

Letters to the Editor

The toxic effect of language on medicine

Editor—In the main I agree with Michael O'Donnell's criticism of the style of language used in the medical literature, (November/December 1995, pages 525–9). However, he suggests that the writer of the sentence 'This [an intervention] results in a reduction in the proportion of the population that will drive cars' . . . abandons simplicity and directness of expression because . . . he wants to sound more 'scientific'. He goes on to suggest that 'This means fewer people will drive cars' would be better. Easier to read perhaps, but not necessarily correct. If the intervention was occurring at the same time as an increase in the population, a reduction in proportion could also result in an *increase* in the number of people driving cars. Here lies the problem. Simplicity is often sacrificed for the sake of precision. Is there an easy solution?

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Brain stem death

Editor—It is good to read [1] that the Working Group reviewing criteria for the diagnosis of 'brain stem death' wish to avoid confusion of this term with 'brain death' in future. It is no longer claimed that, by the time this state is diagnosed, 'all functions of the brain have permanently and irreversibly ceased' although this was the basis upon which Conference of Colleges concluded in 1979 that 'the identification of "brain death" means that the patient is dead' [2].

It is now suggested that 'ir-

reversible loss of the capacity for consciousness, combined with irreversible loss of the capacity to breathe' should be regarded as the definition of death. This definition is unlikely to gain universal acceptance. Apart from philosophical objections [3, 4] and the lack of convincing theory of consciousness [5], there is the difficulty that permanent loss of the capacity for consciousness is essentially untestable and can only be inferred from destruction of all possibly relevant parts of the brain. Hence the preference for a 'whole brain' concept in the USA and other countries.

The tests used in the UK to diagnose 'brain stem death' do not suffice for a factual diagnosis of death of the whole of the brain stem [6]. In particular, whereas Mollaret and Goulon [7] required evidence of peripheral circulatory failure amongst their criteria, patients currently pronounced 'dead' on the UK 'brain stem death' criteria retain vasoregulatory control which is likely to be brain stem mediated [8–9].

Let us be clear about what 'brain stem death' really is. It is a clinical syndrome, defined by simple bedside tests, to which it appears that a short-term fatal prognosis invariably attaches—though it should be noted that the criteria as now used have never been prospectively tested and that proof of infallibility is inherently impossible [10]. That said, its diagnosis marks a late stage in the dying process. But, as Sir Sydney Smith said more than a century ago [11]: 'Death must be distinguished from dying, with which it is often confused'.

References

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- 7 Mollaret P, Goulon M. Le coma dépassé. *Revue Neurologique* 1959; 101:3–15.
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- 10 Shewman DA. The probability of inevitability: the inherent impossibility of validating criteria for brain death or 'irreversibility' through clinical studies. *Statistics in Medicine* 1987;6:535–53.
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Brain stem death—In response

Editor—Like Dr Evans, I welcome the working group's decision to drop the term 'brain death' and use the term 'brain stem death' when referring to death diagnosed on neurological grounds. The report represents more than a terminological readjustment; it epitomises a recognition of the fact that criteria of death must be logically derived from explicitly formulated philosophical premises.

It has been argued for over a decade that brain stem death was both the 'physiological core of brain death' and 'the substratum of the cardinal signs (coma, apnoea and absent brain stem reflexes) elicited at the bedside' [1]. The term 'brain stem death' is also perhaps more honest than the term 'brain death' in that it reflects the limits of what is known (or