

consent cannot be obtained. Are we justified in continuing the present practice of assuming that all patients want cardiopulmonary resuscitation? In Marguerite E Hill's survey all patients felt that resuscitation should be discussed with them, and more than half the women over 60 did not wish for resuscitation.² Do we accept that patients are entitled to realistic information on cardiopulmonary resuscitation and the right to make their own decisions?

When medical futility is the reason for a non-resuscitation decision this should ideally be discussed with the patient. This can encourage consideration of other treatment issues and offer the patient the opportunity to talk of hopes and fears.³ However, this is sometimes impractical or there is no time. A lack of prior discussion should not oblige a team to carry out a pointless procedure. To use breast cancer as an analogy, a doctor would not be expected to provide a liver transplant for a breast cancer patient with liver metastases. Unless the patient raised the matter independently, the doctor would not need to discuss this. Similarly, the only time when consent need not be routinely sought is when survival of cardiopulmonary resuscitation is very unlikely.

Change is difficult. Discussion on cardiopulmonary resuscitation with most patients would be time consuming, though there would eventually be savings in the time of skilled medical personnel if some unwanted resuscitation attempts were avoided. Nurses often know that a patient does not "want to go on." Though doctors could not base a non-resuscitation decision solely on a nurse's report, good interdisciplinary communication would promote patient autonomy.

Should we question the assumption of consent for such a violent, invasive procedure that precludes the possibility of a peaceful death?

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Futile treatment need not be offered

EDITOR,—The advice given to R Morgan and colleagues by the Medical Protection Society and the Medical Defence Union that "legally if a patient requests cardiopulmonary resuscitation it should be provided" is both ill considered and, in the light of published work, incorrect.¹ Doctors are not obliged to offer futile treatment even if the treatment is demanded by a patient or a patient's family.

Studies investigating survival from cardiopulmonary resuscitation have shown repeatedly that for certain conditions such as pneumonia and metastatic malignancy this treatment is of no medical benefit, with survival rate of, or approaching, 0%.² Similarly, George *et al* and O'Keeffe *et al* have shown that the morbidity index before cardiac arrest identifies patients who will not survive an attempt at resuscitation.^{3,4} The index is a weighted scoring system based on diagnoses, clinical observations, and biochemical findings. The score associated with failure to survive was ≥ 9 in George *et al*'s study and ≥ 5 in O'Keeffe *et al*'s study.

Should a doctor take the advice of the defence societies and comply with a request for cardiopulmonary resuscitation from a patient who has metastatic bronchial carcinoma and is admitted to hospital with septicaemia and hypotension due to pneumonia? Published survival studies suggest a

0% survival rate after a cardiac arrest in such cases. The morbidity score for such a patient before an arrest is 10, indicating that he or she would not survive an attempt at resuscitation. Thus a request for cardiopulmonary resuscitation should be declined, and the reason for this should be discussed with the patient and his or her family.

The Medical Defence Union and Medical Protection Society should reevaluate their advice before a doctor is faced with unnecessary litigation. Is it really illegal for a doctor to withhold a requested treatment that is of no medical benefit? Professional judgment and common sense suggest that it is not.

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Discuss implications with the patient

EDITOR,—I wish to add a further dimension to Dominique Florin's editorial on decisions about cardiopulmonary resuscitation.¹ For a "do not resuscitate" order to be humane, ethical, appropriate, and perhaps legal a senior doctor needs to be prepared to discuss with the patient, probably at length, the implications of his or her illness. Such discussion should cover the implications in relation to cardiopulmonary first aid; subsequent intensive care (this is often neglected: a patient who is successfully resuscitated after a respiratory or cardiac arrest often requires further intensive care); prolonged recovery; and uncertain outcome with the possibility of dependent survival. This discussion with the patient may be duplicated with concerned relatives.

A do not resuscitate order, if it is to be appropriate, also needs to be reassessed in the light of the patient's changing health and wishes almost daily. Some of the manifest deficiencies in the present system have arisen because of lack of time. Doctors of all grades are in short supply in the NHS.

Those of us who work in intensive care see that dying is not always the worst outcome for our patients. Partially successful resuscitation followed by a variable period of progressively futile intensive therapy followed by death is a far sadder end and could perhaps be avoided more often if the issues were faced earlier in the patient's illness.

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Terminally ill patients may want to live

EDITOR,—In their short report on decision making in cardiopulmonary resuscitation Marguerite E Hill and colleagues state that one third of the doctors they surveyed would attempt to resuscitate patients with incurable malignancy but that patients' requests for resuscitation declined with increasing age.¹ We have conducted an interview survey into hospice patients' attitudes to investigative and invasive procedures.

The interviews were done by medical students, who were not identified as being connected with

the hospice. Twenty three randomly selected inpatients at Leicestershire Hospice, all of whom had incurable and advanced malignancy, were interviewed. If a patient did not understand any question the procedure was explained in a standard way. One of the 14 questions was, "If your heart stopped unexpectedly would you want to be resuscitated?" Eleven patients answered "Yes, definitely" and eight answered "No, definitely." One patient wanted resuscitation and another did not want it but were less definite; two patients answered "Don't know."

These responses were not related to the patients' age or their self assessed World Health Organisation performance (activity) status. Only one patient became emotional when discussing resuscitation. When the key nurses of these 23 patients were asked about resuscitation in the event of an unexpected cardiac arrest all answered that it would be inappropriate. There was thus a considerable discordance between the responses of the terminally ill patients and their nursing carers, even though patients' and nurses' ratings of performance status were highly correlated ($r=0.78$, $n=23$, $df=21$, $P<0.001$).

Hospice care aims to improve quality of life rather than to prolong life. This unit has held a policy of not resuscitating patients, and this policy is clearly reflected in the nurses' responses. The question of resuscitation is not routinely discussed with patients or relatives. In the light of our findings and the legal obligation to provide cardiopulmonary resuscitation if it is desired² we believe that we should be even more careful to discuss treatment options and listen to patients' wishes and to educate them about possible outcomes. Perhaps the most important lesson is that even a terminally ill patient with an incurable malignancy may find life worthwhile and precious.

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Microscopic haematuria

Examine urinary deposit before cystoscopy

EDITOR,—The algorithm of diagnostic tests for microscopic haematuria in Fritz H Schröder's editorial is illogical.¹ Once microscopic haematuria has been detected and infection excluded the next stage is to locate the site of bleeding. Practically this is either renal or urological, and the distinction can be made by light microscopy of a freshly provided centrifuged urinary deposit. Phase contrast microscopy can help distinguish dysmorphic from non-dysmorphic erythrocytes in difficult cases. The recommendation to perform cystoscopy before this simple, non-invasive, cheap, and effective procedure will condemn many patients with readily demonstrable glomerular haematuria to an unpleasant, uninformative, and unnecessary investigation. This is especially important in the younger age group, in which glomerular disease causes haematuria in a higher proportion of cases.

The detection of microscopic haematuria of glomerular origin is certainly grounds for further investigation since the commonest primary glomerulopathy—IgA nephropathy—was reported to progress to end stage renal disease in