day, with some fascinating accounts of celebrations, rivalries and scandals. So, this book will interest physicians as a fresh, side ways look at the 'flickering lamp' of the history of medicine in the capital.

The anecdotes confirm that doctors were more eccentric in yesteryear and certainly willing to place a wager for any reason and at any time, forfeits being paid for as wine for the next meeting. In the 1850s there were even fines levied on bachelors of the Club, as a Minute records that if Drs Dyer and Barclay were not married in six months, then they would be required either to accept helpmates suggested by the Club, or be fined in champagne. Unfortunately, the minutes do not record whether this pressure was effective!

In one sense, in the 18th and 19th centuries the Club was far ahead of its time, because the apothecaries, or 'Physician's Cookes', then selling almost anything, or surgeons, who had separated from the barbers only shortly before, were surprisingly invited to join the jealous intellectual elite of the Oxbridge physicians to talk as equals about matters of common interest and forge relationships between the three branches of medicine. Perhaps the well-documented jealousy was more public and political than personal. The 18th century saw the foundations of five new hospitals in London, and this may have stimulated the widening of medical meetings.

Dr Hay has written an afterword about the late William Mann of Guy's, although he *was* in fact recognised for his work for the Royal Household with a CVO. There are interesting reproductions of some pages from the records of the Club, with photographs of some of the members and a complete list of current and past members, and a foreword by Sir Richard Bayliss.

RICHARD THOMPSON
*St Thomas' Hospital*
*London*

# letters

## TO THE EDITOR

Please submit letters for the Editor's consideration within three weeks of receipt of the Journal. Letters should ideally be limited to 350 words, and can be submitted on disk or sent by e-mail to: Thomas.Allum@rcplondon.ac.uk

### Cardiopulmonary resuscitation and do not attempt resuscitation orders: legislation may be helpful.

Editor – Saunders considers my statement that medical students use the terms 'geriatric crumble' and 'GOMER'[1] to be defamatory and prejudiced, and surveying his own students suggests that my views are unfounded as none of them knew what GOMER meant. GOMER – 'get out of my emergency room' – is a widely understood (and used) term in North America[2] and as the *BMJ* is an international journal it seemed appropriate to use both terms. I suspect they all understood the term 'crumble' but I doubt many would admit using it to a senior consultant. However, what is relevant is that some students and doctors – in common with society at large – have negative and stereotyped attitudes about frail elderly patients and this may explain why these patients tend to be treated badly.

Is linking the issue of ageism in medical care to the use of 'do not attempt resuscitation' (DNAR) orders misplaced? Doctors exhibit prejudicial views about who is, or is not, to receive a DNAR order[1], which must imply that discussion of ageism in this context is legitimate. While age may be associated with increased likelihood of cardio-pulmonary resuscitation (CPR) failure, it is interesting to note that it is not chronological age itself that is relevant but the underlying cause of the cardiac arrest[3]. Predicting who will benefit is difficult, but in a typical piece of medical doublethink, Saunders considers CPR to border on futility in terms of effectiveness but also wishes to preserve its use when a doctor decides that it should be done and is worthwhile.

Saunders asserts that legislation is not a solution to the problem of too many people receiving CPR on the basis of a report assessing the impact of legislation on resuscitation in New York State, USA[4]. In this time series comparison, the proportion of patients with DNAR orders increased dramatically from 32.7% to 83.9% – surely a remarkable effect of legislation – which allowed doctors to assume consent to CPR unless a DNAR had been written according to guidelines involving discussion with the patient or next of kin. Other studies of USA legislation[5] have concluded that 'hospital policy…may even have been enhanced by the New York State legislation[6].' These data suggest that there is a case for legislation as a means of increasing the proportion of patients in whom legitimate DNAR orders are written, and thereby, reducing futile CPR attempts.

Although legislation may have increased use of DNAR orders and reduced CPR attempts, it also clear from these studies that legislation may not have influenced the physician's likelihood of discussing use of DNAR orders with patients or families[4,5,7]. It is this issue that is at the crux of the debate about use of DNAR orders.

