The authors use their paper to highlight their disagreement with the national guidelines but their argument is weakened by selective or inaccurate quotations from the literature. The guidelines do not say that 'no Do Not Attempt Resuscitation (DNAR) decision can be made without prior discussion with the patient'. Many acutely ill patients (nearly 50% in a recent study²) will be incompetent to make decisions about their care, but the guidelines recognise this and also acknowledge that some patients will not want to be involved in decisions. However, they do recommend that most competent patients, and the families of incompetent patients, should usually be involved in decisions in keeping with the requirements of the Human Rights Act.¹

The authors repeatedly refer to situations where CPR is 'ineffective' as if this was easily determined, but 'futile' CPR is difficult to define and even more difficult to predict. We know that even experienced doctors are not very good at predicting CPR outcomes and in one study their predictions were no better than chance.³ Despite this, the authors seem happy for junior doctors in their department to make these predictions and take decisions on the basis of 'futility'.

Doctors do not like discussing CPR decisions with patients; it is difficult, time consuming, there are many uncertainties and there is much potential for misunderstanding. On the other hand, patients and the public have very different expectations of us than they had a few years ago, and the Human Rights Act gives their expectations legal support. We can either accept this reality or continue to try to find reasons to ignore it.

References

- 1 The British Medical Association, the Resuscitation Council and the Royal College of Nursing. *Decisions relating to cardiopulmonary resuscitation*. A joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing, January 2002 (www.bma.org.uk/ap.nsf/Content/cardioreus)
- 2 Raymont V, Bingley W, Buchanan A, David AS *et al*. Prevalence of mental incapacity in medical inpatients and associated risk factors. *Lancet* 2004;**364**:1421–7.
- 3 Ebell M, Bergus GR, Warbasse L, Bloomer R. The inability of physicians to predict the outcome of in-hospital resuscitation. *J Gen Intern Med* 1996;**11**:16–22.

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In response

Kevin Stewart's and Camilla Long's comments and the situation described by Philip Berry¹ illustrate the muddle arising from varied interpretations of unsatisfactory guidelines. We quote 'selectively' from the guidelines to illustrate the confusion caused by the juxtaposition of the statement: a patient's wish to receive cardiopulmonary resuscitation (CPR) should be respected but it is for the doctor to make the final decision. What should we do when wish and decision are at odds?

We agree with Long that the fall in decision rates when we introduced a policy obliging discussion on CPR before making a Do Not Attempt Resuscitation (DNAR) order was probably due to reluctance to enter into discussion.

Stewart is correct in stating that many elderly patients do not have capacity when acutely unwell, but on admission to hospital they are at 'foreseeable' risk of death. We believe the admitting doctor should make a CPR decision.

Difficulty in prediction is not a reason why a decision should not be made. We did not use the term 'futility' but made reference to situations where expectations of success were very low. Doctors must make many decisions, often with little discussion, where outcome is difficult to predict. CPR is just one.

Our approach is that the first decision is to decide what treatment is appropriate, then to discuss with the patient whether they want it. We do not feel obliged to offer treatment which we believe to be inappropriate. We agree that this situation may change once the Court of Appeal rules on the case of *Burke v the General Medical Council* concerning whether or not doctors must provide treatment (in his case, feeding) whatever his circumstances. Human rights legislation was at issue in the High Court Judgement. Like others, we await the Court of Appeal review with anxiety.² Long is concerned that patients will be unable to tell if CPR decisions,

without discussion, were made to avoid distress or because of a reluctance to discuss the issues. Our policy is that reasons for not discussing should be recorded in the notes. Our most recent (September 2004) audit of 172 inpatients found we made 164 CPR decisions within 24 hours. Of these, 116 were DNAR orders. We made 22 DNAR orders without discussion, citing a poor prognosis for survival and the need to avoid distress and/or confusion.

We are trying not to shirk discussions; our audits show we have them on a daily basis. We do not suggest good documentation means good care, but poor documentation is a likely predictor of poor discussion rates, perhaps reflecting less satisfactory care. Decision rates vary greatly; with rates of 15–98% found by a survey of 13 elderly care departments.³ Our policy permitting DNAR orders to be made without discussion when patients are acutely ill is central to becoming comfortable discussing CPR. Our audits show us moving with the times to a policy that maximises patient autonomy and choice – an example of best practice.

References

- 1 Berry P. An audit into consultation in 'do not attempt resuscitation' decisions. *Clin Med* 2004;**4**:471–2.
- 2 Gillon R. Why the GMC is right to appeal over life-prolonging treatment. *BMJ* 2004;**329**:810–11.
- 3 Cauchi L, Diggory P, Vigus J. Implementation of cardiopulmonary resuscitation guidelines in elderly care departments. A survey of 13 hospitals shows wide variability in practice. *Resuscitation* 2004;**63**:157–60.

