

and to be prepared to put the necessary effort into looking after the relatives.

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1 Adams S, Whitlock M, Higgs R, Bloomfield P, Baskett PJF.  
Should relatives be allowed to watch resuscitation? *BMJ*  
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## Effect on relatives needs study

EDITOR,—Most of the writers considering whether relatives should be allowed to watch resuscitation were in favour, using Sarah Adams's account as strong evidence.<sup>1</sup> We should keep in mind, however, that her account is the account of only one relative. It is noteworthy that her mother chose to remain outside the screens while her son was being resuscitated. Had she given her account of that tragic incident, it may very well have given us a completely different perspective.

Peter Bloomfield notes that ambulance staff report that "witnessing resuscitation is a terrible experience for relatives." Before we start advocating that relatives might be present during resuscitation procedures we should have more formal studies of the short term and long term effects of such an experience on relatives who have attended such procedures previously—mainly those relatives present when ambulance staff carry out resuscitation procedures at home.

I feel that Bloomfield's view was the most practical of those presented—ask the relatives to leave in a way that allows those who feel they must remain to do so; keep the relatives fully informed; and allow sufficient time for the relatives to remain with the body immediately after death. Simple counselling should be given to the relatives immediately after that, emphasising that they could not have done anything more had they stayed and that the patient was unconscious and would not have been aware of their presence. This would aid in preventing or alleviating feelings of guilt.

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1 Adams S, Whitlock M, Higgs R, Bloomfield P, Baskett PJF.  
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## A successful American programme

EDITOR,—Sarah Adams's account of her brother's death at an equestrian event raised several issues regarding the rights of relatives to be present during resuscitation.<sup>1</sup> The account and the subsequent viewpoints of eminent doctors, who mostly supported the rights of the relatives, mirrored a debate among American emergency room nurses that began with a letter in their official journal in 1991 supporting the rights of relatives to be present during resuscitation.<sup>2</sup>

The Foote Hospital in Jackson, Michigan, USA, has operated a planned programme of family member presence during resuscitation since 1982.<sup>3</sup> This programme stemmed from two incidents in which relatives demanded the right to be present: in the first case the relative had been in the ambulance during the initial resuscitation attempts, and in the second case the relative belonged to the family of a police officer who had been shot. The staff of the emergency room at the Foote Hospital questioned whether it was ethically correct to exclude relatives and close friends during resuscitation, as had previously been the norm. Since the hospital's programme began, no resuscitation

attempts have been interfered with. Relatives or close friends have occasionally fainted or become hysterical but they have quickly been escorted from the room.

The key to the programme's success stems from several factors, which were suggested by Peter Bloomfield.<sup>1</sup> Chief among these is the need for a trained person, in addition to those in the resuscitation team, who can discuss the procedure with relatives or close friends and offer to stay with them during resuscitation. They should be able to enter and leave as they wish; in fact, most relatives and close friends stay for only a short time. The resuscitation team allows them to hold the patient's hand or just to sit close by.

Malone suggests that it is ethically questionable to exclude relatives or close friends from such a procedure.<sup>4</sup> Exclusion may devalue the death to a clinical procedure or a failure of treatment rather than a unique human event that touches the lives of others. But if close friends or relatives are admitted to an event that is traditionally the reserve of health care professionals then loose talk and black humour, occasionally used to defuse a tragic situation, may have to be carefully monitored. Of major concern is the grieving relative or friend holding the patient's hand, who may be unfamiliar with terminology such as "Everyone clear!"

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- 1 Adams S, Whitlock M, Higgs R, Bloomfield P, Baskett PJF.  
Should relatives be allowed to watch resuscitation? *BMJ*  
1994;308:1687-9. (25 June.)
- 2 Martin J. Rethinking traditional thoughts. *Journal of Emergency Nursing* 1991;17:67-8.
- 3 Hanson C, Strawser D. Family presence during cardiopulmonary resuscitation: Foote Hospital emergency department's nine-year perspective. *Journal of Emergency Nursing* 1992;18:104-6.
- 4 Malone R. The ethics of exclusion and the myth of control. *Journal of Emergency Nursing* 1993;19:33-34A.

