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"DO NOT RESUSCITATE" DECISIONS

Full CPR should not be used for ordinary dying

The Analysis article on when and how to discuss "do not resuscitate" decisions with patients evades discussing the difference between ordinary dying and dying from cardiac arrest and attempted full cardiopulmonary resuscitation (CPR).[1]

In ordinary dying the vital organs fail and the heart is the last vital organ to stop. In cardiac arrest the heart is the first vital organ to stop and full CPR may restore life, whereas in ordinary dying CPR cannot restore life. Cardiac arrest is usually a complication of an acute myocardial infarction.

Most people who die in hospital are clinically frail and die despite "best treatments and doing it all" because all systems fail. Yet unless a do not attempt CPR (DNACPR) order is in place, a cardiac arrest call is put out as the person dies. CPR is a complex, invasive, and traumatic clinical procedure, damaging to the body and to dignity. If we are asked "Did he suffer" after a patient has had a failed CPR, we should answer "Yes, we damaged his body and his dignity."

Full CPR should be used only for the correct indication—cardiac arrest—and not in the presence of an absolute contraindication, ordinary dying. The General Medical Council guidance says we need to discuss DNACPR only with patients at increased risk of cardiac arrest—those who have had an acute myocardial infarction. However, to protect patients from undignified and brutal dying, we need to complete DNACPR forms. "Goals of care" or the "universal form of treatment options" (www.ufto.org) would seem a better approach in clinical frailty than focusing only on DNACPR.[2]

Doctors should recommend only wise treatments, which are likely to work and that result in more benefit than suffering. Full CPR has no place in the care of clinically frail patients.

Gordon Caldwell consultant physician and clinical tutor, Worthing Hospital, Worthing BN11 2DH, UK
gordon.caldwell@wsht.nhs.uk

1 Etheridge Z, Gatland E. When and how to discuss "do not resuscitate" decisions with patients. *BMJ* 2015;350:h2640. (20 May.)

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Authors' reply

In the Tracey case, no distinction is made regarding the mode of dying. Mrs Tracey had advanced lung cancer, a cervical spine injury, and pneumonia.[1 2] Testimony given by David Pilcher, chairman of Research Councils UK, states that the chance of successful resuscitation in such a case is extremely low. As far as has been reported, Mrs Tracey had no cardiac problems; she was therefore likely to die of what Caldwell describes as "ordinary dying," from overwhelming cancer and infection. Nonetheless, the court found that the decision should have been discussed with her. The law as it stands makes no distinction regarding the mode of dying, meaning resuscitation should be discussed with all patients who wish to have such a discussion unless they are likely to suffer physical or psychological harm.

Cardiopulmonary resuscitation (CPR) was originally introduced for arrhythmia caused by myocardial infarction and was not intended for frail patients at the end of their lives. However, when a hospital patient stops showing signs of life, staff will not know whether this is due to arrhythmia, and the presumption is therefore to resuscitate unless a do not attempt CPR (DNACPR) order is in place. It is vital to make such decisions in advance.

We agree that systems such as the "universal form of treatment options" may provide a better approach than focusing only on DNACPR forms. However, the associated guidance does not seem to have been updated in light of the court of appeal judgment (page 2, point 2: "where you feel a clinical decision has been made, . . . and the patient has shown no indication that they wish to know about resuscitation, we are not encouraging you to have a conversation that you would not have previously had").[3]

Although the current system is not perfect, we believe mechanisms that increase patients' involvement in decisions about their care are likely to be positive, and the law around CPR decisions provides for increased involvement. An absolute definition of frailty is difficult to achieve, and all patients should be approached individually and involved as much as possible in discussions about their care, subject to the caveats in the Tracey judgment.

