### Elective ventilation

Sir—Dr Williams (July 1993, pages 214–5) highlights the very real concern that elective (or 'interventional') ventilation for organ donation might produce persistent vegetative survivors. His assertion that the precedents set by the Tony Bland case may in future lead to the more humane treatment of such cases may well be correct. Most authorities believe, however, that a period of between three and 12 months must elapse before the diagnosis of persistent vegetative state can be confirmed. It follows that there may be a legal obligation to continue basic supportive measures over that period. But it would clearly be catastrophic if persistent vegetative survivors were to result from interventional ventilation.

How often that may happen is not known but the currently planned PIVOT study (Potential of Interventional Ventilation in Organ Transplantation) may define this more clearly. Meanwhile, we feel that it is irresponsible to advocate the widespread adoption of the strategy before establishing precisely the risk of producing persistent vegetative survivors or of other yet unforeseen problems. Without this knowledge, relatives cannot be given the information necessary for them to give their assent.

Dr Williams correctly identifies the current lack of intensive care beds as a problem and a recent multidisciplinary meeting organised by the King's Fund also concluded that this was a factor in holding down donor rates. Interventional ventilation would further increase the need for intensive care beds and Dr Williams suggests using high-dependency facilities as a possible alternative. We would disagree most strongly with this for two reasons: first, because attempts to provide appropriate care at this level have proved disastrous: they have clearly demonstrated the need for 1:1 nursing by experienced intensive care staff if the lungs are to be kept clear of infection and the circulation and other physiological variables stable. Without this, potential donor organs may be lost and all concerned may suffer even more; second, because the care of the potential organ donor is becoming more rather than less sophisticated and labour intensive, with calls for the wider use of invasive monitoring and aggressive support to optimise donor organ function.

Finally, it is open to question whether, as Dr Williams contends, interventional ventilation would be able to operate within the current legal framework. The strategy involves giving treatment to incapacitated patients since they remain alive (and are therefore patients rather than cadavers) until brain stem death is formally diagnosed. The fundamental guiding principle in managing incapacitated patients has always been that any treatment they receive should be in their best interests. Does this apply in these circumstances when patients will have been selected on the basis that death is inevitable? Indeed, if anything, the treatment could be regarded as being contrary to their best interests in that it prolongs the process of dying with the added risk of producing persistent vegetative survivors. It would seem, therefore, that the legality of interventional ventilation is debatable and, for this reason, we have recently written to the Law Commission seeking guidance.

M S NIELSEN
*For the Council of the Intensive Care Society*

### Staff grade doctors

Sir—I read with interest the College report *Staff grade doctors: towards a better future.* Repeatedly throughout the article it referred to doctors working in 'hospital medicine'. Does this mean that doctors working for instance in community paediatrics are going to be excluded from staff grade posts? If, as I understand it, community doctors are not to be excluded from staff grade posts, I would be most grateful if the report of the working party could be amended accordingly.

However, if I am wrong, and there will be no staff grade doctors/associate specialists responsible to a named consultant community paediatrician—I would be most grateful if the members of the working party could point out to me why.

I would like to believe that we live in a day and age where the concept of solely 'hospital' doctors ceases to exist and that doctors in fact work in the community where hospitals exist.

AIDAN MACFARLANE
*Consultant Community Paediatrician, Radcliffe Infirmary, Oxford*

### Cardiopulmonary resuscitation

Sir—It is perhaps understandable that Dent and Gillard (October 1993, pages 354–5) question whether resuscitation training is effective, especially given results from studies such as the Bresus Study [1]. There is no doubt that the general level of proficiency in CPR amongst doctors and nurses is poor. Indeed, there is evidence that even many CPR trainers [2], cannot perform it effectively. This does not mean that it is not worthwhile to train to do it properly. To achieve this, one needs an efficient instructor with substantial practical experience of resuscitation to train all levels of medical and nursing staff on a regular basis; in addition, the hospital must have a common policy on resuscitation working practices including a formal 'Do not resuscitate' procedure. To assess the value of the training programme it is also essential to keep full records of every resuscitation attempt.

Does such a comprehensive programme improve the survival rate from cardiac arrests after CPR attempts in hospital? The Table shows that following the appointment of a qualified resuscitation officer at Leicester General Hospital in January 1993 there was a substantial improvement in the success rate of CPR

attempts. It is therefore worthwhile to expand resuscitation training and regular updating as widely as possible, and patients and their relatives should be included in deciding on whether or not to initiate CPR.

