Letters

Please do not resuscitate

Solution is flawed

Editor—Conroy et al offer a challenging solution to advance decisions on cardiopulmonary resuscitation (CPR), but the basis for that solution is fundamentally flawed.[1]

They start from the premise that all institutions should provide cardiopulmonary resuscitation unless an overt decision has been made to the contrary.[2 3] This is a common position in most UK NHS trusts, but there is no ethical, legal, or clinical demand on professionals that they must provide CPR.

Current UK guidelines describe a presumption in favour of CPR in the absence of an advance decision but are equally clear that it would be unreasonable to resuscitate anyone in whom the burdens of treatment clearly outweigh the potential benefits**.** The presumption in favour of CPR has been interpreted by many health authorities as a default for CPR, but such a position is not supported by the guidelines and runs counter to personalised decision making by removing personal choice. It is also exceptional, since no other medical treatment comes with a default position. Unfortunately, Conroy et al's solution is to suggest an equally unacceptable position, a default against CPR.

Conroy et al are right that the current guidelines need to be reviewed, but not for the reasons they state. Current UK guidelines are the source of much confusion among clinicians.[4] They contain many contradictions and confusing statements and provide no framework for making clinical decisions. It is possible to make sense of advance decisions on CPR, and had the authors done so they would have arrived at a framework that individualises decisions, involves patients or relatives and partners when appropriate, and does so without placing an unnecessary burden on patients and carers.[4] Instead the authors try to work through this confusion, and by offering a default against CPR they fail to reach a caring solution.

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1 Conroy SP, Luxton T, Dingwall R, Harwood RH, Gladman JRF. Cardiopulmonary resuscitation in continuing care settings: time for a rethink? *BMJ* 2006;332:479-82. (25 February.)
2 British Medical Association, Resuscitation Council (UK), Royal College of Nursing. *Decisions relating to cardiopulmonary resuscitation: a joint statement.* London: BMA, January 2002.
3 Decisions relating to cardiopulmonary resuscitation: a joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing. *J Med Ethics* 2001;27:310-6.
4 Regnard C, Randall F. A framework for making advance decisions on resuscitation. *Clin Med* 2005;5(4):354-60.

Do we perform cardiopulmonary resuscitation on living or dead people?

Editor—Cardiopulmonary resuscitation (CPR) in the continuing care setting is controversial.[1] Patients' rights are central to decision making on resuscitation in the NHS[2] and independent sector,[3] but it is unclear what these rights are.

Although the European Convention on Human Rights and Fundamental Freedoms[4] formed the basis of the joint resuscitation statement,[5] this convention was never intended to help shape one's response to a cardiac arrest. In applying articles from the convention to CPR, the statement has articles supporting and discouraging CPR, and sometimes doing both at the same time. The statement also tacitly acknowledges that to compel someone to perform CPR against their own wishes in order to satisfy another's decision would contravene their human rights. This reduces patients' decision making rights to one of making unenforceable decisions.

The absence of a legal definition of death complicates things further. Do we resuscitate living people on the brink of death or dead people with a chance of returning to life? If the latter, can anyone honestly claim that the dead have a right to life?

I would not submit such inflammatory suggestions if the subject were not so important. Most of us fear death, overestimate the chances of successful CPR, have little idea of the associated morbidity, dislike difficult conversations, and do them badly. This probably skews patients' wishes in favour of CPR. The risk of failure or of survival with significant morbidity is extremely high in certain identifiable patient groups,[1] and attempting CPR on these groups is distressing. Perceived pressure for healthcare professionals to perform CPR against their own clinical judgment for fear of breaching patient rights is an absurdity of contemporary medicine.

The current joint statement suggests blanket policies withholding CPR might contravene human rights. This same statement also legitimises default positions. Our default is not to resuscitate. We clearly advise patients and families of this in our literature and openly invite dialogue if people are concerned. We have had one concerned patient in 15 years, whose specific wishes were respected by arranging transfer to a more suitable healthcare setting.

