Journal of medical ethics, 1987, **13, 171-172**

Editorial

Surgical intervention in dementia

Raanan Gillon *Imperial College of Science and Technology and King's College, London University*

In this issue Mr George Gafner describes a proposal to quieten the incessant yelling of a severely demented old man by cutting one of the nerves supplying his vocal cords in order, in effect, to turn down the volume of his shouting. The proposal was accepted by a multi-disciplinary group within the hospital concerned and by the patient's wife (who, although at the time was feeling guilty, ambivalent and anxious and 'like I'm on an emotional roller coaster', nonetheless a year after her husband's death still believed that the operation would have been justified and that her husband would have opted for it had he been able to do so). However, the operation was turned down by the Department of Surgery at the hospital on the grounds that it carried some risk and involved non-medical surgery: 'it was unethical to operate on healthy tissue'.

In a commentary on Mr Gafner's paper Dr George Robertson rejects the option of such surgery, suggesting that if a surgical solution is sought tracheostomy would be simpler, safer, more effective and reversible if circumstances changed. But he adds that to concentrate on the pros and cons of surgical interventions in such a case would be inadequate – instead the broader issue of the aims of medical care for severely demented patients requires analysis. For example the patient had had 'recurrent pneumonias' – what was the good of treating these? Was such treatment likely to 'improve the general condition of the patient'? A host of drugs had failed to quieten the patient – was this because of under-dosage so as to avoid periods of unconsciousness and reduce the risk of pneumonias? Why? Should not the achievement of a more dignified state for the patient than that of continuing shouting be aimed at? Would written evidence of what the patient would have wanted in such circumstances have helped to resolve matters, including written evidence about whom he would have wished to be his proxy decision-maker?

In trying to analyse such issues it is often helpful to start with the normal case. In the case of loud and protracted shouting by a patient in a hospital the 'normal case' is hard to discern but perhaps help can be gleaned from some 'philosopher's examples'. Thus, suppose a hospital patient voluntarily and persistently shouted, severely disturbing other patients, family and staff, then steps would properly be taken to change the person's mind by reasoning. If that were unsuccessful then depending on the urgency of the medical treatment required by the noisy patient steps would be taken to ensure that he left the hospital as soon as possible, in the interests primarily of the other patients but also of the staff. If the lack of hospital treatment were sufficiently detrimental to the patient then doubtless urgent treatment would be administered – if possible in a soundproofed room – but if the patient insisted on continuing to shout loudly and repeatedly then any non-essential treatment would be withheld and he would be asked to leave; if he refused doubtless the police would be enlisted. Thus in the normal case such shouting, if voluntary, would be vigorously opposed within a hospital setting.

Now suppose that such shouting were involuntary and unwanted by a normal patient who simply was unable to control it. It is difficult to construe a realistic case but let us imagine somebody with the equivalent of intractable hiccups in which each diaphragmatic contraction was accompanied by a loud and totally involuntary shout: or someone with uncontrollable, frequent and very noisy coughing or sneezing. In such cases the medical staff would, it seems safe to assert, have no hesitation in seeking means to stop the undesired and uncontrollable noise. Medication would usually be tried in the first instance but if it did not work and if a surgical remedy existed that would doubtless be offered (indeed cutting the phrenic nerve is sometimes used to cure intractable hiccups).

These two 'hypotheticals' indicate two important points about normal medico-moral assessments. The first is that in general doctors try to do what their patients want them to do – and that may include risk-taking (as in surgery or medication) in order to obtain benefits which the patient and the doctor judge to outweigh those risks. The second is that the interests of others and in particular of other patients may override the *prima facie* desire to do what the patient wants. Combined, these two lessons can be restated as the familiar moral claim that doctors ought to respect the autonomy of their patients – but that such respect must be compatible with respect for the autonomy of all affected.

