DNR policy

Sir—Whilst there is increasing emphasis on involving the patient or surrogate in the 'do not resuscitate' (DNR) decision (April 1993, pages 135–8 and 139–40), little is known about current practice in the UK. We recently reviewed the case notes of all patients who died in the acute geriatric unit at Bristol General Hospital during a 12-month period. There was no formal DNR policy in use at that time.

Of 113 patients who died, 91 (80.5%) were documented 'not for resuscitation'; 51 (45%) of the 113 patients were felt to be mentally competent on admission to hospital, but resuscitation status was discussed with only three (3%) patients and two of them initiated the discussion themselves. In 17 (15%) cases the relatives were consulted.

Our study shows that patients are rarely involved in resuscitation decisions despite research suggesting they would welcome the opportunity to discuss them [1]. Relatives are more frequently involved, although it has been shown that both doctors and spouses are poor predictors of patients' wishes [2,3]. Our reluctance to discuss DNR status means that, unless patients initiate the discussion themselves, we continue to 'best guess' their wishes.

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Sir—One must congratulate the Clinical Medicine Board and its Chairman on their excellent and judicious discussion of the factors that should be considered when deciding whether or not to attempt resuscitation (April 1993, pages 135–8). Their recommended guidelines will be warmly welcomed, with their emphasis on obtaining the views of the relatives and all others concerned in the care of the patient (including the patients themselves) without seeking to shift responsibility. However I find disturbing the implication that if there is disagreement the clinical or unit director should arbitrate.

No physician, I am sure, would feel that they had fully assessed the situation without ascertaining and giving full weight to the views of the other doctors and nurses involved; and if there is disagreement that is not easily resolved by discussion, it would be sensible to seek further medical opinion at a senior level (to clarify and agree such things as the likely prognosis, if this is in doubt). But this opinion should be that of someone with special expertise, and I do not see what would be gained at this stage by referring to the clinical or unit director—indeed, should the clinical or unit director seriously try to override my clinical decision, I would be tempted to report them to the GMC!

This is not to deny that taking DNR decisions can be difficult and controversial. This is an important part of the consultant's role, and no one, I trust, would be appointed as a consultant who had not had the appropriate training, and was believed capable of taking such decisions. Having considered all the relevant factors, the final decision must surely be taken by the doctor with overall responsibility for the clinical care of the patient and I am concerned that the College does not state this clearly and unequivocally.

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Sir—Florin (April 1993, pages 135–40) states that there is no published evidence to suggest how many crash calls are inappropriate. Such a firm statement is usually unwise. Among other information we have reported that nearly 40% of cardiac arrest calls were clearly inappropriate for reasons which we are all familiar with [1].

It is interesting that the highest rate of inappropriate calls was in our Accident and Emergency Department (more than 50%); yet this is the one place where this is acceptable when patients are brought in urgently.

References

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Sir—The paper by Cox and Wakeford (April 1993, pages 147–50) does not give an honest list of the 'against' factors in the MB PhD programme. There are two major problems.

First, no one has adequately analysed the benefit to medical students of immersing themselves in some minute area of research for three years at a time when their career plans are far from formulated. The likelihood is that the majority of people on the MB PhD programme will end up spending their career doing something completely different from the topic of their PhD. While training in research methods is of course valid, why not do the research on something that you