**Table 1.** Resuscitation audit 1993—Leicester General Hospital

| | Calls | False | Arrests | Survive | Discharge |
|---|---|---|---|---|---|
| April | 38 | 8 | 30 | 5 (16%) | 2 (7%) |
| May | 34 | 10 | 24 | 3 (12%) | 2 (8%) |
| June | 31 | 2 | 29 | 15 (51%) | 5 (15%) |
| July | 32 | 8 | 24 | 10 (42%) | 5 (21%) |
| August | 22 | 4 | 18 | 10 (55%) | 3 (17%) |
| September | 21 | 1 | 20 | 9 (45%) | 4 (20%) |

(The percentages shown are appropriate to resuscitation attempts and not the original calls figure.)

### References


1 Tunstall-Pedoe H, Bailey I, Chamberlain DA, Marsden AK, *et al.* Survey of 3275 cardiopulmonary resuscitations in British Hospitals (the BRESUS study): methods and overall results. *Br Med J* 1992;**304**:1347–51.

2 Wynne G, Marteau T, Evans TR. Instructors: a weak link in resuscitation training. *J R Coll Physicians Lond* 1992;**26**:372–3.



R G WILLIAMS
*Resuscitation Officer*
J E F POHL
*Consultant Physician*
*Leicester General Hospital*


Sir—When evaluating cardiopulmonary resuscitation (Dent and Gillard, October 1993, pages 354–5) more attention should be paid to who is designated to take part in resuscitation teams and who is permitted to resuscitate. Most studies on training, for example Seidelin and Bridges [1], concern themselves primarily with junior house officers, and a recent audit [2] dealt with resuscitation teams led by senior house officers, some of whom had only just been appointed to this grade and had had little experience. Consultants may lack resuscitation skills [3] and, along with registrars, have multiple other commitments, while house officers who need both training and experience in resuscitation, are more likely to be in the locality of cardiac arrest.

McIntyre and Slater [2] found a trend in improved initial outcome on a coronary care unit where nurses are trained and permitted to defibrillate and give certain drugs at cardiac arrest. Should not more consideration be given to the training and enabling of the first rescuer, usually a member of the ward nursing staff, as suggested by Seidelin and Bridges[1]? Indeed, when Kourwenhoven, Jude and Knickerbocker initially promoted closed cardiopulmonary resuscitation, it was intended as a means whereby 'Anyone anywhere can now initiate cardiac resuscitative procedures' [4].

In addition, outcomes might be improved if the composition of the 'crash team' were reconsidered, so that each team included someone, not necessarily a doctor, with substantial experience and regular training in cardiopulmonary resuscitation.

### References


1 Seidelin PH, Bridges AB. Cardiopulmonary resuscitation: effect of training junior house officers on outcome of cardiac arrest. *J R Coll Physicians Lond* 1993;**27**:52–3.

2 McIntyre AS, Slater M. A clinical audit of cardiopulmonary resuscitation. *J R Coll Physicians Lond* 1993;**27**:34–9.

3 Thwaites BC, Shankar S, Niblett D, Saunders J. Can consultants resuscitate? *J R Coll Physicians Lond* 1992;**26**:265–7.

4 Kourwenhoven WB, Jude JR, Knickerbocker GC. Closed-chest cardiac massage. *JAMA* 1960;**173**:1064–7.



T R ALLISON
*Registrar in Public Health, Manchester*


### Therapeutic conservatism

Sir—Dr I McKee and Dr Griffin (October 1993, pages 473–4) suggest that my figures for the amount spent by the Department of Health on providing independent drug information are inaccurate, and particularly point to the role of the professional advisers in family health service authorities. As they are doubtless aware, professional advisers to FHSAs have a wide range of duties of which prescribing is only part, and sometimes a small part [1]. I am glad to note that both Dr Griffin and Dr McKee consider advice from these sources as independent and promoting rational prescribing.

The Prescription Pricing Authority was set up to refund pharmacists; that its database can be used to provide feedback to GPs on their prescribing is a useful spin off, and not its main function. However the authority cannot be in any way construed as delaying GPs with independent advice on prescribing as Dr I McKee suggests.

Dr I McKee further suggests that there is no longer a danger that naive doctors will be beguiled into prescribing excessively expensive and unproven drugs by pharmaceutical promotion; this ignores the recent evidence from Inman and Pearce [2] that that is precisely what does occur in a proportion of doctors (there are other interpretations which could be put on these data which are less kind both to the medical profession and to the pharmaceutical industry). Finally, Dr I McKee suggests that doctors who prescribe conservatively or in a cost conscious fashion for their patients are operating a double standard, and uses the example of hypertension: a doctor who would prescribe an ACE inhibitor for himself rather than, for instance, a thiazide, is forgetting what he is trying to achieve in treating hypertension. If he is trying to prevent strokes, then he should preferentially use a medication which