From an old fogey to a young fogey

Peter Harvey
Emeritus and Honorary Consultant Neurologist, Royal Free Hospital
Practical Neurology, 3, 124–5

I read Richard Davenport’s ‘Neurological letter from Scotland’ (Practical Neurology, 2002, 2, 370–371) with growing interest and a certain sense of smug satisfaction. If in the next few months he feels certain prickles of irritation between his shoulder blades at 3am it will be because young SPRs across the land are plunging kitchen knives and other implements into the backs of Davenport R. After a complete break from the National Health Service I have recently returned to teach and attend meetings. My return confirmed to me that there was indeed a basis for an increasing fear that I had been trying to deny, on the grounds of ‘old fogeyism’, that over the last few years I had been seeing an increasing number of claims alleging clinical negligence against young neurologists. Their causes are various but they all stem from lack of the clinical experience that can only come from exposure at the coalface. The younger generation don’t see the wood for the trees, they are dismissive of psychiatric symptoms as of no relevance to their particular expertise, and are too ready to take the escape route of the destinies of surgery, obstetrics and other specialties. This is, of course, the fault of the training system. This meant long hours with often terrible conditions in ‘diagnosis by regurgitation of lists’, sometimes with a blindfold and a pin, sometimes with an attempt at prioritization.

These are all skills learned by exposure to patients, through old-fashioned apprenticeship. They are not learned from lectures, from slides, from videos, interactive CDs, PowerPoint presentations, subliminal messages while asleep, or reading endless lists of differential diagnoses. Our neurology trainees are, to a person, extremely bright, interested, have a sense of humour and are (mostly) highly articulate (all prerequisites for a good clinician) but I sense an over-dependence on ‘learning by lists’ and, for their stage of training, inexperienced clinical skills.

The best job I ever did, before entering neurology, was working for two cardiac surgeons in London. I shared a rota with a variety of bright-eyed and bushy-tailed surgical trainees from all over the world who had come to learn at the fingertips of the two masters. As a mere physician I was expendable, so I did a one in two on call, and they did a one in however many there were of them at any one time. For over a year I was on a vertical learning curve – hearts, lungs, kidneys, livers, electrolytes, and even, let it be said, the nervous system, all in various states of disorder, failure and decay, all to bedeal with – the capacity of surgeons to create clinical material for physicians to teach on has never ceased to amaze me.

I would arrive at 8.30 am on the intensive care unit (ITU), take over the postoperative care of yesterday’s successes and failures, and then hop between the wards, where I would clerk in the day’s admissions and minister to the com-
A teenager who wanted to die

Erik K. St Louis
UI College of Medicine and Iowa Comprehensive Epilepsy Program, UI Hospitals and Clinics, Iowa City, USA
*Practical Neurology, 2003, 3, 125–126*

I was dismayed to read the account of active euthanasia carried out by the eminent neurologist Professor van Gijn in a recent issue of *Practical Neurology* (2002, 2, 362–363). At a glance, his actions seem reasonable enough. R had a terminal dominant hemisphere glioblastoma, failed previous surgery and radiotherapy, and refused adjuvant chemotherapy given his inability to realize his life’s aspirations and the knowledge that he had to live out his remaining days suffering with severe aphasia and I would press the button. Thus I would resuscitate the patient.

The next morning, bleary but triumphant, roughly shaved at the nurses’ sink, refreshed by a cooked-to-order Great British Breakfast, I would repeat yesterday, except my enthusiasm for the ITU patients was all the greater for having resuscitated them the night before, until at 5 pm I would return to the residency, a posh house in a dilapidated state, would fill an enormous glass with blocks of ice, fill it to the top with Teacher’s whisky and sink into a bath nearly filled to the brim with barely bearable hot water. Here I would luxuriate, sipping whisky, and reading 2 days of newspapers, and would wake up in a bath of cold papier maché. I had an old sieve that, turned upside-down over the plug-hole, allowed the water to drain, and having cleared the sodden Times and Evening Standards out, dressed and refreshed, my girlfriend (as they were called in those days – ‘partners’ were either in Law Firms or on the dance floor) and I would go to one of the many Good Food Guide restaurants that lay dotted around the environs. The sleep that night was the sleep of the dead.

Hard work, yes, but exposure to clinical material the like of which was unique, and quite irreplaceable. So what is the answer? I think Richard Davenport is absolutely right, but his sleep is going be very disturbed for the next few years.
and immobility. Professor van Gijn gave R the lethal injection the very next day, after their initial meeting.

While respect for autonomy is a valid and honourable principle at the core of modern medical practice, several deficits in moral logic occurred prior to the rash and overly expeditious decision to terminate this young man's life. Before honouring a patient's expressed autonomous wish, the principle of respecting autonomy requires that the individual possesses clear decision-making capacity, has actively participated in a non-coercive discussion that enabled understanding to choose among viable alternatives, and a lack of any confounding influences.

R was 16 years old, probably old enough to be considered adult and autonomous without confounding influences, but already requiring extreme ethical caution. But there are substantial doubts as to whether adequate counselling regarding therapeutic alternatives in palliative care was provided. While this patient and his family may have presented with a clear agenda in an extremely tense scenario fraught with drama, appropriate palliative care was suboptimal, including, most glaringly, effectively recognizing and removing the influence of acute depression. Failing to fully acknowledge the confounding influence of R's aphasia in voicing his wishes was another ethical foul (the patient's family had to provide the 'correct interpretation' of R's requests so how could van Gijn have known what those wishes may have been, in the absence of an advanced directive?).

If any exists, the most ethically honourable scenario for considering physician-assisted suicide (or active euthanasia for that matter) is within the confines of a longitudinal physician-patient relationship, to enable the construction of mutual trust and understanding and the creation of an unambiguous, unfettered statement of rational wishes for future end-of-life care. Fundamentally, this approach enables assembly of thorough medical knowledge about the accuracy of the diagnosis and prognosis. Critically, it also allows the best opportunity of excluding the potential confounding influence of an evolving treatable depression.

Professor van Gijn's case presentation is valuable in underscoring the importance for neurologists and primary care physicians alike to initiate discussion for completion of advance directives during initial visits. Admittedly, in our busy clinics and wards, this imperative may not even be on our pragmatic radar screens, but failure to encourage our patients and their families early-on toward consideration and recording of their wishes in these vital matters may lead to avoidable terminal angst and confusion.

RESPONSE

J. van Gijn
University Department of Neurology, Utrecht, the Netherlands; J.vanGijn@neuro.azu.nl

I agree with Dr St Louis that my actions leave room for discussion; that was one of my reasons for writing this account. For the sake of brevity many events were implied rather than fully recorded. The physician who had a long-standing relationship with the patient was involved in the decision-making and the psychiatrist made an extensive assessment. Unanimity of all parties involved is an essential condition if a patient requests irreversible action to end suffering.