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1 Conroy SP, Luxton T, Dingwall R, Harwood RH, Gladman JRF. Cardiopulmonary resuscitation in continuing care settings: time for a rethink? *BMJ* 2006;332:479-82. (25 February.)
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3 Independent Health Care National Minimum Standards Regulations. *Care Standards Act 2000.* www.dh.gov.uk/assetRoot/04/07/83/67/04078367.pdf (accessed 26 Feb 2006).
4 European Convention on Human Rights and Fundamental Freedoms. www.echr.coe.int/NR/rdonlyres/D5CC24A7-DC13-4318-B457- 5C9014916D7A/0/EnglishAnglais.pdf (accessed 26 Feb 2006).
5 Decisions relating to cardiopulmonary resuscitation. A joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing. www.bma.org.uk/ap.nsf/Content/cardioresus/$file/cardio.pdf (accessed 26 Feb 2006).

Automatic refusal is as harmful as offering resuscitation to all

Editor—We disagree with Conroy et al that discussion of cardiopulmonary resuscitation (CPR) with the patient or relatives wastes time and resources and is a diversion from other care activities.[1] They move from the aim of not providing wasteful and harmful practices to the more arguable assertion that there should be a general presumption of non-intervention in these settings.

In our local unit for continuing care we have offered a discussion about end of life care, including decisions on resuscitation routinely after admission and reviewed every six months or so. In the past three years 20 people have had these discussions. Almost all our patients are cognitively impaired (18) and incapacitated (19). Four discussions resulted in a discussion to offer full resuscitation (basic CPR by staff and calling an ambulance), and all have been for

fit people who would benefit from resuscitation. Two discussions have resulted in an order to provide basic resuscitation only (basic CPR by staff for five minutes but not calling an ambulance), recognising that heroic efforts are futile and that a quick response to basic CPR would allow a good recovery. Most (14) have agreed that CPR was futile, and this order has been followed in several cases.

Our discussion has not been a waste of time. We asked relatives about the patient's attitudes to death, terminal illness, and treatments before their illness. The discussion and decision improved the therapeutic alliance with the relatives, improved trust in our service, and enabled nurses and doctors to tailor end of life medical care to achieve the best possible quality of life and death for each individual patient. Relatives (and the single patient who could discuss this with us) felt that the individual medical and personal circumstances of the patient were being carefully and respectfully considered. This surely is a better marker of quality of care than issuing an order not to resuscitate "without further discussion," as the authors rather brutally put it.

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Communication is key

Editor—Conroy et al are right to point out that the potential benefits and risks of cardiopulmonary resuscitation are not the same for everyone.[1] However, the suggestion that decisions about interventions should be based on the care setting, rather than the needs of individuals, seems wholly inappropriate. The proposal that elderly people may be offered the choice of refusing a care home on the basis of its resuscitation policy ignores the reality of the pressure which is routinely placed on elderly patients and their families to find and move into a care home, to free up a hospital bed, often without the benefit of rehabilitation.

Part of the medical profession's role is surely to develop effective communication of both the risks and the benefits of interventions, at both population and individual levels. There is also a duty to find out what is important to individual patients and to respond to those needs. For many, this will entail a discussion about the end of life and the interventions they would and would not wish to receive. Given that over half of all deaths occur in hospitals, it is unacceptable to offer lack of time and expertise in discussions about end of life as reasons for the continued failure to give due attention to the skills needed by doctors and others to fulfil this duty.

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1 Conroy SP, Luxton T, Dingwall R, Harwood RH, Gladman JRF. Cardiopulmonary resuscitation in continuing care settings: time for a rethink? *BMJ* 2006;332:479-482. (25 February.)

Obesity, polycystic ovary syndrome, infertility treatment

Lifestyle modification is paramount

Editor—We agree with Balen et al that lifestyle modification, including effective exercise regimens and dietary advice, should be the first line of treatment in women with polycystic ovary syndrome.[1] Our Cochrane review has been widely cited as supporting the use of metformin in women with this syndrome, but like Balen et al we too concluded that metformin should be used as an adjuvant to general lifestyle improvements and not as a replacement for them.[2] An update of the Cochrane review should be available this year.