Zac Etheridge specialist registrar in geriatric medicine, Medicine for Older People, Stoke Mandeville Hospital, Aylesbury HP21 8AL, UK
zac.etheridge@yahoo.co.uk
Emma Gatland barrister, Harcourt Chambers, London, UK

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SOLVING HEALTH INEQUALITY

Inequity of access to NHS healthcare is still a problem

Hawkes argues that, so long after the inception of the NHS, inequalities of access to healthcare over the socioeconomic spectrum must make a trivial contribution to disparities in outcomes.[1] The evidence is clear that this is not the case.

The economic status of a patient's immediate area of residence has a bearing on whether any treatment for cancer is received, and distance between residence and treatment facility affects receipt of radiotherapy or access to surgery for lung cancer. It affects whether the diagnosis is made through emergency admission or elective referral. I summarised the evidence in an editorial,[2] and additional evidence on colorectal cancer has been published.[3]

Registration of all cases of cancer makes it much easier to assess access to care for this group of diseases. It would be naive to believe that poorer patients with other conditions do not face the same difficulties.

The recent publication of guidelines on referral of people with suspected cancer will affect cancer outcome results if it means that access becomes more equal. More resources will be needed for investigations and it is to be hoped that a lot of the work will be done for disadvantaged people. On the other hand, any drive for savings in the NHS that seeks to control demand carries a high risk of disproportionately denying access to people who are not adept at pressing their case for clinical assessment. In times of increasing parsimony in the health service, inequalities are likely to increase.

Epigenetic phenomena are an interesting possibility that might explain some effects of

inequality, but until they are elucidated efforts to ensure equity of access to healthcare must be vigorously pursued in the NHS.

S Michael Crawford clinical lead for research, Airedale NHS Foundation Trust, Keighley BD20 6TD, UK michael.crawford@anhst.nhs.uk

1 Hawkes N. Solving the mystery of health inequality. *BMJ* 2015;350:h3389. (24 June.)

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FDA LETTERS AND SPONSOR RELEASES

From the FDA, we still hear mostly thunderous silence

Lurie and colleagues' comparison of FDA letters not approving applications for new drugs and associated public announcements from sponsors provides a valuable but rare peek behind the Food and Drug Administration's "iron curtain." The discussion section begins, "our analysis found that the FDA's reasons for not approving marketing applications for new molecular entities are not being fully conveyed to the public."[1] On the basis of the striking results, this seems an understatement. Consistent with research using other FDA document types,[2-6] much of the information to which clinicians have access comes to us (or doesn't) only after it's been filtered by vested interests.

Thanks to this excellent paper, we now know that seven drugs had worrying mortality rates. But because this and other results were reported in aggregate and were de-identified, clinician-readers are left in the dark about information that could be crucial to safe prescribing. We can only hope that the FDA exercised due diligence and ensured that any drug related safety signals were prominently disclosed in the product labelling.

Why does the FDA remain silent on such important matters? A key reason is how it has interpreted and implemented exemption 4 of the Freedom of Information Act (see section on policy considerations). In a 2006 article, the lead author of the current paper referred to "the imposing edifice of the confidential commercial information exemption" in an article entitled "Sometimes the Silence is Like Thunder."[7]

The current paper provides a welcome respite from the usual thunderous silence. The referenced Transparency Task Force made several recommendations consistent with a re-interpretation of exemption 4, giving greater consideration to public health relative to drug company interests. But since a 2010 report on public disclosure,[8] there has been little apparent follow-up, raising concerns that the agency is failing to escape its tradition of translucency.

Erick H Turner physician-researcher, Oregon Health and Science University, Portland, OR 97239, USA turnere@ohsu.edu

1 Lurie P, Chahal HS, Sigelman DW, et al. Comparison of content of FDA letters not approving applications for new drugs and associated public announcements from sponsors: cross sectional study. *BMJ* 2015;350:h2758. (10 June.)

