BRAIN DEATH: SOME CONUNDRUMS

The diagnosis

Over the 13 years since the Transplantation of Human Organs Act, 1994 was passed, we continue to face practical problems when a patient is proven to be dead by the tests listed under it. Readers of this journal may wish to contribute their own experiences and suggestions after reading of our difficulties.

The vast majority of Indians, including the literate sections, remain either ignorant of this Act and its provisions or have a very fuzzy notion of it. This underscores the need for continued efforts at broadcasting the rationale for promulgating the Act and explaining its various sections. We continue to face relatives who, one eye on the oscilloscope tracing the electrical patterns generated by the heartbeat, refuse to accept that their patient is dead. Presence of the PQRST complex is, in their minds, proof positive of life. They go on to state that we must continue doing all that is humanly possible to save their patient.

The concept that the diagnosis of death no more rests only on the permanent cessation of the actions of the heart needs to be disseminated. Evidence of extensive, permanent, irreversible damage to the brainstem as adequate and legally valid ground for the diagnosis of death must gain general acceptance. Over time, we must shed the word ‘brain’ in the term ‘brain dead’. We shall thus spare untold agony, suspense and expense to the families of patients who have died.

In doing so we shall also help patients in desperate need for intensive care that could save their lives. As matters stand, the dead patient remains on a ventilator, intravenous drips and a variety of drugs. As long as the body remains in the intensive care unit, no other patient can be brought in to use these life-saving facilities.

Conveying the diagnosis to the family

The consultant attending to the patient is the ideal conveyor of the diagnosis to the family. Seniority, experience and authority facilitate transmission of the sad fact in a humane manner and help the family accept their loss. Unfortunately, the consultant is often busy elsewhere when the diagnosis is made and it falls upon the resident doctor to explain the changed circumstances to the family. It is often difficult for the junior doctor to put forth clearly the concept of brain death and answer questions from family members mesmerized by the electrocardiogram on the screen.

Some institutions are trying out a different tactic. As soon as brain death is suspected, the medical social worker is alerted, as the formal diagnosis will take at least 6 hours. During this period, using the skills learnt in training in social work, she initiates a dialogue with the family after introducing herself. She discusses the gravity of illness and offers help in any form required by the family. She keeps the family posted with changes occurring as the tests for brain death are carried out and as the second series of tests is awaited. After the final diagnosis is made, she conveys it to the family. Since she has built up a rapport with the family, it is less difficult for her to broach the topic of organ donation, emphasizing that the family is under no obligation to make such a donation. The family often finds it easier to discuss pros and cons of organ donation with her and make a decision.

Making the diagnosis when there is persistent metabolic abnormality

Since the criteria for the diagnosis of brain death listed in the Act assume that there is no significant metabolic abnormality, what is to be done when there is persistent metabolic abnormality? Adhering to the letter of the Act will mean losing several potential organ donations.

A suggestion has been put forth that contrast-enhanced CT scan be used to study cerebral circulation. If this shows total absence of entrance of contrast into the brain, can we make the diagnosis and take follow up action?

Red-tape frustrates organ donation

An accident victim admitted to hospital is deemed ‘a medico-legal case’ and details of the patient must be provided to the relevant police station at once. After the police have registered such a patient, it becomes mandatory to inform them on certifying death. No action can be taken on the body till the police decide on whether or not an autopsy is required.

We have observed delays of up to 7 hours from the time we inform the police station to the time we are told about whether or not an autopsy is required. Even when relatives have agreed to donate organs for transplantation after brain death and the need for urgent action is explained to the police, hours elapse ere we are told whether or not we can proceed to harvest organs. As we wait, the utility of the organs is downgraded and there are occasions when we have to offer our apologies to the family of the patient that despite their permission, we cannot utilize the organs to help other patients.

Taking organs after the heart has stopped

This is becoming increasingly difficult. Unlike the brain dead patient, where a minimum of 6 hours is available for discussion with the family and setting into motion all that is needed to harvest and transplant organs, here we have very little time. Under the circumstances, explanation to relatives, the time taken by them for making the decision and overcoming police and other formalities usually renders the organs unusable.

AT WHAT AGE SHOULD SURGEONS BE FORCED TO STOP OPERATING IN PRIVATE HOSPITALS?

At first sight this question sounds arrogant. Surely, the surgeon will stop operating as soon as he feels that he can no more do justice to the needs of his patients. Who, more than the surgeon himself, is aware of the need for the eye of an eagle, the heart of a lion and the hand of a lady? As the lens clouds, retina degenerates, heart departs from its natural rhythm and races wildly on mild stimulation and the hand trembles, the surgeon will gracefully bow and walk away from the operation table where he had ruled and performed for so long.

Will he, really?

