

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