## Elderly patients and resuscitation

### Advanced age is not a factor

EDITOR,—Marguerite E Hill and colleagues and R Morgan and colleagues have highlighted the difference between doctors and patients regarding resuscitation decision making.<sup>1,2</sup> We sought the opinions of doctors and nurses regarding 100 elderly patients admitted through casualty in a district general hospital. All patients were over 70 (mean age 80 years); 59 were admitted under the care of a general physician and 41 a geriatrician. There was no formal resuscitation policy.

A questionnaire was completed by the junior doctor (senior house officer or registrar) and senior ward nurse in all cases and by the consultant in 88 cases. Each was asked whether the patient should be resuscitated, the degree of discussion that had taken place, and the importance of various factors (graded on a scale of 1-5) in making a decision.

There was no significant difference, by matched analysis, between junior and senior doctors in the likelihood of making a decision for resuscitation; consultants felt that 55/88 (63%) should be resuscitated and juniors 63/100 (63%). In 23/88 (26%) cases there was disagreement between junior and senior doctors. Nurses felt that 51/100 (51%) should be resuscitated. In only 53/88 (60%) cases was there agreement among all three groups. There was no difference between general physicians and geriatricians.

In only 7/33 (21%) cases, when the consultant felt that resuscitation was not appropriate, had there been any discussion of resuscitation with either the patient or a relative. Junior doctors

reported discussion in only 8/37 (22%) such cases. Even if discussion had taken place, in only one case did either the consultant or junior doctor feel that the opinion of patient or relative was of major importance (graded 4-5) in making a resuscitation decision.

"Agism" did not seem to be practised by either doctors or nurses. The mean age of those for resuscitation was 79 years and those not for resuscitation 81 years. In only 5/88 (7%) and 8/100 (8%) cases did consultants and junior doctors respectively feel that age was a major factor (graded 4-5) in deciding resuscitation status.

Do not resuscitate orders are poorly recorded in hospital notes.<sup>3</sup> In only 13/33 (39%) cases when the consultant felt that resuscitation should not be performed was there a record of "not for resuscitation" in the notes.

In summary, despite a *BMJ* editorial in 1982 which stated, "No longer should the choice [regarding resuscitation] be left unspoken, undiscussed, and less important, unrecorded"<sup>4</sup> doctors and nurses continue to exclude patients and their relatives from the decisionmaking process of resuscitation.

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- 1 Hill ME, MacQuillan G, Forsyth M, Heath DA. Cardiopulmonary resuscitation: who makes the decision? *BMJ*  
1994;308:1677. (25 June.)
- 2 Morgan R, King D, Prajapati C, Rowe J. Views of elderly patients and their relatives on cardiopulmonary resuscitation. *BMJ* 1994;308:1677-8. (25 June.)
- 3 Stewart K, Abel A, Rai GS. Resuscitation decisions in a general hospital. *BMJ* 1990;300:785.
- 4 Bayliss RS. Thou shalt not strive officiously. *BMJ* 1982;285:1373-5.

## Some patients can benefit

EDITOR,—Marguerite E Hill and colleagues<sup>1</sup> and R Morgan and colleagues<sup>2</sup> advocate that patients should be more involved in decisions about whether they should be given cardiopulmonary resuscitation. The information given to patients about cardiopulmonary resuscitation, however, strongly influences their opinions. Murphy *et al* showed that patients' preferences for cardiopulmonary resuscitation were reduced when they were given accurate estimates of survival.<sup>3</sup> We have found that British and American doctors and nurses overestimate the potential for survival after cardiopulmonary resuscitation, and they will probably convey this overoptimistic view to their patients. Perhaps attention should be given to educating health professionals about cardiopulmonary resuscitation before patients are educated.

We have surveyed health professionals, in both Britain and the United States, about their attitudes to decisions on whether to resuscitate patients and their current practice (unpublished data). In Britain 73 of 114 doctors and nurses stated that patients were infrequently or never involved in decisions on cardiopulmonary resuscitation and 69 thought that they should be more involved. More surprisingly, in the United States, where patients are legally required to consent to "do not resuscitate" orders, 50 of 208 doctors and nurses stated that patients were infrequently or never involved in the decisions. Perhaps this shows the difficulties that arise when policy in such sensitive matters is dictated by law. We have used audit methods to agree and subsequently initiate a policy for making decisions on cardiopulmonary resuscitation, and this has resulted in a considerable improvement in the documentation of do not resuscitate orders. This policy is being updated to include discussion with patients when appropriate.