

Letters

Prolonging life and allowing death

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The paper, "Prolonging life and allowing death"¹ states: "The ultimate responsibility for the final decision rests with the doctor in clinical charge of the infant", but then the authors "advocate a team approach to decision-making", noting that support for families with disabled children may be insufficient.

In fact, the doctor's expertise enables him or her to decide if a treatment is available which will or may ameliorate the "severely compromised infant"; if not, the duty to care remains: to ensure adequate nutrition, hydration and symptom control. Social factors, support for families, access to facilities, have no place in determining a doctor's duty to a patient.

If the Government or hospital managers decide that caring is too expensive or too burdensome for parents or their child and that death is the most "humane" option, it is the duty of ethics committees to inform them and the public that our profession cannot be party to such death-making decisions. "Lack of confidence towards the doctor" still continues in Germany.² This must not be allowed to happen here.

References

- 1 Campbell AGM, McHaffie HE. Prolonging life and allowing death: infants. *Journal of Medical Ethics* 1995; 21: 339-44.
- 2 Vogel F. *Ethics in human genetics*. Report of the 2nd symposium of the Council of Europe, 1993 Nov 30. London: HMSO, 1993: 54.

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Cardiopulmonary resuscitation in the elderly

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In their paper Mead and Turnbull¹ advocate that mentally competent elderly patients should be routinely consulted about cardiopulmonary resuscitation (CPR). We believe that this is unnecessary, impractical, unwelcomed by some patients, irrelevant to others and not supported by the results of their study.²⁻⁶

We have reviewed resuscitation status shortly after admission for all our elderly patients and usually decide against CPR in about 20% of them.⁷ Around one fifth of our elderly patients will die in hospital and about one third will have moderate or severe confusion at the time of admission. Many will have the sorts of conditions which make CPR unlikely to succeed. We have surveyed casenotes of all our elderly inpatients⁸ and found that 39 of 128 (30%) were unsuitable candidates for CPR attempts on the basis that it could be predicted that resuscitation would fail (ie medical futility). There is no ethical or legal obligation to obtain consent for Do Not Resuscitate (DNR) orders in such patients⁴ and we would not consider initiating discussions about CPR with them. Mead and Turnbull have studied a highly selected group of patients who had recovered from acute illness and were awaiting discharge. It seems unlikely that the views of this group accurately reflect the views of the patient population as a whole and, of course, the groups in whom we have to make the most difficult decisions (those who die in hospital and those who are confused) had already been excluded.

Mead and Turnbull found no evidence of serious psychological sequelae following their discussions, although this is not unexpected since the environment in which the discussion was held would have been very

different from that in which most clinicians have to make real decisions.

Patients may not want to discuss CPR or may misunderstand what is being proposed. Heller and colleagues implemented the sort of policy that Mead and Turnbull have advocated but the patient, her family, the local press and the local MP misunderstood it and took exception to it.⁵

Elderly patients' preferences for CPR depend on their understanding of its success rate, and are greatly reduced when they are given realistic information about its likely outcome⁹ (contrary to the informal impression gained by Mead and Turnbull). Most patients in this study thought that CPR was usually successful and, unsurprisingly, many wanted it for themselves. Cardiopulmonary resuscitation is, of course, usually unsuccessful, with only about 10-20% of inpatients surviving to discharge.^{3,4} Furthermore, there is a 1-2% risk of surviving in a persistent vegetative state.⁴ If Mead and Turnbull had given a more detailed description of CPR, including information on outcome they might have enhanced their study and found far fewer patients favouring resuscitation.

Mead and Turnbull found that 35% of their patients wanted to be consulted about CPR, 14% didn't and 51% didn't mind. The abstract, however, states that "86% were willing to be consulted" about resuscitation. Strictly speaking this is true, but it gives the impression that most wanted to be involved in CPR decisions, whereas, in fact, 51% didn't care whether they were involved or not. The abstract might just as easily have said "65% didn't mind if they weren't consulted about CPR". Sixty-five per cent of those surveyed also felt that doctors should make the final CPR decision. This suggests that many were quite happy with the medical profession acting in a paternalistic fashion. This doesn't fit with the recommendation by Mead and Turnbull