The complications of obesity both in infertility treatment and in subsequent pregnancy are well known.[3] However, lifestyle modifications can bring about beneficial metabolic changes despite only modest reductions in weight, and body mass index (BMI) may not be a sensitive enough measure to detect clinically significant changes in metabolic parameters, with waist circumference being a better marker in women.[4] More research is needed to ascertain whether the complications in pregnancy are due to obesity itself or to underlying insulin resistance.

An additional concern not mentioned in the editorial is fetal programming. If evidence were found to support the hypothesis that insulin resistance in the mother could "programme" the fetus to become obese in later life,[5] then failing to treat insulin resistance in women seeking fertility treatment now may be creating problems for future generations.

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1 Balen AH, Dresner M, Scott EM, Drife JO. Should obese women with polycystic ovary syndrome receive treatment for infertility? *BMJ* 2006;332:434-5. (25 February.)
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Asking obese women to lose weight before treatment increases stigmatisation

Editor—As Balen et al say,[1] epidemiological data show that obesity is associated with adverse pregnancy outcomes. However, long term maintenance of weight loss among obese populations is low, estimated at 15% over at least three years of follow-up in one systematic review.[2] Weight loss in shorter term studies, whether of dietary or pharmacologic treatments, six months to two years in duration, does not generally exceed a mean of 5-10 kg, and typically is closer to 3 kg, after accounting for placebo effects.

This translates to less than a 2-4 kg/m^2 reduction (or in more typical results, just over 1 kg/m^2) in body mass index (BMI) for a woman of average height. These estimates are generous, because typical lifestyle and drug trials for weight loss suffer from non-compliance or dropout rates exceeding 30%,[3] and participants who drop out of weight loss trials frequently do so because of treatment failure.[4] This magnitude of weight loss is unlikely to be sufficient to alter the decision of a clinician who has already chosen to withhold treatment because of obesity, although as the authors indicate, it may be sufficient to improve ovulatory function in women with polycystic ovary syndrome.

To suggest therefore that obese women defer treatment until they achieve a particular BMI is equivalent to refusing most of these women reproductive care. Women are entitled to choose a less than ideal treatment if they have received appropriate information on risks, benefits, and effectiveness.

A health related quality of life measure has identified body weight, fertility, and menstrual problems as three of the five most important areas of concern for women with polycystic ovary syndrome.[5] Although recommending weight loss is reasonable and prudent for all the reasons put forth by Balen et al, to suggest that obese women with the syndrome and infertility defer fertility treatment for a potentially indefinite period of time will only add to their sense of stigmatisation.

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Paying for research related injuries in the US

EDITOR—That the United Kingdom considers clinical trial patients to be covered by consumer contract law puts it at odds with the United States.[1 2] Because the US Food and Drug Administration (FDA) does not consider the informed consent process to be a contract between researchers and subjects, US subjects are not protected by consumer laws.

Standard consent form language tells US subjects that "By signing this consent form you do not waive any of your legal rights" but does not describe those rights. In 11 years on an institutional review board I've seen only one consent form state that "You have the right to obtain legal advice if you're injured in this study."

For subjects injured in US clinical trials, many consent forms state that "Treatment for research related injury will be made available. Costs associated with this treatment will be billed to your insurance company. Costs not covered by your insurance company will be your responsibility."

Because of insurance deductibles, co-payments, and lifetime benefit limits, injuries in clinical trials could be a costly experience for some injured subjects. US patients without health insurance probably shouldn't try to enrol in clinical trials.

Other consent forms note that sponsors will pay to treat research related injuries, but only costs "that are a direct result of taking the study medication and are not covered by your medical or hospital insurance coverage, provided you have followed all the instructions of the study doctor and his or her staff."

