Letter by Woodworth and Simard Regarding Article, “Outcome Following Decompressive Hemicraniectomy for Malignant Cerebral Infarction: Ethical Considerations”

To the Editor:

We read with interest the excellent article by Honeybul et al1 wherein important ethical issues are raised about decompressive craniectomy.

Heroic, potentially risky surgical interventions are increasingly being used for patients with terminal or life-altering conditions, such as hemispheric stroke and recurrent glioblastoma. Increasing numbers of patients and their families are forced to confront the idea of surgery near end-of-life, typically with little preparation. This compels surgeons to act as intermediary advisors—helping to choose between a major intervention aimed at a hoped for recovery, versus letting go and allowing nature to take its course. In such cases, medical decision-making is affected critically by numerous factors, including rapid advances in new technologies, malpractice concerns, and differences in culture and personality.

Medical advances are occurring at a blistering pace, not least of all in neurosurgery. Improvements in the management of heretofore fatal conditions, combined with anecdotes of seemingly miraculous recoveries in patients who refused to give up, provide much needed hope for families struggling with severe injury and disease. Many surgeons can cite examples wherein a young child or an older person thought to be near death recovered, whether through hope, prayer, extraordinary effort, or a new exciting treatment. Although these are powerful, emotional experiences that can positively affect medical decision-making, it is important that we thoughtfully communicate not only the potential of medical technology but also its limitations, especially in the context of severe disease and aging.

Unfortunately, medical malpractice avoidance is woven into nearly every aspect of medical decision-making, at least in the United States. It is estimated that one third of malpractice suits against surgeons are related to a decision not to offer a surgical procedure. This can set up a strong pressure to recommend surgery when time or circumstances do not allow a complete discussion with the patient and family.

People from diverse cultures and backgrounds have widely varying views and expectations about the role and the limits of medical care. This can create complex issues and unfavorable interpersonal dynamics during moments of extreme emotional stress. Often, the time required to engage in discussions that thoroughly cover issues surrounding a patient’s life-threatening condition may not be available. Informed consent, which is intended to comprehensively review the risks and benefits of a given medical intervention, typically does not address issues of cultural, religious, or expectations.

In their article, Honeybul et al1 touch on ethical considerations that may come to bear when the patient is young, or when the patient has already expressed a definite view that they would not want to survive with severe disability. These are situations in which decisions about potentially life-saving surgery are easy—we agree with the authors on the advice they would give such patients and their families. Unfortunately, many cases are not so easy, such as those involving patients, no longer young, who have not formally expressed definite views on survival. What should guide us in these cases? What guides neurosurgeons, such as Mr Honeybul and colleagues?

A thoughtful dialogue with patients and their loved ones has become increasingly important as our ability to successfully intervene in critical life-threatening conditions evolves. As we move forward and weigh each of the aforementioned issues, surgeons are challenged to strike a balance between acknowledging human dignity and mortality on the one hand and maintaining hope and an innovative spirit on the other. Some of the greatest discoveries have occurred when, in the face of apparently insurmountable adversity, people refused to succumb and instead found unexpected solutions. As surgeons, we must be unyielding in our efforts to provide life and well-being for our patients, even as they move toward what we know may be the inevitable outcome. As surgeons, we look forward to the day when life-saving interventions for conditions, such as hemispheric stroke and recurrent glioblastoma, will no longer have to be surgical.

Disclosures

None.

Graeme Woodworth, MD
J. Marc Simard, MD, PhD
Department of Neurosurgery
University of Maryland School of Medicine
Baltimore, MD

Letter by Woodworth and Simard Regarding Article, "Outcome Following Decompressive Hemicraniectomy for Malignant Cerebral Infarction: Ethical Considerations"
Graeme Woodworth and J. Marc Simard

Stroke. 2015;46:e245; originally published online October 6, 2015;
doi: 10.1161/STROKEAHA.115.011336

The online version of this article, along with updated information and services, is located on the World Wide Web at:
http://stroke.ahajournals.org/content/46/11/e245

Permissions: Requests for permissions to reproduce figures, tables, or portions of articles originally published in Stroke can be obtained via RightsLink, a service of the Copyright Clearance Center, not the Editorial Office. Once the online version of the published article for which permission is being requested is located, click Request Permissions in the middle column of the Web page under Services. Further information about this process is available in the Permissions and Rights Question and Answer document.

Reprints: Information about reprints can be found online at:
http://www.lww.com/reprints

Subscriptions: Information about subscribing to Stroke is online at: http://stroke.ahajournals.org//subscriptions/