readers letters:

What is 'a Christian practice'?

On behalf of The Mission Practice, referred to under its previous name by Richard Montgomery in his letter (Spring 1999), ***Paul Jakeman*** *replies:*

Having been a focus for Christian medical work for most of this century, we should perhaps have a pat answer, yet the present doctors in the practice are currently asking the same question! There are some things we are sure of: all the doctors and employed staff are practising Christians and we all believe that the Christian gospel has something to offer everyone who walks through our doors. We have a heavy workload among a deprived and needy population, and the partners would all cite our Christian motivation as the reason for being in the East End of London. We try to run the practice in as 'Christian' a way as possible, in terms of our clinical responsibilities to patients, students and PCG, and in our business probity in dealings with the Health Authority and commercial suppliers. We try to maintain the tradition of a five minute devotion (a 'thought for the day') immediately before morning surgery, to which any patients in the waiting room are invited, and we have recently established a role for a part-time chaplain, who is available for patients who wish to contact him, and who runs an Alpha course on our premises. We pray regularly together, and we hold ourselves accountable to a 'Council of Reference' made up of local church leaders.

Our vision is for a healing ministry in the name of Christ. The tension is what this means within a 'normal' NHS practice - we have to be professional in our dealings with our patients who have very different worldviews from our own. The six partners come from a spectrum of evangelical traditions, and we do not have uniform thresholds for raising spiritual matters within the consultation, any more than we have identical views on thorny ethical issues, though we do have a remarkable unity of purpose. We have recently been invited to take our exploration of Christian healing ministry further by supporting a non-NHS 'Whole Person Clinic'. This is seeking to minister to body, mind and spirit holistically and is currently under discussion.

We would welcome the opportunity to discuss these issues with others who wrestle with them, or equally with those who may be appalled at the comfort of our Christian ghetto - perhaps we should be spread around (as are many other Christian doctors in the East End and elsewhere) being salt and light individually in secular practices!

Transplants: are the donors really *really* dead?

David Hill's claims (Spring 1999) that brainstem death is prognostic and not diagnostic of death, and that this matters in transplant practice, have provoked some strong responses. Oxford consultant urologist and transplant surgeon ***David Cranston*** *writes:*

As a surgeon who continues to be actively involved in transplantation, I would like to take issue with some of David Hill's comments. He raises a number of important points which need further discussion.

All the transplant surgeons I know are acutely aware of the complex issues surrounding cadaveric organ donation and the care that is needed in dealing with the relatives, the staff and the wider public over these issues. It is one of the reasons why there is a clearly defined separation of the medical staff looking after the patient on the intensive care units from the transplant team. The staff in the ICU are responsible for doing all they can for the patient, and deciding when brainstem death has occurred. Two clinically independent doctors who have been registered for five years or more and have experience in intensive care normally carry out the diagnosis of brainstem death. (Two, not because of doubt, but for the reassurance of staff and the wider public.) One of the doctors is usually the consultant in charge of the patient and he should be experienced in intensive care and acute medicine.

At this point the transplant co-ordinator may have been contacted, but no other member of the transplant team is involved. The transplant surgeon has nothing to do with the diagnosis of brainstem death apart from checking the records before he operates to ensure the correct documentation is present. After the second set of tests has been done a death certificate can be issued. The transplant co-ordinator will speak with the relatives, openly and sensitively, about the possibility of organ donation. Many find a small measure of comfort in the prospect of helping other people in this way at this time of desperate sadness.

The transplant surgeon is now involved for the first time, and for the benefit of the recipient has an ethical responsibility to keep the organs in good condition during their removal. This may involve giving certain drugs to maintain blood pressure and a good urine output.

Finally, it is important to make it clear that the concept of brainstem death has not arisen because of the increased need for donors for transplantation. It has arisen because of the increasing medical technology with modern techniques of resuscitation that are now part and parcel of all ICUs. If transplantation were superseded tomorrow by better treatment of organ failure, patients who are brainstem dead would still occur wherever ICUs are established and ventilators would continue to be switched off. This is a code of practice that has evolved over the last 30 years from Harvard in 1968, Minnesota in 1971, and from the British Royal Colleges in 1976 and 1979.

