NEUROSURGERY, THE PUBLIC AND THE LAW*

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(Received for publication May 19, 1961)

BEFORE beginning my presidential address, I should like to express to the members of the Harvey Cushing Society my sincere thanks for the impressive honor you have conferred upon me and, by reflection, upon the institution I represent. I am additionally indebted to you for this opportunity to speak to you about some questions which seem to me of prime importance to our society, to the specialty of neurosurgery and certainly to the public and our relations with the public in the light of both the law and our destinies as neurosurgeons. What I have to say may not be new, but it is important enough to warrant repetition for older members of our specialty and to remind younger members of what may lie before them.

I do not know what the situation is here in Mexico in relation to the problems I shall set forth, and for that reason many of my remarks may seem of no great moment to our Mexican colleagues. If some of the questions I shall mention present no difficulties in your country, you are to be congratulated on your good fortune.

It is entirely possible that in the course of this presentation I may say some things that are unpleasant to hear. In so doing, however, I certainly mean no personal affront to anyone, and I hasten to affirm at the outset that no one realizes more than I that the final responsibility for the care of the patient reposes with the physician to whom the patient has entrusted his life and physical integrity.

The older members of this society no doubt have encountered many of the problems about which I shall speak. Yet, since I know of no source from which some of this information can be obtained except the university of hard knocks, I think it may be useful to present a few examples of pitfalls which may undermine the way of the neurosurgeon, but which nonetheless can be avoided by the exercise of good judgment and a certain degree of practical insight.

Neurologic surgery to me is still the queen of the surgical arts, intracardiac surgery not being excluded. W. Lister Reid, senior honorary neurosurgeon-in-charge in the Royal Prince Alfred Hospital, Sydney, Australia, has, I think, expressed this succinctly in the following paragraph:

“When we think about Neurology and Neurosurgery we must realize that the Brain is the Temple, the Spirit, the Delicate Mechanism that controls every tissue in our bodies. There is so much that we do not know about this Central Control Mechanism that it is not possible to put too much Effort and Research into an attempt to solve its many mysteries, and to treat its numerous maladies.”

THE PATIENT SHOULD BE TOLD

Neurology and neurologic surgery have not yet come to be the exact scientific disciplines that I was led to believe them to be or as I thought they were when I was a medical student. As a student it seemed to me that we knew reasonably well how the brain and spinal cord and their peripheral connections functioned, and it thus followed that anyone who took the trouble to learn neuro-anatomy could arrive at the exact diagnosis of almost any given condition by adding up the symptoms and signs in a sort of rationalistic résumé.

Members of this society of course know that such an action simply is not true and cannot be true. What is more, we all know that for the most part we are confronted with grave risks when we undertake an operation on the nervous system. The nature of our

* Presidential Address at the meeting of the Harvey Cushing Society, Mexico City, Mexico, April 18, 1961.
surgical efforts being what it is, we realize that any procedure that we propose may bring great benefit to the patient, but we are also mindful that our intervention may be accompanied by risks. Consider what we all know: that the simplest operation on a peripheral nerve can result in greater disability than the patient had before the procedure was performed. Surely, then, we cannot do less than to exercise every care and to weigh every risk in arriving at a diagnosis and in planning and executing the operative procedure. Next, the inescapable corollary is that the patient and his anxious relatives should be told in unmistakable terms exactly what is involved and what the chances for success and failure are. It is far better, in every respect, to preface the operation with such an understanding than it is to try to explain, after the operation, a result that is not what either the patient or the neurosurgeon desired or anticipated. We must insist on what has been well named an “informed consent.”

It is, I believe, a wise precaution to explain to patients and their relatives, particularly when they ask about the risks of surgical procedures, that operations on the brain sometimes can be followed by paralysis, aphasia, impairment of vision and other untoward developments. We should be prepared to defend these risks as constituting less of a hazard to the patient than the disease that we are seeking to overcome.

By all means, we ought also to consider carefully and to appraise judiciously the potential benefits and relief of suffering as opposed to the prolonged hospitalization and needed care and expense to the patient and his family before we undertake palliative procedures. Today, in view of the fact that more efficient pain-relieving drugs and tranquilizing agents are readily available, I doubt that the same indications are present that obtained some years ago for cordotomy, lobotomy and sectioning of sensory roots.

HEROIC MEASURES

I fully agree with the remarks of my colleague, Dr. Edward H. Rynearson, and what he said about heroic measures in *C.A. Bulletin*, and I should like to repeat a paragraph from his remarks:

“When a doctor and his consultants have sincerely judged that a patient is incurable, the decision concerning further treatment should be in terms of the patient’s own interests and reasonable wishes, expressed or implied. Proper treatment certainly includes the use of all natural means of preserving life (food, drink, etc.), good nursing care, appropriate measures to relieve physical and mental pain, and the opportunity of preparing for death. Since the professional standards of conscientious physicians vary somewhat regarding the use of further means, such as artificial life-sustainers, the doctor should feel free in conscience to use or not use these things, according to the circumstances of each case. In general, it may be said that he has no more obligation to use them unless they offer the hope of some real benefit to his patient without imposing a disproportionate inconvenience on others, or unless, by reason of special conditions, failure to use such means would reflect unfavorably on his profession.”

It is very distressing to me, and much more distressing to the anxious and grieving relatives, to stand beside a patient who has incurable cancer or irreparable damage to the brain, and observe a tube in the bladder, a tube in the stomach and a tube in the trachea, while oxygen is being piped in and antibiotic agents are constantly being injected. Indeed, sometimes even a thoracotomy wound is visible, through which cardiac massage for an arrested heart has been carried out.

I believe the patient and his responsible relatives, after they have been informed of the facts, are the ones to decide beforehand that such heroic measures should not be instituted. The physician, who knows that these measures are of no avail in respect to the future turn of events, should not have to await the request of the responsible relatives to desist from them.

Many years ago, when I was very young and not very experienced, I was tireless, night and day, in administering therapy to a patient who obviously could live only a few days because he had an incurable disease. The Roman Catholic priest, who was also watching the patient with me and who had