CORRESPONDENCE

ETHICAL PROBLEMS IN INTENSIVE CARE

Sir,—Many doctors involved in the care of critically ill patients will welcome Miss Bishop's article on "Ethical problems in intensive care and clinical research", and Professor Payne's editorial comments on it (Bishop, 1978; Payne, 1978). They draw attention to the difficult ethical problems raised by intensive care medicine. There are two criticisms of Miss Bishop's essay which I would like to make.

First, it is sketchy. Several difficult issues were raised; the proper use of intensive care facilities, euthanasia, the care of the terminally ill, the ethics of clinical research and the personal convictions of doctors. These were discussed altogether in about 2000 words when each requires considerable thought and analysis. Second, a number of statements were made, the evidence for which is anecdotal. It may be that intensive care facilities and skills are used to prolong the act of dying. It may be that there is a degree of apathy among clinicians about medical ethics. However, such statements should be supported or challenged on the basis of evidence accumulated rationally, although this may be difficult to do.

Presumably the object of publishing this essay was to promote (and perhaps provoke) thought and discussion into the issues raised. Therefore, I would like to describe some of the practices in the Intensive Therapy Unit in this hospital.

Patients with brain death

During the past year nine patients have been declared dead according to the criteria put forward by the conference of Royal Medical Colleges and their Faculties (Statement, 1976). All these declarations have been made within 72 h of the patients' admission. When brain death was suspected, blood was obtained for tissue typing. When brain death was diagnosed the transplant surgeons and ophthalmic surgeons were informed. It was then the responsibility of these surgeons to ask the next of kin for permission to remove the appropriate organs. If permission was granted for removal of the kidneys, mechanical ventilation of the lungs was continued until this was accomplished. The kidneys from six patients have been removed during the past year.

Where there were contraindications to the use of the kidneys for transplantation, mechanical ventilation of the lungs was discontinued at the point when the diagnosis of brain death had been made. The following points are important: first, the intensive therapy unit medical and nursing staff took no part in the removal of organs, other than obtaining blood for tissue typing and informing the transplant surgeons that brain death has occurred. This action is not against the donor's interests. It does, however, allow the kidneys to be removed as soon as possible after brain death has been diagnosed. Second, the relatives were not asked formally for their agreement to discontinue mechanical ventilation. The precise nature of the discussion depends on the relatives themselves, although increasingly relatives are asking, "Are you going to switch off the machine?" It is explained that their loved one's heart and lungs are being kept working by the mechanical ventilator and that the person they knew and loved is dead, and that therefore there is no point in continuing to use the machine.

The decision to discontinue mechanical ventilation is a medical one. It is the doctor's responsibility, gently and patiently to help the relatives accept this situation. Third, although the diagnosis of brain death must be made by doctors, the senior nurse in the Intensive Care Unit and the nurses looking after the patient are brought fully into the discussion. If there are nurses in the Unit who have not seen brain death before, the consultant-in-charge of the Unit explains to them what is happening.

Patients for whom intensive therapy is no longer appropriate

During the past year there have been 354 admissions to this Unit and seven patients have been in this group. These are not patients who have died during intensive care treatment. They have died after intensive therapy support has been withdrawn. The philosophy in this unit is that patients are in one of two groups. First, in a majority of patients the evidence indicates that there is a reasonable prospect of the patient's recovery. In this case he receives the appropriate treatment. Second, in a few patients, the available evidence indicates that there is no reasonable prospect of survival. All intensive therapy support is stopped. The direction of treatment is changed to ensure that the patient dies in comfort and with dignity. Such decisions are taken after discussion among all the consultants concerned, in consultation with the junior staff and the nursing staff. The final decision is made by the consultant-in-charge of the patient. It is one of the functions of the consultant-in-charge of the Unit to bring together all the interested parties, as often as is necessary, to decide whether or not to continue with intensive therapy support.

Close contact is maintained with the relatives throughout the patient's stay in hospital. These patients remain in the Unit until death. This policy is adopted for three reasons. The patient and his relatives do not feel abandoned. The nurses wish it. It reminds the medical staff of their responsibility always to care completely, whether or not life can be preserved.

