DNR policy

Sir—Whilst there is increasing emphasis on involving the patient or surrogate in the 'do not resuscitate' (DNR) decision (April 1993, pages 135–8 and 139–40), little is known about current practice in the UK. We recently reviewed the case notes of all patients who died in the acute geriatric unit at Bristol General Hospital during a 12-month period. There was no formal DNR policy in use at that time.

Of 113 patients who died, 91 (80.5%) were documented 'not for resuscitation'; 51 (45%) of the 113 patients were felt to be mentally competent on admission to hospital, but resuscitation status was discussed with only three (3%) patients and two of them initiated the discussion themselves. In 17 (15%) cases the relatives were consulted.

Our study shows that patients are rarely involved in resuscitation decisions despite research suggesting they would welcome the opportunity to discuss them [1]. Relatives are more frequently involved, although it has been shown that both doctors and spouses are poor predictors of patients' wishes [2,3]. Our reluctance to discuss DNR status means that, unless patients initiate the discussion themselves, we continue to 'best guess' their wishes.

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ANDREW PADKIN
Registrar in Medicine, University Hospital, Nottingham
RICHARD ROBINSON
Registrar in Medicine, Peterborough District Hospital

Sir—One must congratulate the Clinical Medicine Board and its Chairman on their excellent and judicious discussion of the factors that should be considered when deciding whether or not to attempt resuscitation (April 1993, pages 135–8). Their recommended guidelines will be warmly welcomed, with their emphasis on obtaining the views of the relatives and all others concerned in the care of the patient (including the patients themselves) without seeking to shift responsibility. However I find disturbing the implication that if there is disagreement the clinical or unit director should arbitrate.

No physician, I am sure, would feel that they had fully assessed the situation without ascertaining and giving full weight to the views of the other doctors and nurses involved; and if there is disagreement that is not easily resolved by discussion, it would be sensible to seek further medical opinion at a senior level (to clarify and agree such things as the likely prognosis, if this is in doubt). But this opinion should be that of someone with special expertise, and I do not see what would be gained at this stage by referring to the clinical or unit director—indeed, should the clinical or unit director seriously try to override my clinical decision, I would be tempted to report them to the GMC!

This is not to deny that taking DNR decisions can be difficult and controversial. This is an important part of the consultant's role, and no one, I trust, would be appointed as a consultant who had not had the appropriate training, and was believed capable of taking such decisions. Having considered all the relevant factors, the final decision must surely be taken by the doctor with overall responsibility for the clinical care of the patient and I am concerned that the College does not state this clearly and unequivocally.

G S SPATHIS
Physician, St Helier Hospital, Carshalton

Sir—Florin (April 1993, pages 135–40) states that there is no published evidence to suggest how many crash calls are inappropriate. Such a firm statement is usually unwise. Among other information we have reported that nearly 40% of cardiac arrest calls were clearly inappropriate for reasons which we are all familiar with [1].

It is interesting that the highest rate of inappropriate calls was in our Accident and Emergency Department (more than 50%); yet this is the one place where this is acceptable when patients are brought in urgently.

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R D THOMAS
Consultant Physician and Cardiologist, Royal United Hospital, Bath

MB PhD at Cambridge

Sir—The paper by Cox and Wakeford (April 1993, pages 147–50) does not give an honest list of the 'against' factors in the MB PhD programme. There are two major problems.

First, no one has adequately analysed the benefit to medical students of immersing themselves in some minute area of research for three years at a time when their career plans are far from formulated. The likelihood is that the majority of people on the MB PhD programme will end up spending their career doing something completely different from the topic of their PhD. While training in research methods is of course valid, why not do the research on something that you

are going to spend your career doing, and therefore, do it after graduation. This problem is compounded by the fact that members of staff in the preclinical departments are only too keen to grab intelligent young men and women for three-year PhD studentships, given that they do not have to bother with raising funds since these are provided through the clinical school. The motives of the supervisors of these PhD students may therefore not be of the purest!

Second, and here I speak as a graduate tutor as well as a NHS consultant, I believe these students are disadvantaged in two ways. It is difficult to complete a PhD in three years—the majority of students in this university do not do so, yet they can overrun by a few weeks or even a term without any real problem. The MB PhD students will not be able to do so, since they will have to complete their clinical studies. They will then be trying the impossible, writing up a PhD and training to be a proper doctor. The end result is that their PhD will be shorter and probably poorer than average, and/or their clinical training will be compromised. Completing a PhD is a difficult and demanding task. Learning clinical skills is equally difficult and demanding. To combine them is ill advised.

Many of us feel that the MB PhD programme is designed more to show the clinical school as being trendy than to benefit the young people who are seduced into it.

N R C ROBERTON
Consultant Paediatrician, Addenbrooke's Hospital, Cambridge

What is it like to have an angioplasty?

Sir—Dr Geoffrey Dean's interesting article entitled 'What is it like to have an angioplasty?' (January 1993, pages 73–4) reminded me of a similar article written about a year ago by an American cardiologist about his personal experience with coronary angioplasty [1]. There were, however, differences which might be worthy of reiteration.

The American doctor, though overweight, hypercholesterolaemic and fond of prime ribs, roast beef and hot fudge sundae, was completely asymptomatic at the time of his coronary arteriography and subsequent angioplasty. The British physician, not particularly overweight, with a normal cholesterol and careful about his diet, suffered post-infarction angina which prompted his diagnostic study followed by coronary angioplasty

The American doctor's procedure was done from the brachial artery through a cutdown, so that he 'could go home soon after the study'. The British physician had his study performed through the femoral artery via a percutaneous approach. As a matter of fact, the American cardiologist went back to the catheterisation laboratory in his more familiar role to witness his patient's coronary angioplasty just two days after his own. The British doctor did not specify how soon after his procedure he resumed his normal activities.

The American cardiologist had a thallium stress study done after he had his coronary arteriography completed; it was normal. The British physician had his treadmill test before the cardiac catheterisation; his stress test showed positive ischaemic ST-T changes.

Although there are many similarities between the experiences of the British and American doctors, there are also obvious differences which are of note. Do these differences say something about the attitude or temperament of the British doctor versus his American colleague toward the overall philosophy in the management of coronary artery disease?

Reference

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TSUNG O CHENG
Professor of Medicine,
The George Washington University, Washington

Oxygen desaturation during endoscopy in the elderly

(see also p. 340)

Sir—Dr Solomon and his colleagues conclude (January 1993, pages 16–18) that 'continuous cardiac and oxygen saturation monitoring should be routine practice' in endoscopy in the elderly. Their paper does not support this view. Their results show very small differences in oxygen saturation between those given oxygen and those given air, with narrow confidence intervals. They also show no difference in the frequency of arrhythmias between the groups.

The logical conclusion is, at least superficially, the complete opposite, namely that oxygen supplementation is valueless in preventing arrhythmias. This conclusion is in harmony with much published evidence, which they quote. It may be at variance with professional opinion but evidence is to be preferred to opinion.

Unfortunately the study is almost certainly too small to answer the critical question, whether occasional patients may become sufficiently anoxic to be at risk.

M J S LANGMAN
Department of Medicine, The University of Birmingham

Fund raising for the uninitiated

Sir—We much enjoyed the article 'Fund raising for the uninitiated' by Dr Stephens (January 1993, pages 75–7).

We have gone through a similar exercise here at the Leicester General Hospital where we raised £150,000 for an endoscopy suite with CC TV facilities for teaching purposes.

An avenue not mentioned, which we feel is very wor-