
Ethics and Morals in Neurotraumatology

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Perhaps you are wondering why a paper on ethics and morals has been put at the beginning of our congress.

The reason is that all we do as doctors must be put into a framework of commonly accepted ethical rules, or rather: it ought to be put into this framework. Ethical matters have always been a major concern of doctors in their relations with their patients. However, it has to be taken into consideration that this is not only a problem which concerns doctors, but that nurses and relatives are also involved, as well as the interests of lawyers, priests, philosophers, journalists and radio and TV reporters. Please allow me a comparison - and since we meet here on an island in the sea it will be a comparison from navigation: If we compare the hospital to a ship and the patients, doctors and nurses to the ship's passengers, then ethics could be considered the compass which allows the ship to steer its correct course. A compass, however, is directed by a magnetic field (if it is not a modern gyroscope!), and so ethics could be seen as this magnetic field which directs and guides the ship, that is, the behavior of the doctors.

Of course, it would be easier to simply refer to the Hippocratic oath from five hundred years before Christ, which still forms the basis of our actions. Nowadays, however, we must take into consideration the concept of the "autonomy of the patient" as demanded by Human Rights, a concept which was of no relevance at the time of Hippocrates.

Moreover, the cost-effectiveness of life-support medicine must also be taken into consideration, particularly in times when resources have become limited. Some of these problems have been dealt with in the proclamations of Helsinki (1964), Tokyo (1965) and Venice (1983).

The progress made within the last decades has also brought new problems which are also relevant for neurotraumatology, and this means that we have to look for new bearings. To stay within our metaphor, we have to look for a correct course for our ship. This refers in particular to intensive care units. Despite all the regional regulations it should be possible to avoid the situation where, within the EU, the fate of a patient with severe brain injury will depend not only on the hospital in which he is treated but also on the country where the accident occurs.

Ethics is the science of ethical behavior and the sum of ethical principles. It is concerned either with immanent principles or with the results of human actions (the ethics of principles, the ethics of results). Plato, Aristotle, Saint Thomas Aquinas and, in modern times, Immanuel Kant have all dealt with ethics.

Medical ethics differs from general ethics in that it concentrates on problems in the fields of health and health care. However, if we discuss medical ethics we must not do so in isolation. Medical ethics is part and parcel of our society and is influenced to a high degree by the general situation and it is this fact in particular which causes great difficulties for a general consensus.

In neurotraumatology two areas are of particular relevance: Reanimation and Persistent Vegetative State (PVS) and in the latter case, particularly the question of the reduction or interruption of treatment. Excluded from our considerations are the question of brain death and the legal and medical problems of death by request, collaboration in suicide, the various forms of the so-called "aid in dying", interruption of pregnancy, etc.

As far as diagnosis of brain death is concerned, we would like to say only that the criteria for this have been accepted all over Europe. In most countries legal regulations exist, and in Salzburg we set up a charter of transplantation twenty-five years ago which was much stricter than the federal law which ensued later. Since the diagnosis of cerebral death is of great importance in neurotraumatology we would like to stress that we most energetically oppose any attempt to modify these criteria. This would not achieve the result of shortening the treatment but could result in general opposition from society.

The criteria for treatment or for continuing treatment in the case of PVS depends no doubt on the sociocultural context, so that even in the EU marked differences exist. This results in on the one hand, a feeling of uncertainty which we are all familiar with and, on the other hand, the necessity for an ethical correlation or reorientation of our course. How divergent the opinions concerning the treatment of apallic patients can be, is demonstrated by the national report "Doctors' Views on the Management of Patients in Persistent Vegetative State (PVS)" within the research project "The Moral and Legal Issues Surrounding the Treatment and Health Care of Patients in Persistent Vegetative State".

This area of debate was triggered by the case of Tony Bland, which is well-known to all of you. The verdict was given by all three instances and by the Lord Justices in London, although not unanimously, which once more demonstrates the inherent problems. As you all know, in this verdict it was stated that it was legal to stop all mea-

asures for prolonging life including artificial breathing, nutrition and infusion if prolonged treatment does not result in any further therapeutic, medical or other advantage for the patient. The cessation of therapy was "in the best interests" of Tony Bland. Obviously, this did not meet with unanimous approval and there, in fact, divergences from country to country. This was all the more surprising since we all belong to the same European culture and have the same roots in spite of our differences. German doctors rejected by a majority the cessation of artificial nutrition whilst British doctors, by a majority, accepted it as we will see later.

A central point for continuing treatment of PVS patients is the reliability of the prognosis. This has been a controversial issue in recent publications. It must be said very clearly that 'persistent' in PVS does not of necessity mean 'permanent'. Furthermore, one must bear in mind, as Andrews and colleagues discovered in 1996 - that 43 per cent of PVS patients had been *wrongly* diagnosed as being PVS, and that one half of all patients with posttraumatic PVS recovered within one year!

