Cardiopulmonary resuscitation: junior doctors' attitudes

Sir,

In their article Scott et al (vol 64(7), 2003, p. 425) show that nearly 50% of trainee physicians and surgeons do not feel adequately trained in cardiopulmonary resuscitation (CPR). We were intrigued that they included both surgeons and physicians as very few cardiac arrest teams include members of the surgical team. In contrast nearly all medical senior house officers (SHOs) and registrars are or have been members of the cardiac arrest team. One would expect them to have had more training and be more comfortable in the arrest situation than their surgical colleagues.

In addition nearly 42% of Scott et al's study group felt that do not resuscitate (DNR) orders should only be made by specialist registrars (SpRs) and above. Yet it is of note that SpRs and consultants, despite making the most resuscitation decisions, actually have the least current experience of cardiac arrests (Hudsmith et al, 2001) making them even less suitable to assess patients for resuscitation and discuss this with patients and their relatives.

Scott et al seem surprised that while 52% of the junior doctors felt they had adequate training in arrest situations, only 20% had actually attended an advanced life support (ALS) course. Indeed the authors attribute this to worrying overconfidence among these juniors and even suggest stronger appraisal to detect this. It must be remembered that ALS is not the only form of training in cardiac arrests. Many members of the arrest team are perfectly capable of performing their roles without specific ALS training. ALS training is only really essential for those doctors and nurses leading the arrest teams or working in areas with a high incidence of arrests. Providing such training for other doctors is unlikely to be an optimal use of scarce resources.

These doctors would benefit far more from training in basic life support and defibrillation, with additional training in identifying patients who would not benefit from resuscitation, in early identification of deteriorating pre-arrest patients and in discussing end of life decisions with patients and their relatives. Such training should be mandatory for all doctors responsible for inpatients and should be a pre-requisite for obtaining a certificate of completion of specialist training. It should also be updated on a regular basis.

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Hudsmith L, de Bono J, Davies R, Hampton J (2001) Cardiopulmonary resuscitation: the thought and the deed. *Clin Med* **1**(6): 517

Sir,

This study included surgeons at various stages of training, including preregistration house officers, some of whom would have been anticipating future posts in medicine involving responsibility for cardiac arrests. Furthermore, all trainees at all grades in all specialties know they may find themselves first attendee or assistant at an arrest situation at any stage of their duty shift.

de Bono and Hudsmith assert that SpRs and consultants are less suited to making resuscitation decisions because of their lesser experience on cardiac arrest teams. We feel that no such simplistic extrapolation can be made; the ability to address the complex moral and clinical issues around a DNR order cannot be correlated with exposure to the protocol-driven experience of making a CPR; it requires a degree of personal and professional maturity which is often, although admittedly not exclusively, better developed at more senior grades.

We accept that training in this area should not simply be a matter of all doctors in all specialties completing an ALS course; however, while training authorities continue to insist upon a valid ALS certificate for accreditation in certain specialties, juniors and other health-care professionals are likely to regard possession of such a certificate as the 'gold standard' of training. The question remains as to how best to train juniors in end-of-life and DNR scenarios. We strongly agree with de Bono and Hudsmith that such training should be a mandatory part of accreditation and would suggest that it should begin in the preregistration year.

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Correction

In his example of how one case with a terrible outcome can radically change practice, Mr Hall (vol 64(7), 2003, p. 390) stated that an anaesthetist in Newham gave an hypoxic mixture by mistake in casualty and caused the death. In fact the practitioner giving the hypoxic mixture was not an anaesthetist but a consultant in accident and emergency.