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AIR POLLUTION

Wood burning stoves increase global warming with emissions

PHILIP TOSCANO/PA

A comprehensive review identified the misguided nature of favourable taxation for diesel vehicles: "global warming has been negatively affected, and air pollution has become alarming in many European locations."[1] Policymakers did not adequately consider the serious health effects of particles less than 2.5 microns in size ($PM_{2.5}$)—known since 1993 when the Six Cities study was published—and the additional global warming from nitric oxide and nitrogen dioxide, ozone, and black carbon emissions.[1]

Other equally misguided policies continue. Pollution from domestic wood burning is increasing (17% of UK $PM_{2.5}$ emissions in 2013, similar to the 18% from road transport).[2] A new log burning stove emits more $PM_{2.5}$ each year than 1000 petrol cars.

The UN Environment Program/World Meteorological Organization recommended phasing out log burning stoves in developed countries to reduce global warming and dangerous air pollution.[3] Even using sustainably sourced wood, methane and black carbon emissions from a log burning stove cause more global warming than those from a gas heater or electric heat pump.

Despite the concern about nitrogen dioxide, $PM_{2.5}$ are thought to affect more people than any other pollutant—the estimate of 29 000 UK deaths from air pollution relates to $PM_{2.5}$.[4]

Effective policies should aim for the greatest possible reduction in health damage with available resources. London's $PM_{2.5}$ average (15.5 $\mu g/m^3$) is much higher than the WHO guideline of 10 $\mu g/m^3$, now considered inadequate.

London's annual mean PM_{10} from wood burning (1.1 $\mu g/m^3$) far exceeds the predicted city-wide reduction of 0.17 $\mu g/m^3$ from phases 1 and 2 of the Low Emission Zone to reduce traffic pollution.[5] Solving the wood burning problem could generate more benefits for less cost than additional measures to reduce traffic emissions.

Health professionals must explain this to policymakers, so that—instead of repeating past mistakes—future policies use the best, most cost effective ways to minimise damage to public health from air pollution.

Dorothy L Robinson senior statistician and adjunct senior lecturer, University of New England, Armidale, NSW 2351, Australia drd.robinson@gmail.com

4 Hawkes N. Air pollution in UK: the public health problem that won't go away. BMJ 2015;350:h2757. (22 May.)

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SMOKING RATES DURING PREGNANCY

Smoking rates among pregnant women are in fact plateauing

Kmietowicz's headline claims "smoking rates among pregnant women fall to all time low of 11.4%."[1] We expect better both from the government and from *The BMJ*: the figure is actually plateauing (12.0% in 2012-13) and is based on flawed data.

Firstly, the seemingly low numbers refer to "women at the time of delivery" and do not describe smoking during pregnancy.[2]

Secondly, the number of maternities with "unknown smoking status" has doubled from 1.4% in 2013-14 to 3.0% in 2014-15. In nine regional health areas smoking status was unknown in more than 10% of maternities (from 15.4% in Peninsular to 35.7% in Lincolnshire East).[2] Yet these unknown numbers were included as non-smokers in the calculations. If the missing numbers had been counted as smokers (as they should have been), the overall rate would be closer to 11.7%.[2]

Lastly, self declared data are unreliable, especially when considering the shame experienced by women who do not quit despite warnings, which is sadly all too common while quality of care remains poor.[3 4] Exhaled carbon monoxide measurement is cheap, fast, non-invasive, and reliable.[5]

Misinformation from public bodies charged with public health seems to have become common.[6] It must be wrong to give undue support to a government that then masks the absence of comprehensive and effective health policies. Accurate epidemiology and reporting are the cornerstones of effective public health policy.

Alain Braillon senior consultant, University Hospital, 80000 Amiens, France braillon.alain@gmail.com
Susan Bewley professor of complex obstetrics, Women's Health Academic Centre, St Thomas' Hospital, London SE1 7EH, UK

1 Kmietowicz Z. Smoking rates among pregnant women fall to all time low of 11%. *BMJ* 2015;350:h3335. (19 June.)

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