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Instructions to authors appeared in the issue of 2 January 1993, p 55

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Editor's Choice

Is there a doctor in the house?

Most doctors quiver when they hear this question. The public imagines that all doctors can cope with all circumstances, but most doctors have special skills and know that when unsupported by particular staff, equipment, and drugs they can do little. This is especially true of resuscitation—because many doctors have not been adequately taught the necessary skills, and even when they have the skills decay rapidly if not used regularly. This week's *BMJ* contains several papers that look at resuscitation.

Firstly, two authors from Reading show that 29 of 30 candidates for the membership of the Royal College of Physicians neglected fundamental rules of management when presented with a scenario of a hospital patient in cardiac arrest (p 1578). Twenty four had inadequate basic life support skills, 19 used drugs wrongly, and most made mistakes with defibrillation. Most of these candidates passed the exam eventually, and these are the doctors who will often be leading arrest teams. This study joins others showing the poor quality of the resuscitation skills of members of the general public, nurses, medical students, and hospital consultants. A study from the Netherlands shows that resuscitation skills decay within months of initial training and suggests that retraining is needed every six months (p 1576). One of the problems with training is that different organisations teach different techniques. To combat this problem the European Resuscitation Council has produced agreed guidelines on basic life support p 1587) and advanced cardiac life support (p 1589).

One difficulty associated with resuscitation is to know whether to begin or not. Many patients do not want to be resuscitated. A group from Middlesex shows that nurses were often unaware of which patients had "do not resuscitate" written in their notes (p 1577), while two ethicists from London present for discussion guidelines on when to withhold cardiopulmonary resuscitation (p 1593).

Resuscitation attempts to haul people back over the line that divides death from life, but everybody is now aware that the line is nothing like as clear as it once was. Britain has recently seen a great debate over the treatment of patients in the persistent vegetative state, and the courts have decided—as they have in other countries—that it is acceptable to withhold feeding from such patients, meaning that they then die. Keith Andrews was unhappy with that decision, and he today presents cases of people who have shown some recovery from a persistent vegetative state (p 1597) and raises questions about letting such patients die (p 1600). Raanan Gillon, editor of the *Journal of Medical Ethics*, responds (p 1602).

Finally, an even more taboo subject is raised in our personal view column: one male doctor describes how he was sexually assaulted by another male doctor (p 1620). The assaulted doctor writes: "I was physically revolted at the thought of his touching me. I could not comprehend how he could assault me in this way. I was numb from his crass betrayal of our friendship." One central message is that the doctor did not know how to respond to the assault.

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