

Brain death — there can be no doubt!

Richard P Lee

In this issue of the Journal, Guignard and colleagues present a report describing a short, simple survey they carried out to assess the practice of brain death certification in intensive care units in Australia and New Zealand.¹ They asked ICU directors whether brain death certification was performed on the basis of clinical testing alone, or whether their units conducted imaging investigations (in addition to or without clinical testing) to prove absence of cerebral perfusion.

Why ask these questions when there are such robust and respected guidelines² for clinicians to follow in Australia and New Zealand? There are several reasons.

First, just because there are robust guidelines, this does not mean that everyone adheres to them. If the question is not asked, how will we know? There is ample evidence in the literature that in different clinical settings, practice may vary widely within a country, and strong evidence-based guidelines do not always lead to consistent practice.

Second, conducting a survey such as this can put our minds at rest. Intensive care physicians work in a high-pressure environment, sometimes with competing interests. We can see the value of organ donation as a concept, we are great patient advocates, and we want to be absolutely sure we are doing the right thing when we diagnose brain death. It taints our practice if there is any doubt about our diagnosis. Recent journal articles and press reports, which raise concerns about the surety of the diagnosis of brain death, are a direct challenge to the perception of our impartiality in the matter of brain death and organ donation.³⁻⁷ We are often in the position of looking after the interests of a potential organ donor as well as a recipient, so our behaviour and diagnoses must be beyond reproach. It should never be said that a suspect diagnosis was made to facilitate organ procurement.

Thirdly, as organ donation after cardiac death is now common practice, we have to be careful that no confusion arises in the public's mind about the meaning of brain death. Imprecise use of the term in the lay press and the unpredictability of the outcome of severe brain injury occasionally lead to reports of "brain dead", head-injured patients giving interviews about how doctors "wanted to turn off my life support and look at me now". We can't avoid the confusion entirely, but we must follow the guidelines exactly, use precise language when discussing brain death, and educate our colleagues and lay people whenever the opportunity arises.

Disappointingly for this survey, the response rate was very poor. Disappointing because not only was the time involved minimal for five demographic and two clinical questions, but the questions revolved around an issue, as previously stated, that is very important to clinical practice in the ICU. One must

then ask: Was the target group suffering from survey fatigue, or were the questions not easily answered or not appropriate? Perhaps the answer is in the latter reasons. The questions were limited and the options provided may not have reflected current practice. Perhaps one, or more than two, clinical tests are being used.

Thus, of the 88 ICU directors contacted, only 47 (53%) responded. They indicated that the vast majority of brain death certification in their ICUs was done on the basis of two clinical tests alone, with a minority of units using supplemental imaging investigations. Looked at from another angle, only 42 of 88 ICU directors contacted (48%) reported that two tests were performed routinely in their ICUs, despite the Australian and New Zealand Intensive Care Society guidelines clearly indicating that two clinical tests are the method of choice if the preconditions are met.²

We should not be afraid to question our practice or ask what our colleagues are doing. Guignard et al have attempted to do this in their article. The outcome leaves questions unanswered. Perhaps the survey should have been better phrased and more options for answers provided, but it is important to take the opportunity to raise awareness and challenge our preconceptions.

We have good guidelines to follow in the diagnosis of brain death and they should be followed carefully so there can be no doubt!

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