Clinical & Scientific letters

Letters not directly related to articles published in *Clinical Medicine* and presenting unpublished original data should be submitted for publication in this section. Clinical and scientific letters should not exceed 500 words and may include one table and up to five references.

Cardiopulmonary resuscitation: the thought and the deed.

In the last few years there has been much concern amongst the public and national press about 'do not resuscitate' (DNR) orders made on hospital inpatients {see previous articles in this issue of *Clinical Medicine* by Peter Watkins and John Saunders}. This has coincided with a seismic shift in the way in which DNR orders are made. Until recently, the majority were made by junior doctors[1]. This year the British Medical Association in conjunction with the Resuscitation Council (UK) and the Royal College of Nursing have produced guidelines to help doctors make these decisions[2]. These re-emphasize the importance of senior clinicians in making DNR orders for specific patients.

We distributed a questionnaire to all physicians attending the weekly medical grand round. This consisted of forced binary or multiple-choice questions aimed at assessing physicians' recent experiences of cardiopulmonary resuscitation. Sixty-five physicians completed questionnaires: 18 consultants, 11 specialist registrars (SpRs), 24 senior house officers (SHOs), and 12 pre-registration house officers (PRHOs).

Our results illustrated that more than half the registrars and consultants were making resuscitation decisions on a weekly basis (17/29) and 80 per cent were making these decisions at least once a month (23/29). Junior doctors were much less likely to make resuscitation decisions. Two of the PRHOs had made resuscitation decisions despite both national and local guidelines. All but one of the medical SHOs were making some DNR orders, although less frequently than their senior colleagues (Table 1 below).

Despite making the DNR orders most frequently, consultants and SpRs had attended the fewest arrests in the previous year. Over half the consultants had attended none (10/18), and only one more than five (Table 1).

Our worry is that doctors attending less than five arrests a year will not have up to date knowledge of arrest situations and may therefore find it more difficult to relay realistic information to patients and their relatives. The vast majority of doctors making DNR orders are now consultants or registrars, but our study shows that almost all consultants and nearly half the registrars had attended fewer than 5 cardiac arrests in the previous year. This does not conform to the recent Department of Health guidelines for consent to treatment, which recommend that doctors only seek consent if they are capable of performing or have received training in seeking consent for that procedure[3].

The solution to this problem is not obvious. Neither the public nor doctors are likely to want a return to the old system of decisions being made by the junior doctors alone. It does however re-emphasize the importance of making resuscitation decisions as a team rather than as individuals.

References

1 Hayes S, Henshaw D, Rai GS, Stewart K. Audit of resuscitation decisions has little impact on clinical practice. *J R Coll Physicians Lond* 1999;33:348–50

2 Decisions relating to cardiopulmonary resuscitation. A Joint statement from the British Medical Association, Resuscitation Council (UK), and the Royal College of Nursing.

3 Department of Health. Twelve Key Points on Consent. London: DoH, 2001.

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A standardised order form improved decision-making and documentation of DNR orders

The department of health has announced strict guidelines for NHS Trusts on drafting policy to address 'do not resuscitate' (DNR) decisions[1]. The importance of audit in this area of medicine was emphasised. Audit of resuscitation decisions may have little or no impact on clinical practice, and even where guidelines are present they are frequently ignored[2]. We successfully used significantly

Table 1: Frequency with which physicians make DNR orders, and their attendance at cardiac arrests.

	Frequency with which doctors make 'DNR' orders				Number of arrests attended in previous 12 months			
	Never	Infrequent	At least once a month	Most Weeks	None	0–5	5–20	20+
Consultant (*n*=18)	0%	22%	22%	56%	56%	39%	0%	6%
SpR (*n*=11)	9%	9%	18%	64%	9%	36%	56%	0%
SHO (*n*=24)	4%	38%	42%	17%	0%	8%	50%	42%
PRHO (*n*=12)	83%	17%	0%	0%	0%	8%	83%	8%