Former consultant anaesthetist and ICU director ***John Searle*** *from Exeter also disagrees with David Hill:*

The discussion raises important issues about the definition of death and the ethics of removing organs for transplantation from brainstem dead individuals. If David Hill is right when he

says that the brainstem death tests are only prognostic and not diagnostic tests, his concerns about current practice are justified. The key question is: 'What is the relationship between death of the person and death of the brainstem?'

David Hill is correct when he points out that historically death has been diagnosed on the basis of there being no respiration and no heartbeat and no circulation. When the brainstem is irreversibly destroyed by disease or accident, respiration ceases, oxygenation fails and within a few minutes the heart stops beating and there is no circulation.

By the early 1970s doctors were able to interrupt this process by intubating a patient's trachea and ventilating the lungs with a machine. Thereby oxygenation was maintained, the heart continued to beat, and blood circulated, despite the patient being in the deepest coma. The question was 'Were such people dead or alive?' This situation is in no way comparable to patients who require mechanical ventilation of the lungs because respiration has ceased due to some cause which does not affect the brainstem or the level of consciousness, such as polio or demyelinating diseases.

Since, biologically, neither the lungs nor the higher centres of the brain can function without the brainstem it seems entirely reasonable to conclude that death of the brainstem is death of the person. Indeed, in my own unit it was always our practice to give the time of death as the time when brainstem death was diagnosed. What was then taken to the operating theatre for the removal of organs was a corpse, albeit with the processes of oxygenation being maintained artificially. The purpose of the brainstem death tests is not to determine whether or not the person is going to die but whether or not that person is dead.

Two ethical questions follow the diagnosis of brainstem death. First, can any medical intervention benefit that individual? Clearly the answer is 'no' which is why mechanical ventilation should be withdrawn. There is no benefit from ventilating a corpse. Secondly, can benefit be provided for anyone else? Clearly the answer to that is 'yes'. It is these answers to these questions which are the ethical foundation for the removal of organs for transplantation.

*Manchester pro-life commentator **Stuart Cunliffe** agreed with the article and believes something has to be done:*

The traditional criterion for death was irreversible cessation of respiration and heartbeat. Brain death criteria were introduced to provide prognosis of death if life support were withdrawn. Then the 1979 Memorandum of the Medical Royal Colleges[1] said brain death represents the stage at which a patient becomes truly dead. Doctors who said death would occur were now willing to say it had occurred already. 'Commonly,' the Memorandum said, 'death is not an event: it is a process, the various organs and systems supporting the continuance of life failing and eventually ceasing altogether to function, successively and at different times'.

We are Christians. We know that man is body, soul and spirit[2]. We believe that soul and spirit reside within the body and leave the body at death. Life and death are absolute opposites. A patient cannot be alive and dead at the same time; there must be a moment at which death occurs. But when? When brain damage prevents communication and makes unassisted breathing a problem, or when the body ceases to function and evident signs of life cease?

'Brain death,' says the Memorandum, 'represents the stage at which a patient becomes truly dead, because by then all functions of the brain have permanently and irreversibly ceased'. I would challenge the truth of that last statement, which has not been and cannot be demonstrated. Proponents of the idea that brainstem death equals death may put forward a medical argument for moving from heart to brain in diagnosing death. But where is the moral and spiritual justification for it? Let it be produced.

Brain death was intended as a prognosis of death, not a diagnosis. Is it not true that the only time brainstem death is used as a diagnosis of death is when a patient's organs are wanted for transplant? Is it not significant that after two decades of organ transplantation, 'death' has not replaced 'brain death' as the diagnosis? Permanent lack of awareness is not necessarily death, even if it could be proven. The possibility cannot be excluded that some donors retain some degree of awareness during the surgical removal of vital organs.

I do not believe that brain death is death. Moreover, it is unethical that knowledge of the fact that the patient will be breathing and his heart will be beating when his organs are removed is being kept from potential organ donors and from next of kin being asked their approval for excision of organs from donors.

Something needs to be done.

References

1. Conference of Medical Royal Colleges and their Faculties in the United Kingdom. Memorandum on the diagnosis of death. *British Medical Journal*, 1979; i: 332
2. 1 Thessalonians 5:23

The Editor welcomes original letters for consideration for publication. They should have both Christian and healthcare content, should not normally exceed 400 words, and if accepted may have to be edited for length.

Write to:
Triple Helix
157 Waterloo Road
London SE1 8XN
Fax: 0171-620 2453
e-mail: CMFUK@compuserve.com