

Transfer of patients requiring neurosurgery

Central register of neurosurgical beds would prevent delays

EDITOR,—Owen Dyer has reported the events surrounding the death of Malcolm Murray, who was transferred to Leeds with head injuries after considerable difficulty was encountered in locating a more local neurosurgical bed.^{1,2} We have prospectively audited our acute neurosurgical referrals from the Lister Hospital over the past nine months. In most cases we have been able to refer our patients to one of the two nearest centres. On several occasions, however, we have experienced similar difficulties to those described by Dyer. Indeed, on four occasions we have had to contact six neurosurgical centres to arrange transfer and subsequent assessment and care. This has resulted in considerable delay, which could have had an adverse effect on clinical outcome, and in the duplication of effort in the relay of complicated clinical information.

We would welcome a central register of the emergency neurosurgical beds that are available as this would facilitate the referral and, when necessary, the transfer of these critically ill patients.

F S HADDAD
Orthopaedic registrar
A R J MANKTELOW
Orthopaedic registrar

Lister Hospital NHS Trust,
Stevenage SG1 4AB

- 1 Dyer O. Bed register could be set up after patient's death. *BMJ* 1995;310:688-9. (18 March.)
2 Dyer O. Consultant attacks inquiries that criticised his care. *BMJ* 1995;310:891. (8 April.)

Burr holes are within the remit of every competent surgeon

EDITOR,—Mr Anthony Percy of Queen Mary's Hospital, Sidcup, is reported as complaining about the criticism levelled against him in respect of a patient with a severe head injury who, after numerous telephone calls and a delay of five hours, was sent by helicopter 300 km to Leeds because no intensive care bed could be found for him in the neighbouring hospitals; he subsequently died.¹ In my opinion Mr Percy should do some self examination and question why, during this considerable lapse of time, he did not take the patient to the theatre and make one or more burr holes with the aim of removing a blood clot and reducing the intracranial pressure. This would

almost certainly have halted the deterioration in the patient's condition and would have made his transfer elsewhere much safer if it was still thought necessary.

Such a procedure could well have been life saving and should not be beyond the competency of any fellow of the Royal College of Surgeons. In comparable circumstances a surgeon would not, for example, refuse to operate on a patient with a ruptured ectopic pregnancy or a strangulated hernia and intestinal obstruction.

CHARLES LANGMAID
Retired consultant neurosurgeon

Cardiff CF2 5NR

- 1 Dyer O. Consultant attacks inquiries that criticised his care. *BMJ* 1995;310:891. (8 April.)

Mr Percy's reply

EDITOR,—If Charles Langmaid is accusing me of refusing to operate on this patient he is doing me a severe injustice. Had burr holes been appropriate I would have taken the patient to the operating theatre and made them myself, even though I have not done this operation for some years. If the patient had had an extradural haematoma with worsening clinical signs then burr holes would have been appropriate, and I would not hesitate to take such a patient to theatre myself if I could find no one better able to do so. This patient, however, had a severe cerebral contusion with oedema and a diffuse subdural clot: making a few burr holes would probably have resulted in his condition worsening.

I have discussed this case with many neurosurgical colleagues and am advised that the patient required a formal craniotomy, which it would not have been appropriate for me, as an orthopaedic surgeon, to carry out—any more than it would have been right for me to operate on a patient with a ruptured ectopic pregnancy, a strangulated hernia, or intestinal obstruction. I would be prepared to operate on any of these emergencies in a life threatening situation in the middle of the bush somewhere, but this was southeast London. This patient required a neurosurgical unit with a bed in an intensive care unit. No such beds were available in London or the immediate surrounding area. This is the issue that needs to be addressed.

A J L PERCY
Consultant orthopaedic surgeon

Department of Trauma and Orthopaedics,
Queen Mary's Hospital,
Sidcup, Kent DA14 6LT

Elective ventilation of potential organ donors

Elective ventilation and diagnosis of death are mutually exclusive

EDITOR,—I am surprised that Hany Riad and Anthony Nicholls wish to debate elective ventilation of potential organ donors further despite recent confirmation of its illegality.¹ Adoption of any medical process requires careful scientific investigation and evidence. The published evidence in support of elective ventilation is based on a tiny study in Exeter of nine patients admitted to intensive care.² Four of these patients were

admitted in breach of the agreed protocol, and in one case brain stem death did not ensue in the intensive care unit and the patient was transferred back to the wards after five days. On a national level this degree of error in diagnosis would create enormous distress.

More concerning is the "soft sell" with regard to the extraordinarily difficult areas of timing of ventilation and time of death. In the original study in Exeter six of the eight donors were ventilated before admission to the intensive care unit. Ventilation is now proposed at the time that apnoea occurs in the intensive care unit "so that artificial ventilation can start when natural breathing ceases."³ Those regularly involved with this stage of patients' care will know that regular respiration in a dying patient seldom transforms rapidly and smoothly to recognisable apnoea. The "last gasp" of an irregular breathing pattern is often confirmed only when bradycardia and asystole occur, and to intervene earlier may relieve hypoxaemia, reduce intracranial pressure, and restore respiratory function. As a result a patient may face the persistent vegetative state instead of death. It is arrogant of Riad and Nicholls to be certain that the onset of apnoea is the time of death. Death can be defined only by properly supervised brain stem testing or by the traditional clinical definition of absence of cardiovascular, respiratory, and neurological function. Until these conditions are satisfied a patient is technically, legally, and morally alive, and the Exeter team's attempt to redefine this is unacceptable. In addition, any possibility of producing the persistent vegetative state is unequivocally unethical.

Persistence in advocating the adoption of elective ventilation despite considerable opposition from those working in intensive care risks jeopardising the excellent relations that have been established between the specialties of transplantation and intensive care. In addition, open debate about differences between the timing and diagnosis of death or the possibility of the persistent vegetative state may be counterproductive to the public's confidence in transplantation.

PETER G M WALLACE
Director

Intensive Therapy Unit, Western Infirmary,
Glasgow G11 6NT

- 1 Riad H, Nicholls A, Neuberger J, Williams SM, Sells RA, Jones MA, *et al*. Elective ventilation of potential organ donors. *BMJ* 1995;310:714-8. (18 March.)
2 Feest TG, Riad HN, Collins CH, Golby MGS, Nicholls AJ, Hamad SN. Protocol for increasing organ donation after cerebrovascular deaths in a district general hospital. *Lancet* 1990;335:1133-5.

Intensive care units have good reasons not to do it

EDITOR,—While we can understand the frustration felt by those caring for patients with end organ failure, it is important that the supporters of interventional ventilation question why this procedure has not been adopted widely by intensive care units.¹ The reasons go beyond legal issues and inadequate intensive care resources and certainly beyond any emotional feeling against organ donation. Indeed, many intensive care units that are committed to organ donation and enjoy an excellent relationship with transplant centres still have reservations with the practice. Experience with the protocol is limited, and its potential for producing

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