

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 electro encephalographs (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.

S GALBRAITH

*Institute of Neurological Sciences,
Southern General Hospital, Glasgow*

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 restricted 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

staff. One aspect of this procedure is that only very rarely does the ombudsman bring face-to-face the complainant and those who are in the dock, so to speak. I should like to see this done more frequently as we know that some complainants are left with the feeling that points they have made have been side-stepped in the investigations and that they have not had the opportunity of refuting directly statements made by the people about whose actions or behaviour they are complaining.

The result of the painstaking investigations by the ombudsman of the grievances he deals with is more often than not to reject them. In 1982–3 he upheld 43 per cent of the cases he investigated. But on the evidence he can claim with justification that his recommendations are effective; in 1982–3 all were accepted by the health authorities concerned, and in quite a lot of cases this led to changes in procedures to the benefit of future patients.

The ombudsman recognises, in his Annual Report, paragraph 99, that the complainants whose grievances he does not uphold often remain 'anxious and unconvinced'. Perhaps a speedier and more direct procedure might mitigate this.

ELIZABETH ACKROYD

Chairman of the Patients Association

Medical Costs, Moral Choices, A Philosophy of Health Care Economics in America.

Paul T Menzel. New Haven and London, Yale University Press, 1983, \$22.50

In his preface Menzel suggests that 'we have two very different reactions to contemporary health care'. He then contrasts the 'it is more important than anything else money can buy' reaction with the 'we are rankled by the incredible leverage over resources that the providers of medical care often appear to have' reaction. Who amongst us – apart possibly from some members of the medical profession – doesn't share this dual reaction?

I was intrigued by the task of reviewing this book: an economist invited by a medical doctor to review a book written by a philosopher. Despite the book's title, the objective of the author seems to be primarily to mount a defence of competitive forces as an efficient, equitable and moral mechanism for the supply of health care. Not that he advocates a wholly free market; but his

sympathies clearly lie in that direction.

Menzel puts forward three 'fundamental and independent' principles in his ethical framework for health care: 'maximum human welfare, justice as distributional equality, and individual autonomy or consent'. On the first two Menzel writes that 'it is relatively easy to defend the independence of the equality principle from the principle of welfare'. This is doubtful at least in the eyes of this economist: if we provide open-heart surgery facilities for those living in remote areas to the extent that they then have as good access to such facilities as those living in large cities, is there *no* conflict with efficiency?

The discussion in chapters 2 and 3 on pricing life raises a number of important and interesting issues and it is here that the author's adherence to the virtue of individual autonomy is most apparent. As later emerges in the book, he is opposed to paternalism. Unfortunately he couches his discussion on this solely in terms of the poor. Two questions are avoided: if the poor *choose* paternalism, what then? and if everybody chooses paternalism, what then? The former, an issue of principle surely, is avoided by suggesting that there is no evidence in practice that the poor so choose. The second is not addressed – yet there is a sense in which one answer is 'the National Health Service'.

An NHS type of system has its dangers as Menzel points out. One such might be that there is 'no *a priori* reason physicians would not dominate an NHS'. In choosing how to deliver health care he poses the fundamental question: 'isn't the problem of justice for pluralistic competitive schemes less intractable than the moral problem of individual autonomy for an NHS?' Maybe: but if in practice, in the face of his own very considerable ignorance and uncertainty about health and health care, the individual is prepared to forego his autonomy in the belief that the strength of the community interest may best serve his own welfare, then maybe not.

There is also a discussion of 'moral priorities' regarding the prevention versus treatment debate. Here however the moral issues seem to intrude unnecessarily. The same issue could be explained in a more matter of fact (but perhaps less stimulating) way by incorporating uncertainty and time preference through the economic technique of discounting the future.

The book raises many interesting issues. It steers a rather varied path. Sometimes it addresses the lofty concerns indicated at the beginning of this

review. Sometimes it is more at the level of the inside of the jacket where we are told that one of the author's 'surprising conclusions' is that 'if individuals had to choose what to spend on their own health care . . . they would spend only a limited amount of the resources available to them'. But it's worth fighting through the latter type of point to follow Menzel on the former.

GAVIN MOONEY

*Health Economics Research Unit
Department of Community Medicine
University of Aberdeen*

Social Work Values: an Enquiry

Noel Timms. London, Routledge & Kegan Paul, 1983. £5.95

'This book is concerned with the current status of value-talk in social work, with delimiting some of the problems raised by such talk and with working towards some remedy for these.' This is the project Noel Timms sets himself in the opening chapter, though it should not lead the reader to assume that Timms is interested in discourse analysis, nor that he aims to produce a guidebook for social workers on the ethics of contemporary social work issues. The focus is softer, the treatment more discursive, the aim less applied: we are given a 'preliminary mapping of the terrain' rather than an architectural plan.

He has considerable fun in showing how social work theorists lay claim to a language of values in writing about their practice, while at the same time allowing an almost complete critical confusion over the content of some of the most central and cherished items, such as acceptance of the client, self-determination and respect for persons. Social work involves doing things to and for others (and indeed refusing to do things on occasion), and the morality of such actions can be, and has been, justified in various ways. Timms also argues that the problem cannot be narrowed to the individual casework relationship but must include wider 'social facts' of an economic, social or political nature.

After the demolition, the work of reconstruction is less assured. Instances of historical controversies in social work, or the contribution of economics and sociology to the question of values seem to give little hope of direction to the practitioner wanting an answer, as Timms himself recognises, to the question 'what ought I to do in my situa-