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Hippocratic oaths: medicine and its discontents: book review

I was interested to read Dr JM Holt's review of Raymond Tallis's new book *Hippocratic oaths: medicine and its discontents* (*Clin*

Med November/December 2004 pp 591–2).

Dr Holt includes the statement taken from Tallis's book that 'there are now many more medical schools places, but there has also been a sharp drop in applicants to the extent that in a year or so nearly all who apply will be accepted.' In fact, this is far from the case, for entry in 2005, applications to study medicine actually rose by nearly 20%, and for entry in 2004, applications rose by nearly 30% from the previous year's figures. This means that there are now more than 19,000 applications for 8,000 places, so it is very unlikely that nearly all who apply will be accepted. The Council of Heads of Medical Schools is working with colleagues to consider how different ways of assessing these candidates can be developed.

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Symptoms and perceptions of disease

Editor – I was fascinated by the very clear exposition of the problem symptoms and perception of disease by Dr Donaghy (*Clin Med* November/December 2004, pp 541–4), but perhaps one aspect of this was under-emphasised. Deconditioning, the opposite of training, may also contribute to the imbalance between symptoms and organ impairment.

As Dr Donaghy points out, there are many reasons for the disproportionate perception of the severity of disease besides the obvious frank malingering including 'compensationitis', and what used to be called 'poor moral fibre'. A patient attending for the first time with back pain might be resentful at a seeming lack of concern on the doctor's part. Another doctor might take the easy way out and unconsciously try to please by ascribing breathlessness to a totally unwarranted diagnosis of emphysema which acquires immortality in the notes and can never be undiagnosed in the patient's mind.

Often, new symptoms have a disproportionate impact simply because they are new. Each of these may set up a vicious circle of decreased activity and reactive

depression on the one hand, and decreased fitness and a real increase in symptoms on the other. The deconditioning then becomes independent of the precipitating factor and so it will persist even if the latter is removed. The implications of this to clinical practice are that the initial management is critical, and to medico-legal practice that even where the acute 'compensationitis' was malingering, the chronic phase might reflect genuine symptoms.

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Team working

Editor – In the November/December 2004 issue Carol Black and Alan Craft see good decision-making in teams that promotes alignment of values and behaviour, forms alliances with members of other teams, and good communication within and between teams as requiring, 'strong leadership' (*Clin Med* November/December 2004, pp 527–33). I agree with this conclusion about the appropriateness of the leadership model in team working but the reality is far from being as precise as the article implies.

In clinical teams, it is possible to identify four basic models of decision-making - all of them previously identified in the NHS. These are the leadership model, the democratic model, the consensus model and full or partial anarchy. The consensus model is found where there is no urgency for a clinical decision and where one key decision will have a long-term effect on the patient. Mental health is one area of the NHS where this model occurs most frequently. By contrast the democratic model occurs where there is an urgent need to take a decision to treat and where non-doctors do not accept a leadership model. Crisis teams dealing with vagrants in community settings contain some doctors who have admitted to allowing themselves to be outvoted in respect of urgent clinical decisions needed because the patient is not likely to reappear (as opposed to being genuinely clinically persuaded about the greater appropriateness of the choice).

The most common alternative to the leadership model is whole or partial anarchy. This defines a situation where the team fails to function as a group and where

each individual clinician insists upon taking their own decision about what they should do with the patient irrespective of the views of other members of the team. Partial anarchy refers to a more common position in which a leadership model operates for a tight central core of decision-making with wider decisions relating to the patient being taken individually.

Anarchy can occur when one professional group is seeking what the team member feels to be greater independence from the team leader, usually the doctor. This is when decisions to behave independently are taken outside the team, as opposed to team discussions where the 'leader' makes major concessions on the clinical decisions taken in order to keep the team together.

In the last 20 years, the practice in clinical teams has drifted away from a firm and unchallenged acceptance of the leadership model in a way than can be clearly measured on a spectrum. The more urgent and acute the condition of the patient, the stronger the leadership model within a formal NHS setting. The more chronic the patient's condition and the fewer clinical interventions needed, the more likely it is for the leadership model to erode into a form a bargaining, the best negotiator often having greater influence than sapiential authority might imply. This erosion is worrying and it is good that the College is addressing these fundamental issues. It is because the patient is not best served by an arrogant team leader who does not take seriously the contribution of other team members, that this is such an intractable issue. The ideal is a team leader who understands the group dynamics and can ensure that they are used to the patient's best interest.

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Fluid, electrolytes and nutrition

Editor – In reading Simon Allison's informative and engaging article 'Fluid, electrolytes and nutrition' (*Clin Med* November/December 2004 pp 573–8), my attention kept on being drawn back to the opening paragraph.

I am sure that Professor Allison meant to