to get involved in the intricate design of rotas that minimise the undoubted difficulties; if more help is needed for these doctors in terms of support, then the case must be made. Training and clinical work must be about 20% more efficient in the next three years – this will cost money, and medical staff have to write their business plans now. It is easy to construct a bad rota – for example, seven successive 13-hour night shifts – and this is what will happen if rota design is left to the most junior person in the Human Resources team. Doctors can take charge: in 1970 I finished my 3:5 rota at Guy's by designing a new rota that was implemented immediately.

Keep an eye on the EWTD area of the Royal College of Physicians website – we post up-to-date ideas and reports, which should help rota design.[1] All reports can be downloaded free of charge.

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Reference

1 Royal College of Physicians. European Working Time Directive news. www.rcplondon.ac.uk/news/EU/index.asp#EWTD

The placebo effect

Editor – Your recent editorial (*Clin Med* 2006;6:433–4) does not make direct reference to the Concise Oxford English Dictionary's first definition of placebo, 'opening antiphon of the vespers for the dead'. The second definition is 'a medicine to humour rather than cure the patient'. The first meaning was brought to my attention during a research project when a patient was told he would be given a placebo but after consulting his dictionary expressed some concern about the proposal!

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Clinical & Scientific letters

Letters not directly related to articles published in *Clinical Medicine* and presenting unpublished original data should be submitted for publication in this section. Clinical and scientific letters should not exceed 500 words and may include one table and up to five references.

Communicating information on cardiopulmonary resuscitation to hospitalised patients

Background

National guidelines recommend readily available written information on cardiopulmonary resuscitation (CPR) for hospitalised patients.[1] Data on the uptake of such written information, however, are limited. In 2004 we explored the strategy of placing a CPR summary document adjacent to patients' beds.[2] The document contained basic information on CPR and encouraged the reader to request a detailed information leaflet. Our study showed reluctance on behalf of the patients to request further information or initiate discussion on CPR but provided no reasons for the poor response.

Aim

The aim of this second study was to determine whether patients fail to notice the summary CPR document or are reluctant to obtain further information on CPR. The reasons for limited uptake of detailed information on CPR were also explored.

Methods

This prospective questionnaire study was approved by the Trust Ethics Committee. An A4 summary document on CPR[2] along with the decision-making process was the first document in the patient's folder on the stroke unit. On the elderly care acute ward it was displayed prominently on the wall over the head-end of all beds. It encouraged the reader to seek further information from a detailed CPR information leaflet which was available through the nursing staff.[2]

Competent patients were randomly invited to participate in the study and verbal consent was obtained. The questionnaire gathered information on whether the patients examined, read and understood the summary document, and if they requested the detailed CPR information leaflet. It also asked for reasons, if any, for not requesting the detailed information leaflet.

Results

The mean age was 82.7 years (range 37–96); there were 49 females and 14 males. Fifty-four per cent had seen the summary document and 53% of those who noticed it acknowledged reading and understanding it. A detailed CPR information leaflet was requested by 28% (Table 1). The reasons for not requesting the detailed leaflet were explored. Three patients found the basic information on the summary document adequate, two were content to leave the decision to their doctors, one found the information too complicated, one felt that she already knew enough, two were not interested, and five did not give

Table 1. Results of the questionnaire.

	Elderly care ward (n=37)	Stroke unit (n=26)	Total (n=63)
Summary document seen	17/37	17/26	34/63 (54%)
Summary document read and understood	6/17	12/17	18/34 (53%)
Detailed information leaflet requested	1/6	4/12	5/18 (28%)

any specific reasons. No one discussed CPR issues any further.

Discussion

A significant proportion of medical professionals have concerns regarding initiating discussion relating to resuscitation issues.[3] There is evidence that obligatory discussions with patients before making every CPR decision results in a significant fall in the number of decisions relating to CPR.[4] In our study only 53% of patients who had seen the document chose to read it, indicating that a considerable proportion declined information on CPR when given the opportunity. Of those who did read the summary document only a quarter requested the detailed CPR information leaflet and they did not discuss it any further. This indicates that only a minority seek detailed information, confirming widespread reluctance. The small sample size and the random participation are the weaknesses of this study as we may have over- or underestimated the proportion of patients who had noticed and read the summary document. The patients' views on CPR were not explored as doing so might have inadvertently compelled some patients to think about CPR. The study highlights the need for further research in this area.

In conclusion, we have shown that the strategy of indirect provision of information on CPR in the form of a summary document could achieve modest uptake but there was overwhelming reluctance among hospitalised patients to seek detailed information and to initiate discussion on CPR.

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Note

The contents of the study were presented as a poster at the Autumn British Geriatrics Society Conference, Harrogate, October 2005.

References

1 Decisions relating to cardiopulmonary resuscitation. A joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing, February 2001. www.resus.org.uk/pages/dnar.htm (accessed 24 March 2006).
2 Sivakumar R, Knight, J, Devlin, C *et al.* Communicating information on CPR to hospitalised patients. *J Med Ethics.* 2004;30: 311–2.
3 Schade SG, Muslin H. Do not resuscitate decisions: discussions with patients. *J Med Ethics* 1989;15:186–90.
4 Diggory P, Shire L, Griffith D *et al.* Influence of guidelines on CPR decisions: an audit of clerking proforma. *Clin Med* 2004;4:424–6.