27 Paulsen EP, Courtney JW, Duckworth WC. Insulin resistance caused by massive degradation of subcutaneous insulin. *Diabetes* 1979;28:640-5.
28 Tattersall R, Walford S. Brittle diabetes, a spectrum of illness in response to life stress: the place of "cheating and manipulation." In: Pickup J, ed. *Brittle diabetes*. Oxford: Blackwell, 1985: 76-102.

# Ethics and politics

The dividing line between ethical and political analysis has long been blurred: sometimes the two merge, sometimes they are in conflict. Socrates encouraged the young men of Athens to think critically about ethical issues. Later it was found "politically expedient" to put him to death for his troubles. Today politicians prefer to put moral philosophers to death by trying to ignore them.

The Warnock committee spent years deliberating over the moral problems of new methods of reproduction only for Enoch Powell to disregard its report and use parliament to promote his personal repugnance of those methods. No major political party has established policies on abortion, euthanasia, the care of handicapped neonates, or any other major medicomoral issue, preferring instead to leave these matters to the individual consciences of members of parliament; regrettably individual conscience may in some cases be tantamount to individual ignorance. The government has not been restrained from imposing a limited drug list by any consideration of the way in which such a list interferes with a doctor's moral duty to provide the best possible service to each individual patient.

Occasionally the conflict is more blatant. In Athens last January there was a research workshop on ethical problems in preventive medicine sponsored jointly by the North Atlantic Treaty Organisation and the European Economic Community. After the meeting contributors met to discuss publication of the proceedings and were told, by the representative from the European Economic Community, that there could be no mention of alcohol as a problem because the community had several wine producing member states.

How can politicians be encouraged to take a more informed interest in the ethical problems of medical practice? The simple answer is to provide them with accurate information. As each new problem develops members of parliament tend to be deluged in mail from whichever lobby believes that its interests are being challenged. The BMA can help to counter partisan views, but the influence of its central ethical committee is, perhaps, less than it might be because the committee's members are judged to be primarily medicopoliticians—responsible to an elected council and representative body—rather than experts in medical ethics.

One organisation that is trying to provide accurate information on medicomoral problems for politicians and the general public as well as doctors is the Institute of Medical Ethics. The institute has expanded the work of the Society for the Study of Medical Ethics and its associated medical groups in the university teaching hospitals (begun in 1963), and membership is now open to the public as well as to those professionally interested. Members receive a monthly bulletin giving information on a wide range of topics in medical ethics and recording relevant official statements. The institute also runs courses for medical and nursing teachers and organises working parties to examine particular problems in medical ethics. The next report—the ethics of clinical research on children—will appear in the autumn.

Whether the Institute of Medical Ethics can satisfy the increasing demand for public discussion and participation in decision making will largely be determined by the amount of financial support that it can attract. Professor Ian Kennedy and Dr John Dawson, head of the BMA division responsible for medical ethics, have both suggested that there should be a British equivalent of the United States President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research to advise the government. Such a commission cannot be independent, however, so long as it depends on the government for funds: this was well illustrated by the President's Commission itself, which ceased to exist in March 1983 when United States government funds were withdrawn.

The Institute of Medical Ethics and its predecessors have never depended on one main source of funds and have thus maintained their reputation for independence and neutrality. The institute does not promote any one sectarian approach to particular problems but tries to provide information about differing views so that people are encouraged to make up their own minds. With adequate support it could make a major contribution to the education of politicians, and the public, and thus help to clarify the dividing line between ethics and politics in medicine.

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# Services for people with head injury

Eight patients with head injuries were found to have been in acute wards of a London teaching hospital for up to two and a half years. Six of them were said to have potential for rehabilitation but apparently had nowhere else to go. They were among 101 patients with disabilities discovered in a survey of 660 "acute" beds reported by C J Goodwill to a recent meeting of the Society for Research in Rehabilitation. Even those who do have intensive rehabilitation, however, may not do well.[1] In A D Tyerman's follow up study—eight months after discharge and on average 20 months after injury—29 of 57 people with head injuries were staying at home and inactive. Since discharge they had tended to become more distressed and their expectations had fallen. Indeed, for many such people the realisation that they will never recover their old selves and their old functions comes at a time when no help is at hand—a finding that underlines the need both for very long term sources of help and for an emphasis on helping patients with head injuries to an acceptance of their new self at an earlier stage by counselling and psychological approaches.

That the prospects are not all bleak, however, became apparent at the Medical Disability Society's symposium on better services for head injury that preceded the other meeting. C D Evans reported that no one in his series who had been unconscious for over three weeks had worked again, and all those who had been in a coma for more than three months were institutionalised; but, by contrast, all those who had been in a coma for no more than 10 days did have work when followed up five years after their injury; in all, 53 of the 96 who had been unconscious for more than an

hour (and usually much more) were working. Expecting too little of these people, he said, could be self fulfilling; concentrated efforts were needed, perhaps over years rather than months, with patients in the precarious intermediate category. Another speaker observed that the model of a smooth recovery curve followed by a plateau might be stultifying: the reality was often more like steps of improvement corresponding to the interest of therapists and others, separated perhaps by periods marked by family or other problems. R Talbot, of Headway (200 Mansfield Road, Nottingham NG1 3HX), the National Head Injuries Association, which does important long term work for sufferers and families, spoke of a man who 21 years after his accident was doing things that he had not been able to do five years earlier.

