied carefully by all health authorities, not only those immediately involved. They illustrate pitfalls in the administration of the National Health Service which authorities everywhere should take to heart since many episodes of like kind never reach the health ombudsman at all; the epitomes now included in the half-yearly reports of selected cases should facilitate this exercise.

Indeed, one of the striking features of the annual reports is the relatively few complaints which are investigated by the ombudsman. This is not only because his field of investigation is constricted by his terms of reference - in particular he cannot deal with cases concerned with clinical judgement - but also because the total number of complaints received is not dramatic: it fluctuates around an average of two a day. Of the 786 complaints which he considered in 1982-3, he rejected 559 (71 per cent) as outside his jurisdiction.

I do not see the relatively small number of complaints dealt with by the ombudsman as reflecting the incidence of maladministration in the NHS. While not wishing to exaggerate the extent to which patients in hospitals, which is primarily the area with which the ombudsman deals, are prejudiced by sloppy practices and sometimes downright carelessness and indifference by staff, we hear in the Patients Association of incidents which would seem to be of concern to the ombudsman, but which do not reach him for a variety of reasons. I suspect that the most common reason is sheer inertia (to many of us framing a complaint coherently in writing is a daunting prospect) compounded by reluctance to prolong an episode which, however distressing it may have been at the time to the complainant, is one which he wants to put behind him so he can get on with daily life.

A trying feature of an ombudsman investigation is very often the length of time it takes. It is right that he should want to interview thoroughly all those implicated in the complaint, but this can be a very time-consuming business owing, for example, to movement of