We are surprised that Morgan and colleagues were advised by the defence organisations that they were legally obliged to provide cardiopulmonary resuscitation for any patient who requested it. Doyal and Wilsher have stated that there is no moral obligation to give useless or harmful treatment.[4] We suspect that in many instances doctors decide against resuscitation and do not discuss it on this basis.

It is disappointing that Hill and colleagues found that some consultants would not resuscitate healthy people aged over 70. This approach cannot be justified, and there is clear evidence that selected elderly patients can do as well after cardiopulmonary resuscitation as selected younger patients.[5]

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Nurses' and doctors' views may differ

EDITOR,—Written orders for nursing and junior medical staff not to resuscitate a patient are documented only in a minority of patients.[1] In the absence of such orders, cardiopulmonary resuscitation of a patient in hospital after a cardiac arrest is most often initiated by nursing staff. Junior medical staff conducting the resuscitation usually decide when to abandon the attempt.

We conducted a survey in a geriatric assessment and continuing care unit to find out if there was any difference in opinion between the consultant, the senior house officer, and the trained nursing staff as to which of 229 inpatients should be resuscitated in the event of a cardiac arrest. Five consultants, five senior house officers, and 35 nurses who were all involved in the patients' care were interviewed.

Of the 139 patients on the acute assessment wards, nurses would resuscitate 78 (56%), more than either the senior house officer (68; 49%) or the consultant (48; 35%). There was a statistically significant difference in opinion between consultants and nurses, and between consultants and senior house officers (McNemar's test, $P<0{\cdot}01$). There was no significant difference in opinion between nurses and senior house officers ($P>0{\cdot}05$). On the continuing care wards, nurses would initiate cardiopulmonary resuscitation in 33 (44%) of the 75 patients, but the consultants did not feel that resuscitation of any of the patients in continuing care would be appropriate.

Nurses' decision to initiate cardiopulmonary resuscitation may be influenced by ethical considerations and potential medicolegal problems as well as "bonding" with the patient—especially those whom they may have been looking after for a significant length of time. Some factors can influence the outcome of cardiopulmonary resuscitation,[2,3] and not all nurses may be fully aware of these. Leaving the decision to initiate cardiopulmonary resuscitation to nurses may lead to some patients being inappropriately resuscitated.

Morgan *et al* show that elderly patients and their relatives favour more open discussion of resuscitation.[4] We feel it is important that any decision taken after such discussion should be clearly communicated to the nursing staff.

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Resuscitation and patients' views

Questioning may be misunderstood by patients

EDITOR,—The editorial and papers on decisions regarding cardiopulmonary resuscitation show the importance of involving patients and establishing written policies.[1-3] We agree with these authors' conclusions but would sound a cautionary note.

Some months ago we instituted a policy whereby mentally competent patients admitted to the unit were routinely asked whether they would want cardiopulmonary resuscitation. Our experience was similar to that described by Morgan and colleagues,[3] with most patients welcoming being involved and wishing to express an opinion. However, on one occasion a relative took exception to the practice and contacted her MP and the local press and television. We were then both accused of running a covert euthanasia policy and attempting to withdraw treatment from elderly patients in order to save money. In the furore that followed we saw how the issue of withholding cardiopulmonary resuscitation is easily confused by the lay public with euthanasia.

While it must be ethically right that patients are involved in these decisions, great care needs to be taken in how their views are ascertained. Who asks patients, when and how they are asked, and which patients are excluded? Is the patient's view always binding, or is it to be considered as part of the overall decision making process? These are all vital questions to address when setting up such a policy. Unfortunately, in practice, it is often easier to avoid these difficult and complex issues—to continue with tradition and let the doctor decide.

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Explaining outcomes may change views

EDITOR,—As mentioned by Dominique Florin in her editorial,[1] I found a discrepancy between elderly patients wishing cardiopulmonary resuscitation and their doctors' decisions on cardiopulmonary resuscitation—78 of 100 patients wished resuscitation but only 11 were designated for resuscitation.[2] In view of this, I looked at the effect of giving information, including success rate on cardiopulmonary resuscitation, to the patients.

I interviewed a further 20 elderly inpatients (mean age 82 years), asking them if they would have wished to have been resuscitated during their hospital stay and their desirability to resuscitate specific patient groups. Their answers are shown in the table.

Effect of information sheet on wishes regarding cardiopulmonary resuscitation

Wish for resuscitation for:	No wishing for cardiopulmonary resuscitation (n=20)	No of patients who changed response after information (n=20)
Yourself	17	6
Those with:		
Dementia	4	2
Severe physical disability	12	5
Terminal cancer	2	1

The patients then read an information sheet which stated, "Resuscitation, which is the procedure we do when a patient has a cardiac arrest, involves: cardiac massage, care of the airway and giving oxygen, giving relevant drugs into a vein and applying electric shock to the chest when appropriate. Successfully restarting the heart in older people is often difficult to achieve." Once they had understood the information, I then asked, "Does this information alter your views on wanting to be resuscitated yourself?" Fourteen of these 20 patients did not change their wish. The table shows the results for the other patient groups. Thirteen of the patients said they would not have wanted to have been given this information on admission and 12 would not have wanted their relatives to have been given it.

These preliminary results suggest the need for a larger study to examine the effects of giving patients more information on cardiopulmonary resuscitation.

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Is assumption of consent justified?

EDITOR,—Discussions on consent to cardiopulmonary resuscitation remain academic while the public is in such ignorance of the procedure. One nursing auxiliary made the comment that the first arrest that she witnessed "wasn't like on television" where everyone runs and in two minutes either a straight line on the monitor signals death or the patient sits up and recovers.

Medical ethicists insist on the right to lifesaving treatment but ignore the fact that, in practice, only very rarely is cardiopulmonary resuscitation a single event. In most cases it begins a train of interventions that include ventilation and transfer to intensive care. Of the approximately 44% of patients that survive the initial arrest, 32% are expected to survive to discharge. The remaining 68% may experience a lingering death in hospital.[1]

We know that a certain number of patients will have a cardiac arrest and that, at the time,