The generally poor services for patients with head injury in Britain are often contrasted with the excellent spinal injury services—where small numbers allow concentration in a few centres of excellence. The far more complex problems of head injury certainly demand specialist management, and P C Eames proposed a model for coherent networks of services with fewer "holes" for people to fall through with their unmet needs. He defined the objectives as enhancing quality of life and wellbeing, quality of treatment, and opportunity for research on the effectiveness of the service and of treatment methods (as urged by a Medical Research Council coordinating group[2]) and also increasing efficiency, especially the very long term cost effectiveness.

Essentially such a model service would depend not on a complete range of extra resources but on a reshuffling of present piecemeal services in a group of districts. This would help provide specialist wards and follow up clinics plus units for intensive and if necessary lengthy rehabilitation. At present patients with head injuries are usually admitted to several different wards of a given hospital and are seen by different follow up clinics. Concentrating services into centres having many patients with different types of head injury problems builds up skills of staff, facilitates research, and eases the management of those with difficult behaviour —advantages that have been reported from the regional head injury service at the Edinburgh Royal Infirmary.[3] It also saves those making slow progress from the depressing contrast in a mixed ward of rapid recoveries on the one hand and from the spectacle of neurological conditions on a downward course on the other.

Dr Eames urged that after the acute phase a setting should be found right away from hospital—away from the "ostensibly legitimate helplessness" associated with being a patient. Staff needed to believe in the possibility of improvement and be prepared to overlap roles in their handling of the many problems posed by the activities of daily living and by physical disability; by blunting of cognitive, communication, and social skills; and by emotional, behavioural, and sexual difficulties—rehabilitation for the real world, for the abrasions of life and the unexpected. For those few profoundly damaged people with intractable behavioural problems a centre like the Kemsley Unit at St Andrew's Hospital, Northampton,[4,5] Dr Eames suggested, should be adequate for two or more regions.

Much is uncertain and controversial. Though there may be advantages in treating as a separate group people with head injuries—who may be difficult and unpleasant besides needing specialist attention—some speakers were dubious about creating "ghettos" of the head injured (except perhaps for serious behaviour disorder). There were doubts about separating them from other disabled people with similar problems. Similar questions are raised about long term accommodation, day centres, and the retraining and sheltered workshops that are badly needed. Furthermore, few reliable data are available on disability rates after head injury—many figures were bandied about at the meeting. And, most fundamentally, we need to know more about the scope and the time scales for recovery and, more generally, improvement of life, with and without intervention, in patients with severe and milder injuries. For cognitive deficits, which are among the most devastating and frequent results of serious head injury,[6,7] these are especially important and difficult questions.[8] Cognitive remediation, said E Miller at the meeting, aims at helping a person to function despite his deficits by using what he has left to the best effect; but as yet we have only a set of ideas with little real proof of effectiveness—though in the long term approaches of proved worth may become established.[9] Probably a cognitive rehabilitation service needs to be provided more widely than places in intensive rehabilitation units.

There is no one to bring all the elements together and keep them together, said R Langton Hewer in his summing up: most victims of head injury are passed from one service to another and then dropped. He wanted principles of management to be defined for health authorities, with every health district producing written policies on the early and the rehabilitation phases, and named consultants to organise recovery services. Proper follow up should be arranged, with registers. Psychiatrists should be brought in when appropriate, especially when behaviour was a problem; and psychologists should give counselling and provide long term continuity. Audit should be built into the system. A multidisciplinary panel, he proposed, should consider the problems and put together evidence on recovery and intervention—essential for getting more money for services for those with head injuries. One useful result of the meeting is that guidelines on the management of patients with head injuries and on services are to be drawn up and debated by the Medical Disability Society (chairman Dr George Cochrane, Mary Marlborough Lodge, Nuffield Orthopaedic Centre, Oxford OX3 7LD).

Finally, how much disability is preventable by optimum early management? Patients admitted to the Birmingham Accident Hospital, said P S London, usually either die or survive without serious long term disability due to brain injury, the severe disabilities being mainly in those transferred from other hospitals. Raising standards of early care in hospitals, especially out of hours by junior staff, might, he said, prevent cases of cerebral hypoxia and other causes of secondary brain damage after injury.

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1 Oddy M, Coughlan T, Tyerman A, Jenkins D. Social adjustment after closed head injury: a further follow-up seven years after injury. *J Neurol Neurosurg Psychiatry* 1985;48:564-8.
2 MRC Coordinating Group. Research aspects of rehabilitation after acute brain damage in adults. *Lancet* 1982;ii:1034-6.
3 Miller JD, Jones PA. The work of a regional head injury service. *Lancet* 1985;i:1141-4.
4 Eames P, Wood R. Rehabilitation after severe brain injury: a special unit approach to behaviour disorders. *Int Rehabil Med* (in press).
5 Eames P, Wood R. Rehabilitation after severe brain injury: a follow-up study of a behaviour modification approach. *J Neurol Neurosurg Psychiatry* 1985;48:613-9.
6 Jennett B, Snoek J, Bond MR, Brooks N. Disability after severe head injury: observations on the use of the Glasgow outcome scale. *J Neurol Neurosurg Psychiatry* 1981;44:285-93.
7 Brooks N, ed. *Closed head injury: psychological, social, and family consequences.* Oxford: Oxford University Press, 1985.
8 Gloag D. Rehabilitation after head injury—1: cognitive problems. *Br Med J* 1985;290:834-7.
9 Miller E. *Recovery and management of neuropsychological impairments.* Chichester: John Wiley and Sons, 1984:142-9.