No-one would want to see an increase in CPR among very frail dying elderly patients, but I do not think the practice of medicine will be enhanced by Saunder's complacent view that 'time may not always permit' explanation of why a DNAR decision has been made, a view at odds with current guidelines, and his closing statement that 'transparency and openness are the key to trust'.

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SHAH EBRAHIM
*Professor of Epidemiology of Ageing*
*Department of Social Medicine*
*University of Bristol*

### *In response*

Professor Ebrahim did not state that medical students 'use' the pejorative terms 'geriatric crumble' and 'GOMER' or even that 'some' (whatever that means) have the wrong attitudes. He actually wrote[1]: 'medical students still rejoice in their stereotypes of geriatric crumble and GOMER patients'. He produced no evidence to support this sweeping generalisation, nor even some thoughtful anecdote. Nor does he now. I did not consider his views unfounded *because* of my sample of student views, but because his statement both lacked evidence and failed to correspond to experience. Nor do I understand the logic of arguing that we should know such generalisations apply to North Americans because the *BMJ* is an international journal. Professor Ebrahim seeks to defend the indefensible.

His assertion that doctors exhibit prejudicial views is self referenced to his own editorial, while his view that I consider CPR to border on futility in terms of effectiveness is incomprehensible. As I wrote[2], at its best, CPR is the gift of life – not my idea of futility. The fact that it usually fails is beyond debate.

The increased documentation of DNAR orders in two of the three hospitals surveyed by Ahronheim *et al*[3] was not associated with a change in the use of CPR, nor was this found by Kamer *et al*[4]. Even the improvement in documentation was not recorded in US hospitals with policies in place[3,5]. So there is no evidence that legislation would be helpful in the UK. More significantly, I am aware of no legislature in the world that has followed New York State in the last 14 years. Moreover, no series of inappropriate failures to initiate CPR has ever been published nor do I know of any anecdotes.

Faced with an unaccompanied dying patient in the A&E department in the small hours of the morning, time does not always permit explanations of urgent decisions. This is the reality of acute medicine for many of us. A treatment that offers the prospect of more harm than good does not promote a patient's best interests and constitutes an unethical assault. I hope the sort of scenarios recently described by Soper[6] or Foxton[7] are rare. To assume that would be real complacency.

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JOHN SAUNDERS
*Consultant Physician*
*Nevill Hall Hospital, Abergavenny*

Editor – I am concerned over the current discussion on resuscitation. Little mention is made of the role of the nursing profession at the sharp end of this debate. It is often a relatively junior nurse, maybe a locum and in the middle of the night who may come across a collapsed patient. There is a complex differential diagnosis of this clinical situation. Nurses are not trained in the art of diagnosis. Even the diagnosis of death is known to have its own pitfalls (all good housemen leave 30 minutes before going to certify a corpse!). How can it be appropriate to consider 'do not resuscitate' or even 'do not attempt resuscitation' when the diagnosis of the acute downturn in the patient's condition will not have been made.

MICHAEL GROSS
*Clementine Churchill Hospital*
*Harrow*

### Biological weapons: the facts not the fiction

Editor – It is disappointing that the College's seminar on biological warfare (as reported in *Clin Med JRCPL* November/December, pp 502–4) made no mention of the most important measure to control biological weapons, namely the 1972 Biological and Toxin Weapons.Convention (BTWC), not least as it was in the news at the time of the seminar. The BTWC bans the production, testing, stockpiling or use of bioweapons, though not purely defensive research as on vaccine production. Such conventions can be breached by states parties, as in the Soviet research cited at the seminar and by Iraq before the Gulf War.

A major shortcoming of the BTWC is that it has no provision for verification. A verification protocol for the BTWC has been under negotiation for several years but was rejected by the current US administration at the November/December 2001 review conference, although it would have allowed a challenge inspection of a state outside the convention suspected of involvement in the recent anthrax outbreak. The US gave two apparently contradictory reasons for its rejection, that the protocol was not strong enough and that it would endanger the commercial confidentiality of its biotechnology industry. There is however suspicion that recent research in the US has been at least 'testing the limits' of the BTWC[1].