It may be thought that such practice amounts to euthanasia. In the literal sense of the word ("a quiet and easy death") it is. However, in the contemporary sense—the deliberate ending of a patient's life in order to relieve intolerable distress—it is not. Turning off an i.v. infusion of an inotropic drug, or discontinuing mechanical ventilation or oxygen therapy in these patients is simply recognizing that curative medicine has nothing more to offer. This point has been discussed in detail by Hare and Mitchell (1975).

Those responsible for instituting and maintaining intensive therapy must also take the responsibility of discontinuing it when this is indicated. The crucial question is, of course, what are the indications for doing just this? Miss Bishop seems to be asking that such indications should be agreed to and accepted by clinicians generally. This is
very difficult to achieve, because what constitutes "no reasonable prospect of survival" today, may not apply tomorrow, because knowledge and experience will have changed. There is certainly no place for pride or prejudice in making these decisions. What is required is a careful weighing of the available evidence. Certainly this may be difficult, but that does not absolve doctors who work in intensive therapy units from the responsibility of doing so.

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AWARENESS DURING ANAESTHESIA

Sir,—In view of the comment on a legal action brought for awareness during anaesthesia (Hutter and Tomlin, 1978) it may be useful to describe the points of interest to anaesthetists in a case in which I was asked to advise. The case was heard some 6 years after the event and all the hospital staff concerned were unable to recall any of the "facts" recounted in the Plaintiff's description of a very unpleasant occurrence. The first independent medical witness to corroborate the Plaintiff's story did not see her until 18 months after the event. The Judge noted this failure to corroborate the story, the considerable delay before the action was commenced, and he decided that awareness had not occurred. The Court heard that techniques associated with a risk of awareness were used by anaesthetists where deeper anaesthesia was considered dangerous, as for instance during Caesarean section. Anaesthetists who use techniques associated with a substantial risk of awareness, without a specific clinical indication should realize that both parties accepted the patient's right to be unconscious and not to suffer pain during surgery (Editorial, 1956).

In the 1977 Annual Report the Medical Defence Union referred to difficulties caused by the lack of detailed notes. I imagine that in the above case the prior offer of a small sum in settlement, without prejudice, reflected the genuine doubts concerning an adequate hearing of the case by the defence society concerned, as a result of such lack of annotation.

Anaesthetists should be aware of "traumatic neuroses" similar to that suffered by this patient. Awareness during anaesthesia may form an intense psychological stress, particularly if pain is experienced in addition. Many patients feel degraded and humiliated by this and react by passive de-personalization. They believe themselves to be mad and may make no effort to relate to staff what had occurred. This patient said that she had hidden in her bedroom on her return home, since she felt unable to meet her family. A similar state may follow anaesthetic dreams and can last for several months. Mayer and Blacker (1961) state that where this condition is found, the most effective treatment is a reasonable, accurate explanation of what has happened. Having regard to the difficulties experienced in the case described above, this explanation should not go further than stating that the patient was resistant to the anaesthetic agents used!

Routine visiting of patients after operation will help to detect similar unfortunate cases, but the patients may first describe their unpleasant recurrent dreams resulting from neuroleptanalgesia, or actual awareness, to their general practitioner. Such patients should be referred back to the anaesthetist concerned, for investigation and treatment.

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DIFFICULTY IN INTUBATION

Sir,—After reading Dr Dennison's letter (1978) I feel bound to ask if it was all really necessary. At our hospital, which is a centre for, amongst other things, rheumatoid arthritis, the problem of difficult intubation has largely been avoided. If we can, we choose extradural analgesia, but when general anaesthesia is unavoidable, we obtain x-rays of the cervical spine to assess the possibility of cord compression at the odontoid, and we check the degree of jaw mobility, during the visit before operation. Where we suspect that tracheal intubation by conventional techniques would be difficult, impossible or unsafe, we prefer to anaesthetize the patient with halothane via a mask and airway or a naso-pharyngeal tube.

Halothane, with spontaneous breathing, is perhaps not the ideal anaesthetic for a patient with rheumatoid arthritis undergoing a major orthopaedic operation, but we feel that it is kinder to the patient (and the anaesthetist) than a long and traumatic intubation. We have generally reserved the use of a flexible bronchoscope, under sedation, for neuro-surgical patients in whom intubation is obligatory.

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