Families, brain death, and traditional medical excellence

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Staff neurosurgeons and residents at a tertiary care hospital designated as a transplant center were surveyed regarding personal opinions concerning brain death and family conferences. Compared to an extensive survey done in 1976, the responses indicated that, while a professional consensus regarding the definition and meaning of brain death has emerged in the past 10 years, a range of personal beliefs and opinions regarding the concept still exists. In spite of the professional consensus, it is still difficult for the physician to communicate gently, yet firmly, to families both the scientific groundwork that validates the determination of brain death, the concept, and the finality of the information.

KEY WORDS • brain death • medical ethics

In an article entitled "Psychiatric Consultation Masking Moral Dilemmas in Medicine," the case of a 35-year-old man involved in a motor-vehicle accident, who had sustained severe head injuries and was declared brain dead, was discussed. In the case report, the victim's wife was advised of her husband's condition. She was asked for permission to turn off the respirator and other life support systems. At this time, according to the report, the organ transplant team requested permission to obtain the patient's kidneys. The wife refused both requests, stating that she wanted to take the patient home and maintain him on a respirator. The neurosurgeon in charge of the case referred the wife for psychiatric consultation.

This case was cited as one of three in which a psychiatric consultation was used to "mask" a moral dilemma. Specifically, the moral dilemma arose between the neurosurgeon and the spouse of the patient. That is, according to the article, the neurosurgeon was not comfortable with the idea of allowing the patient to be taken home to suffer biological death at a later time. It is impossible, the authors conceded, to sort out motives for this discomfort, but they suggested three: 1) a benevolent desire to relieve the family's stress; 2) belief that the patient's wife denied the medical facts because of the stress of the situation; and 3) pressure from the neurosurgeon's colleagues to obtain kidneys.

After counseling the family, the authors advised the neurosurgeon that the decision to discontinue support systems was a moral and a legal issue, not necessarily a psychiatric issue. The consultation ended with the wife deciding to cease mechanical life support. Organ donation was denied.

The following comments are additional observations about the case, and are offered to provide some useful medical-ethical information relevant to counseling families of brain-dead persons. I have analyzed the case from the differing perspectives of seven staff neurosurgeons (one full professor, one associate professor, and five assistant professors), and five neurosurgery residents (ranging in experience from 1 to 5 years). All of these surgeons practice at a tertiary care academic health science center that was designated as a transplant center in June, 1981. The scenario of the young automobile-accident victim is well known to the physicians on this service. By asking the neurosurgeons to read the case and to respond to five questions, constructive information regarding brain death and family conferences has been obtained.

Informal Survey

Do you ever ask a family's permission to disconnect the respirator?

Of the 12 surgeons answering this question, four would ask the family's permission to turn off the respirator. These were all staff neurosurgeons and, when questioned if the "asking" was done in a way so as to indicate that the family could refuse, they admitted that asking for permission was done after the family understood that there was really no choice. Eight respondents, three staff and all of the residents, emphatically stated that they would not ask permission. One assistant professor cautioned that to ask for permission is to mislead the family into believing the choice is theirs, when in fact, it is not. Another staff member stressed that the family must be advised that the patient is legally and physically dead — not just brain-dead. A third-year resident concluded that the problem in this particular
situation arose because the family did not understand that brain-death is death, and that it is irreversible. In seeking permission to disconnect the respirator, the family was led to assume that permission could be refused — that they had some options other than dealing with the death of a loved one. Also, to ask for organs before the family understood clearly that the ventilator would be shut off anyway is asking for a refusal. If the family does not yet comprehend that the patient is about to become a “non-ventilated cadaver,” then how can they be expected to authorize an act that would “really” kill the patient?

The careful choice of the term “non-ventilated cadaver” used in this response is important, and can best be discussed in the context of the second question.

What does “to suffer biologic death” mean?

Not one of the respondents recognized this term. Some, however, took a chance at defining it. One guessed “cellular death,” another simply responded “to die.” Another stated, “If we take the term literally, then it never applies to any patient declared dead from virtually any cause (point zero A-bomb excluded).”

More to the point, one respondent classified the term as “medicalized ‘B.S.’.” Death, he concluded, is like pregnancy. You are or you are not.