Moreover, from a total of 283 doctors, 45 per cent of the inexperienced doctors and 79 per cent of the experienced ones considered the diagnosis of a PVS to be exact after one year. In terms of prognosis, objective diagnostic findings are *de rigueur*.

Here, I would like to discuss a paper by Kampfl, published in The Lancet. Kampfl (and colleagues) describe - as prognostic clues - lesions of the Corpus Callosum (as verified in MRI), of the Corona Radiata, injuries of the dorsolateral brainstem. This has been severely criticized by our learned friend Keith Andrews, who has said that in spite of statistical significance there exists too much overlapping and that numerous patients have recovered from lesions which were considered as *infaust*. In his opinion, there is a danger of this fact being neglected by "health purchasers". We wholeheartedly agree with Andrews in saying that economical consider-

ations must play no role within medical diagnostics. On behalf of my young Austrian colleague Kampf I would like to stress, however, that he did not mean to say that the MRI-findings *alone* determined the prognosis: they were only one stone in the mosaic of a difficult diagnosis. However insecure the problems of diagnosis in this field are, there is a consensus among all doctors in terms of the importance of *time*: The longer a PVS lasts - for some years, say - the smaller are the chances of recovery.

The extent of the divergence of opinion in this area, even within in the EU, can be seen in the questions of limitation of therapy and cessation of therapy. In Germany and in Greece one finds the smallest amount of approval (21%) whereas France shows 78%, the UK 90% and Ireland as much as 100% approval. We must here, however, differentiate between the limitation of treatment and the stopping of artificial nutrition. Such stopping is rejected by 80% of German doctors whereas 73% of doctors in the UK and 70% of doctors in the Netherlands approve of it in principle.

The existent differences in the legal aspect stem from the fact that in some countries artificial nutrition is unanimously considered to be a medical therapy (UK) whilst in other countries (Germany) it is considered not as therapy but as a basic human provision.

As far as the decision about a limitation of therapy is concerned, there is overall approval that even a *progressive debility* does not justify this. There is a danger of sliding into that infamous concept of *a life not worth living*. But 76% of doctors approved of such a limitation if there is no prospect of recovery, which, as we all know, is related to the duration of the PVS. The age of the patient must also be taken into consideration.

As to the legal aspects, we would like to mention the following points: In all European countries there exist laws preventing *eigen-mächtige Heilbehandlung* (treatment without the patient's consent, §110 of the Austrian Law Codex). If a

patient is unconscious, however, such *informed consent* can not be obtained, so that in Austrian jurisdiction the doctor must act in the best interest of the patient. However, this interest can only be guessed at unless a patient's testament exists. But even interpreting such a testament can be very controversial. In Germany, for instance, it is not regarded very highly, whereas in the USA and in the UK it is considered essential. To arrive at a decision everywhere, relatives or "next of kin" are consulted but the general opinion is that a patient's life is "not disposable", that is to say, nobody else can decide about it. Moreover, the opinion of nurses is taken into consideration but it is deemed as *not decisive*. In a symposium held in Graz nurses unanimously and vehemently voted for sustained artificial nutrition and infusion.¹

With regard to the legal framework, we have already mentioned the notorious Tony Bland case in 1993 in London. Here in particular can be seen the enormous impact of the sociocultural context which varies so greatly from country to country. It is - for well-known reasons - strongly biased in Germany. In answer to the theoretical question of how German doctors would comment on the verdict of the English Law Lords, only 33% approved of it, 43% rejected it, 18% were undecided and 5% made no comment. In the UK, for the cessation of treatment (including artificial nutrition) a court sentence is *de rigueur* but in three years there have been only ten cases. In some countries the dilemma of whether the cessation of therapy can be seen as murder (§75) or manslaughter (§76) is solved by making a differentiation between "doing" and "default".

But this judicial hairsplitting does not exempt us as doctors from our responsibility. Removing the probe for artificial nutrition is no doubt "doing"

¹ Even in apallic patients. They pointed out in particular how inhumane and stressful it is to watch a patient's dying slowly. In Tony Bland's case it lasted four weeks!

and constitutes murder or manslaughter - legally speaking. A default of therapy is also illegal under Austrian law.

Returning to our question "Ethics and Morals in Neurotraumatology" we may say in conclusion: A patient in PVS is a living creature who has the same right to dignity and life as everyone else.

Here we come back to our initial metaphor: As the earth's magnetic field always directs the compass correctly – even if there are irregularities in this field - so medical ethics is supposed to guide us on a correct course even if there are irritations and irregularities "from different directions". We would be well advised to we stick to that Roman principle of two thousand years' standing: *Salus aegroti suprema lex* "A patient's health is the highest law". Let us hope very much that we always know what are the best interests of our patients.

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