

for CPR at our District General Hospitals. On a single day in March 1992, the notes of all medical in-patients at one of the hospitals were examined to ascertain which type of patient had been deemed unsuitable for CPR (not for 333's) by their supervising team. In particular, information was sought concerning: reason for not considering patient for CPR; how it was stated; indication of who had been involved in the decision and, in particular, if either the patient or the close relatives knew of the decision, and if the original resuscitation policy was reviewed during the course of the patient's stay in hospital.

Further, it was to be established if the nursing staff were also fully aware of the patient's resuscitation status.

At that time the hospital held 178 medical beds supervised by eight consultant physicians on six wards, the majority of bed occupancy being patients received from the general acute medical take (greater than 85 per cent), routine admissions accounted for only a small percentage. The specialty of acute geriatric medicine was managed at other sites within the city.

Of 133 patients (86 per cent bed occupancy), ages ranging between 17 and 92, only eight (6 per cent) were apparently not suitable for CPR according to the medical documentation. In others, no decision or mention of appropriate action in the event of cardiopulmonary arrest was given. Out of this total of eight, the nurses were apparently unaware of this instruction in four cases.

This random survey showed that reasons for a policy not to resuscitate were not actually documented in the notes and that, at times, decisions had apparently been left to a pre-registration house officer. Although consultant advice may, indeed, have been sought, this was not clearly documented in the notes.

Of the eight entries 'not for 333's' was recorded in seven cases. The remaining read 'patient not for ventilation'.

It would not have been clear to an outside observer as to who had made the decision or on which specific day or hour this had been entered.

The nursing staff in four (50 per cent) of cases were unaware of the medical decision.

There were nine patients (7 per cent) who were actually deemed for resuscitation, despite having terminal disease and who would, at least initially, have been put through the trauma and

indignity of a resuscitation procedure in the event of cardiac arrest.

Individuals are rarely consulted, even in an indirect way, about their own resuscitation policy (2). Surprisingly, one survey of elderly patients found that only 7 per cent requested full CPR in the event that they were found to be in asystole.

Since 1974 in the USA institutional policies for CPR have been introduced. In Britain formal policies are rare, as noted by the Ombudsman in his report.

This study clearly emphasises that there is urgent need of a directive, either at hospital or national level, regarding the delicate decision of whether to resuscitate (3). The Clinical Medical Board is at present considering specific guidelines for resuscitation policies in Britain.

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Child sexual abuse in the Church: the ethics of throwing stones in glass houses

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Over the last several years much attention in the popular press has been directed at revelations that priests and other figures from various religious communities were involved in perpetrating child sexual abuse. Mostly recently, Roman Catholics in the midwestern United States released a report of an independently commissioned investigation that confirmed sexual misconduct and molestation of at least 21 students at a rural boys' boarding school (1). One member of the clergy has estimated that 2,000 to 4,000 priests may have abused 100,000 children (1).

These revelations are invariably shocking to the public and raise concerns about underlying problems in the priesthood and other religious institutions. While there may be specific risk factors for child sexual abuse within religious institutions, it is important to recognize that intentional injuries, and particularly those involving sexual assault, are if not epidemic, then at least hyperendemic in the United States and other western nations. The Catholic Church has taken a proactive approach to the investigation and prevention of child sexual abuse that needs to be sustained, but the intense focus within the press on religious organizations as a setting for sexual abuse should not diminish surveillance and prevention efforts within other social institutions.

The problems disclosed in religious institutions are likely to be particular but not unique. They point to a serious continuing deficiency in our social and public health discourse on sexual assault. Despite increased attention to sexual assault by journalists and the popular press, much of it responsible and not uniformly sensational, we have yet to see candid discussion of the incidence and prevention of sexual assault occur in a routinized way throughout all major social institutions.

Even the health professions, supposedly in the vanguard of intentional injury prevention, are far from exemplary in leading the development of such processes within their own institutions. For example, how many curriculums within schools that train health professionals contain a component on human sexuality? And how many of these deal explicitly with such issues as prevention of child sexual abuse? Certainly most if not all of the primary care specialties, and not only paediatrics, encounter child abuse in routine practice.

At a more basic level, have institutions such as medical schools and specialty training programmes implemented adequate and systematic internal policing and educational efforts in the area of sexual assault? In some US states, such as California, actions to revoke medical licences for sexual misconduct are on the rise and are reported publicly by the state Board of Medical Quality Assurance. Medical leaders need to inquire whether future physicians are sufficiently and effectively trained in managing their own sexual responses to patients, or patients' responses to them in the clinical setting. There is

great variation in the extent to which local medical institutions or national policy-makers have implemented prevention activities to reduce the sexual harassment of female medical students, residents and other health trainees. Medical and public health professionals have much expertise to offer to religious as well as secular organizations in the systematic surveillance, management and prevention of sexual assault. But before we can lead in this effort, surveillance and preventive education systems within our own profession need to be models in concept and practice.

The ethical contradiction of pointing out and documenting sexual assault in other professions and social

sectors is not unique to medicine. But medical practitioners are hardly in a position to cast stones in this regard, as data increasingly indicate a serious problem in our own profession and the absence of a systematic effort to acknowledge the varied influences of sexuality on medical training and practice. While medicine and public health continue to promote consciousness and prevention of child sexual abuse external to the profession, a serious and consistent effort must be made to establish surveillance mechanisms and interventions on behalf of patients and female colleagues within medicine. Only then can the contribution and leadership of physicians to child abuse detection

and prevention have credibility and integrity.

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