However, the important difference between Mr Gafner's case and these two types of hypothetical

case obviously lies in the fact that Mr B is not an autonomous agent whereas in both hypotheticals the patient is autonomous. Is there any reason to assimilate Mr B's case more to one hypothetical than the other? Surely yes, for there is good evidence in Mr Gafner's account that Mr B would not have wished to continue to make a noise that was very disturbing to others – according to his wife he was 'a kind and quiet man who never wanted to bother other people'. Thus it would seem reasonable to assimilate Mr B's case to the second type of hypothetical case, in which patients want medical help to get rid of some antisocial affliction, rather than to assimilate it to the first type of hypothetical case where the patient deliberately chooses to behave antisocially or (in a different variant) deliberately chooses to retain some involuntary and antisocial behaviour that could be prevented.

Such an assimilation would be consonant with the principle, widely accepted in the medical care of non-autonomous patients, of substituted judgement, which acknowledges that the patient's autonomous preferences cannot be determined in such cases but seeks, as the next best thing to respecting the patient's autonomy, to try to respect what the patient *would* have chosen if he or she had been able to make an autonomous decision.

If substituted judgement had been the criterion in the case of Mr B and if his wife's account of his pre-morbid personality and attitudes had been accepted as the best available evidence of what Mr B would have chosen then it is not clear, *pace* the surgery department, that section of a recurrent laryngeal would have been morally unacceptable treatment. The surgery department apparently rejected the operation (and would presumably also similarly have rejected Dr Robertson's alternative of tracheostomy) on the grounds that 'it was not without risk', that it involved 'non-medical surgery' and that 'it was unethical to operate on healthy tissue'. The latter claim as it stands is unclear. Certainly a high percentage of normal ethically acceptable operations do involve operating on healthy tissue; and some apparently ethically acceptable operations involve operating *only* on 'healthy tissue' – for example many cosmetic operations. Similarly *all* surgical operations can be classified as 'not without risk'.

However, the point here and presumably also the point of rejecting 'non-medical surgery' and perhaps too the point of rejecting operation on healthy tissue is the medico-moral requirement that medical and surgical interventions should only be carried out if the anticipated benefit *to the patient* outweighs the risk. The twin spectres contrasting with such moral concerns are of surgery whose risk to the patient far outweighs any likely benefit; and worse still surgery performed on unconsenting patients for the benefit of others. Thus in rejecting the proposed operation the surgery deparment of Mr B's hospital might have been arguing either that Mr B would not have benefited from the operation (or not sufficiently to outweigh the risk), and/or that the operation was not intended for Mr B's benefit at all but entirely in the interests of others, which was morally unacceptable in the absence of consent. Either way it would be against Mr B's interests to have the operation. Here the issue turns crucially on whether or not doing what Mr B would have chosen had he been able to is to count either as a substantial benefit to Mr B, or in the interests of Mr B. There is one sense in which it would be neither – notably that Mr B in his state of advanced senile dementia is probably totally unable to *appreciate* any benefit or interests of any sort, let alone the benefit or interest of ceasing to plague others. But if that argument is used it seems to be equally effective in favour of killing Mr B, as he is presumably just as unable to appreciate the benefit or interest of continuing to exist.

If on the other hand we assess the benefit and the interests of non-autonomous people on the basis of how they would have (or can reasonably be expected to have) assessed their own benefit and interests had they been able to choose autonomously then the surgery department's fears can surely be allayed. For there seems good reason, based on the account given by Mrs B, to believe that Mr B would have considered it a substantial benefit to have an operation that turned down his uncontrollable 'hollering' to 'a very acceptable soft tone', (whether it was section of the laryngeal nerve or tracheostomy). Moreover he would presumably have considered it in *his* interests, a benefit to *him*, as well as a benefit to all around him, for in general it is in one's interests and beneficial to oneself to be enabled to lead the sort of life one chooses and Mr B was 'a kind and quiet man who never wanted to bother anyone'.

Whether Mr B would have chosen what some would see as more radical options such as non-treatment of his pneumonias and higher doses of sedatives perhaps associated with long periods of unconsciousness we cannot say from the story as given. Such assessments would be made more reliable if, as Dr Robertson suggests, people made their views known in advance directives, both about their attitudes to management in various predictable sorts of situations and about whom they would wish to be their proxies to help doctors in their difficult task of trying to do their best for those patients who are no longer able to make autonomous decisions.