Or: "If you are physically injured by the study drug or properly performed study procedures and you have not caused the injury by failing to follow the directions of the study personnel, the sponsor will cover the reasonable medical expenses necessary to treat the injury. No other compensation such as lost wages or payments for emotional distress is offered by the sponsor, but you do not waive any legal rights by signing this consent form."

So injured subjects will have to prove they're not responsible for their research-related injuries.

The most bizarre disclaimer was "In the event of a treatment-related injury, [the sponsor] will reimburse you only for medical expenses for the treatment of bodily injuries that are not mentioned in this consent form as potential side effects and that are directly caused by the use of [the study drug] . . . Compensation for medical expenses shall not be deemed an admission of fault or liability by [the sponsor] or affiliates."

Our institutional review board has rejected some of these reimbursement schemes because we don't believe subjects should be expected to take on financial risks to reduce the pharmaceutical industry's new drug development costs.

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1 Laurence DR. Participants in research. *BMJ* 2005;331:110.
2 Laurence DR. Compensation for non-negligent harm in trials remains shaky. *BMJ* 2006;332:489-4. (25 February.)

"That's all I got handed over"

Missed opportunities and opportunity for near misses in Wales

EDITOR—We share Sithamparanathan's views of the importance of handover.[1] Between December 2005 and January 2006 we carried out a telephone survey of house officers on call in general surgery in the 17 hospitals in Wales.

In six hospitals there was no allocated place for handover. In none of the hospitals was handover bleep-free and uninterrupted. Allocated handover time was no longer than 30 minutes in 16 hospitals and no longer than 20 minutes in 11. A handover proforma providing a minimum of information (outstanding investigations, outstanding patient reviews) had been developed in only two hospitals. Personal lists were used in most hospitals (13), with the potential of patients being lost if the list is mislaid. Six house officers never and five only sometimes received feedback of their management decisions at handover. Eight of them never or rarely presented to the consultant on call.

The potential benefit to the patient of being treated by less tired doctors who work in shifts is offset by information breakdown due to poor handover, rendering the system prone to misses and near misses.

We favour a post-take bedside ward round not only from a medicolegal point of view but also as an opportunity for bedside teaching and learning by giving feedback to the outgoing team. The leadership of senior doctors in the handover process would be of great benefit. Rotas may need to be adjusted to allow sufficient overlap between junior doctors' shifts and senior doctors' working days.

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1 Sithamparanathan M. "That's all I got handed over." *BMJ* 2006;332:496. (25 February.)

Views from a teaching hospital

EDITOR—Sithamparanathan makes valid points about problems with handovers.[1] During the past three months a formal handover process has been instituted at this hospital.

The bed manager, site coordinator, and clinical support workers are present at the handover. This helps with knowledge of bed availability at the beginning of a shift and the site coordinator may sometimes be aware of potential problems in the accident and emergency department or the wards even before the doctors are.

All handovers are registrar led. This ensures that everything is handed over to the incoming team rather than to individuals, and work can be distributed appropriately.

The time allocated for handover has been widely advertised on all wards and on the hospital intranet. This has helped to some extent in achieving a bleep-free period for handover.

Our dedicated handover room has computer facilities where patients' lists can be generated and results checked quickly.

Despite all planning measures, however, we have found that the key to successful handovers is flexibility as you may find yourself having to take handover in resuscitation departments in accident and emergency wards or even in high dependency units.

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1 Sithamparanathan M. "That's all I got handed over." *BMJ* 2006;332:496. (25 February.)

Diagnosis at all costs won't make Bentham turn in his grave


SPL

EDITOR—Barraclough in Soundings concludes that our emphasis on diagnosis at all costs would have Jeremy Bentham turning in his grave[1]; but fortunately the Great Utilitarian took precautions against such an eventuality. He does not have a grave but sits stuffed in a rather nice wooden box in the University Senate Room in London, whence he is occasionally fetched to attend committee meetings. He has no room to turn.

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Competing interests: RL wishes to be cremated (after death).

1 Barraclough K. Medical intuition. *BMJ* 2006;332:497. (25 February.)

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