letters
TO THE EDITOR

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Advance decisions on resuscitation

Editor – Regnard and Randall's framework for making advanced decisions on resuscitation (*Clin Med* July/August 2005 pp 354–360) is pragmatic, sensible and workable.[1] I agree that current guidelines lack clarity and consensus, and this is reflected in a wide variation of practice in the UK.[2] Some hospital policies state that doctors have to ask every patient or the patient's family to decide on their resuscitation status – regardless of their premorbid health or cognitive status, or whether they want to discuss the issue. Consequently, many patients over 90 years old with multiple comorbidities and very poor premorbid functional status, for example, are still 'for resuscitation'. Although this might be suitable for a small number of these patients, clinical experience tells us that this could not be in the patient's best interest for the majority.

Few studies have examined the long-term survival for older patients who have undergone in-hospital resuscitation (ranging from 6% to 18%),[3,4] and most of these studies have included only highly selected patients and lack external validity. Moreover, they have generally not explored the quality of life for long-term survivors or included the 'very old' or 'very frail' patients. Without such information, patients are not truly informed when discussions take place. The method of asking the patient about resuscitation status may also influence the outcome. For example, the answer to the question 'Mrs X, if your heart stops, would you like us to restart it?' is likely to be 'yes'. However, if the patient is told what resuscitation can actually involve (eg use of electrical shocks and insertion of endotracheal tube), the 'no' answer might be more frequent.

As a geriatrician who manages many very frail elderly patients, I welcome Regnard and Randall's recommendation that the patient or family should *not* be burdened with a resuscitation decision if the clinical team is as certain as it can be that resuscitation *cannot* help the patient, or if cardiac arrest *cannot* be anticipated.[1] They also propose that resuscitation efforts for unexpected cardiac arrests should be commenced only if there is a *reasonable* possibility of success.[1] Accurate information about the latter could only come from further studies.

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References

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Risk communication

Editor – Professor Thomson and colleagues have provided a welcome overview of the challenge of communicating to patients the mathematics surrounding the relative benefits and hazards of different treatment options (*Clin Med* September/October 2005 pp 465–9). They highlight the importance of finding the right vocabulary for explaining to a patient the likelihood of v arious outcomes – rightly encouraging us, for example, to choose phrases which use consistent denominators and describe absolute risk.

However, their article focuses largely on the likelihood of an event (adverse or beneficial) occurring, and they refer to this likelihood as risk. A more rigorous mathematical definition of risk includes assessment of both the likelihood (the odds) and the significance (the stakes) of the outcome. Thus, a patient may be prepared to accept the risk of an adverse event if it is fairly common but trivial, but not if it is more rare but fatal. The use of warfarin in atrial fibrillation is a good example: we may be tempted to compare the likelihood (the odds) of an embolic stroke to that of a gastrointestinal (GI) bleed, but we should add that most people recover from a GI bleed with prompt treatment, whereas the same is not true of a stroke. The stakes are higher when considering a stroke, and this has a big impact on overall assessment of the risk.

So risk = odds × stakes. As individuals, we often find it difficult to make a meaningful assessment of risk, especially when it comprises a very unlikely event with a highly significant outcome – the National Lottery does so well because it relies on the inability of the general population to make a rational assessment in combining these two distinct components of risk. A good gambler and an insurance company will take into account both the odds and the stakes; a good physician should do so too.

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Cardiac amyloidosis

Editor – Maredia and Ray (*Clin Med* September/October 2005 pp 504–9) give a