The fact that the term “biologic death” was used in this published case suggests a conflict regarding the meaning of the term “brain-death.” That was why the authors chose the case — the conflict was one that used the psychiatric consultation to mask a moral dilemma. The moral dilemma, which was not stated by the authors but which appears to be fundamental in this case, is that there are two different levels of death: brain-death and biological death. By hinting that there are different levels of death, this article opens a door for both religious and philosophical discussion concerning brain-death. This is a door that The President’s Commission on Bioethics concluded could remain closed.7 By advising the neurosurgeon that the decision, in this case to discontinue life support, was a moral and a legal decision and not necessarily a psychiatric issue, the consultants raised pertinent issues. In stressing these distinctions, however, it is important not to overlook the fact that brain-death is primarily a medical construct, one that has, since 1968, been developed and refined by new technologies and one that is generally equated with the more traditional designation of death, namely, cardiovascular failure.1,2

Do you think a moral dilemma appeared to have aggravated this case?

Six staff members and four residents responded “no” to this question. As was suggested earlier, these respondents felt that the dilemma was one caused by an inappropriate rapport with the family — one that invited a problematic response. One staff member indicated that there was always a moral dilemma associated with declaring someone dead. That is, one could be mistaken. A 1st-year resident identified an alternative moral dilemma (one that the article’s authors also suggested), “to alleviate the suffering of the family.” A 3rd-year resident referred to two recent cases in which a brain-dead pregnant woman was ventilated until her child could be safely born,4,9,10 and cited what he termed a “medical dilemma.” It was his opinion that the criteria for brain-death were still incomplete and would continue to be so for a number of years until more was learned about cerebral death. This goes against the conclusions in the report of The President’s Commission on Bioethics, but indicates that a range of personal assessments regarding the appropriateness of the use of brain-death criteria is still diverse. A 2nd-year resident admitted that talking to families about brain-death was emotionally difficult for him; it is difficult to convey that a “warm, pulsing body” is dead. However, he did not feel this represented a moral conflict.

When a family has difficulty accepting the finality of brain-death, do you request a psychiatric consultation? Do you consult with anyone? Is it an informal or a formal consult?

Eleven respondents (six staff and five residents) indicated that they would ask for consultation. One staff member indicated that he never consulted anyone. Six of the respondents stated that they would consult a staff person informally. Four would consult a chaplain, nurse, or social worker. One indicated that he would consult a psychiatrist in an exceptional case. The request for a consultation did not seem to depend on the legal status of the concept of brain-death; see the next question.

Is brain-death a legal criterion for stopping life support in Pennsylvania?

Seven respondents answered yes, five answered no, one qualified this negative answer by accurately stating that a bill was currently being considered by the state legislature. This bill was finally passed on December 17, 1982, 3 months after this informal survey was taken. Thus, the consultation was sought by the neurosurgeons to provide moral support and advice in dealing with grieving families.

Discussion

While certainly an informal survey, this response to a request for consultation corresponds with Diana Crane’s observations in the 1970’s regarding disconnecting respirators when the Harvard Criteria for Brain-Death were satisfied. Crane surveyed 1410 internal medicine physicians and 650 neurosurgeons and asked them whether they would turn off the respirator on a patient who satisfied the Harvard Criteria for Brain-Death. She asked if they would do this alone, with the family’s consent, or in collaboration with a colleague. The results are shown in Table 1. Analyzing these data, Crane concluded that some physicians viewed turning off the respirator as an act that directly terminated the
TABLE 1
Summary of survey regarding withdrawing respirator support*

<table>
<thead>
<tr>
<th>Physicians Surveyed</th>
<th>Turn Off Respirator</th>
<th>With Consent of Family</th>
<th>With Consent of Colleague</th>
<th>Decision Made Alone</th>
</tr>
</thead>
<tbody>
<tr>
<td>650 neurosurgeons</td>
<td>71% 29%</td>
<td>49% 9%</td>
<td>49% 21%</td>
<td>13% 2%</td>
</tr>
<tr>
<td>1410 internists</td>
<td>72% 28%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Data obtained from Crane, see text.

The emergence of a professional consensus regarding the concept of brain-death in the past 10 years has acted as a common denominator to guide professional medical decision-making. What the Crane study alluded to, however, and what some of the responses to this informal survey suggest is that neurosurgeons are a diverse group of individuals having a variety of personal opinions and beliefs about brain-death. In the 1970's, 29% of those surveyed elected not to turn off a respirator and, of those remaining, 58% sought a consultation.

The report by The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, which dealt with defining death, has done much to clarify the legal, medical, and ethical status of brain-death. The report is important, writes one observer, "primarily because so many physicians were able to reach a consensus on a common set of guidelines... while aware of the ethical and legal implications of developing a set of national standards. For this many physicians from the fields of neurology, neurosurgery, electroencephalography, critical care medicine, anesthesia, and legal medicine to reach a consensus is a truly remarkable achievement."3


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References


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