Here are some sentiments that I have heard expressed by surgeons who have many years ago passed the Psalmist’s three score years and ten:

‘As long as I can help my patients, I will continue to operate.’
‘I have a keen mind. I am interested in recent advances and keep pace with them. I enjoy the challenges thrown up by
surgically treatable disease. I have not lost my stamina. Why should I stop operating?'

'I have a waiting list of patients for surgery that extends over the next 3 months. Should I disappoint all these persons who have faith in my abilities?'

'What? I, retire? Are you crazy? With my experience and wisdom I am far better than many of my surgical colleagues half my age!' A search through the journals shows that unless compulsorily retired or superannuated by hospital rules on reaching a particular age, most surgeons continue well past their prime, undeterred by the fact that their peak performances were in the distant past. Well-administered hospitals constantly monitor the outcome of all surgical procedures and are thus able to focus on the ageing surgeon whose morbidity and mortality statistics are worse than those of his colleagues and take action to prevent harm to his patients.

Unfortunately, few hospitals in India’s private sector fall into this category. Most such hospitals would find it very difficult to comment adversely on senior surgeons who attract large numbers of patients to the financial benefit of the hospital. In the absence of a continuous surgical audit carried out impartially and without excluding any surgeon, howsoever eminent, how are failing ageing surgeons to be weeded out?

A commentator abroad noted that when asked, most surgeons preferred a peer review system to determine their competency, rather than an upper age limit for practising. Would a jury of peers who will decide whether the quality of surgery merits continuation or dismissal be acceptable in India? Would senior surgeons accept the verdict of such a jury, where the average age of its members is 50 years?

SUNIL K. PANDYA

Letter from Australia

Doctors face many ethical challenges in their daily work. One of these—how to behave in relation to the pharmaceutical industry—has generated widespread discussion in the Australian print and electronic media over the past year. A prominent plastic surgeon and former Australian of the Year was forced to admit that her decision to appear in an endorsement for the over-the-counter drug Nurofen, in exchange for a donation to a research foundation of which she is chairperson, was a regrettable mistake because of the negative perception it created. The Australian Medical Association’s ethics committee said that patients expect to receive unbiased, evidence-based advice from doctors, not recommendations that unthinkingly parrot marketing claims of a company, especially when money considerations may have influenced that advice. The Federal Government has now extended its pre-existing legislation that made it illegal for doctors to appear in advertisements endorsing prescription drugs to cover over-the-counter drugs as well.

Publicity was also generated when a Melbourne oncologist lodged an affidavit with the Federal Court in Sydney that alleged improper inducements made to doctors by drug companies as part of their marketing strategy. These included business class travel to attend international company-sponsored meetings (as a delegate, not a speaker), accommodation at lavish hotels and dinners at high quality restaurants. Code of Conduct Guidelines published by Medicines Australia, the pharmaceutical industry’s own watchdog, states that in relation to whether sponsorship is appropriate or not ‘the test is of being able to withstand public and professional scrutiny and the ability to conform to any relevant professional and community standards of ethics and good taste’. The Australian Competition and Consumer Commission (ACCC) considered that what the oncologist was describing breached these standards and it demanded that Medicines Australia should be made to publish data on hospitality expenditure by all drug companies on a regular basis. Not surprisingly, this was vigorously opposed.

Rational prescribing is at the heart of good medical practice and in Australia, promotion of rational prescribing depends on a strong regulatory system operating at the community level, supplemented by the activities of increasingly powerful drug utilization committees in public hospitals and underpinned by the Code of Professional Behaviour published by each of the Royal Australasian Colleges.

Australia has a Pharmaceutical Benefits Scheme to subsidize the cost of prescription drugs and its computers are able to scrutinize the prescribing habits of all prescribers. Doctors whose prescribing is found to fall outside certain percentiles are subjected to practice reviews and can be referred to an inquiry by the Professional Services Review. If evidence of serious unprofessional conduct emerges, the practitioner may be referred to the Medical Board for a hearing that can lead to disciplinary action, even withdrawal of medical registration. On a more positive note, the Federal Government funds the publication of Australian Prescriber, an excellent independent magazine about the rational use of medications. It is available online at www.australianprescriber.com.

The hospital where I work has a Drug Utilization Committee that has the power to decide which drugs can be prescribed within the hospital and to promulgate guidelines on how drugs are to be used throughout the hospital. An excellent innovation has been the production of small laminated cards carrying guidelines on antibiotics and drugs used in emergencies, which clip on behind the doctor’s identification badge for use at any time. Online clinical guidelines and an online hospital pharmacopoeia make evidence-based drug information available at the fingertips of all staff and to all doctors in the community via the internet.

The Royal Australasian College of Physicians’ Code of Professional Behaviour says that ‘the physician should not ask for nor accept any inducement, gift or hospitality which may affect or be seen to affect his/her judgement, and not offer such inducements