



Letters are welcome and encouraged. They should raise points of current interest in the care of critical or high acuity patients or address topics that previously have appeared in the *American Journal of Critical Care*. Please be concise; letters are subject to editing for length and clarity. Include your name, credentials, title (optional), institutional affiliation, city and state, and phone number (for verification, not publication). Address letters to Kathleen Dracup, RN, DNSc, School of Nursing, University of California at Los Angeles, Factor Building, Box 956918, Los Angeles, CA 90095-6918; fax, (310) 794-7482; e-mail, ajcc@sonnet.ucla.edu. Correspondence may be sent via eLetters from the journal's Web site, www.ajconline.org.

Orienting and Training Our New Nurse Graduates

What a timely and challenging topic to choose for the July editorial.¹ Great job! This is a subject that calls for careful thought and attention. In our hospitals we have been screaming for more nurses and putting programs in place to fund more students, but the truth is that most of us are unprepared for the impact of these inexperienced graduates in our organizations—especially given the volume increase and the decreasing number of preceptors. The editorial makes an excellent point related to the need to change the way we handle orientation of new graduates.

In fact, I sent the editorial to nonnurse senior management and to directors in my department, as we are currently discussing a “residence” program for inexperienced hires similar to the one you propose. To keep up with attrition from retiring nurses, we estimate that we’ll need to bring in 40 graduates per year. This kind of rapid expansion will require a new strategy to move these nurses from “new hire” to “novice” and to ensure retention along the way.

Your editorial will help move the conversation along in my organization. Thanks so much for highlighting the issue!

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FINANCIAL DISCLOSURES
None reported.

REFERENCE

1. Dracup K, Morris PE. How will they learn? [editorial] *Am J Crit Care*. 2008;17(4):306-309.

DNAR as Default Status: Desirable in Principle, Difficult in Practice

In her recent article, Barbara J. Daly¹ argues for a reversal of the current norm, which presumes that every patient receives cardiopulmonary resuscitation (CPR) unless there is a specific physician order (eg, do not attempt resuscitation, physician orders for life-sustaining treatment) to the contrary.

Specifically, Daly wants to “restrict use of CPR to those patients who provide adequately informed

consent and for whom CPR has a reasonable chance of success (ie, discharge from the hospital without significant impairment in cognitive status).”^{1(p378)} This argument to reverse the default status has been pushed for many years, and I am sympathetic to it. But whereas Daly raises and cogently responds to 5 important objections, she leaves a rather central issue untouched.

That is, she exempts from her proposal those patients for whom there is a “meaningful chance of producing a desirable outcome.”^{1(p379)} But this phrase, like those in her proposal, contains extremely vague and value-laden terms. Specifically, why is “discharge from the hospital without significant impairment” the right measure of success? What exactly is a “reasonable” or meaningful chance? For more than 20 years the medical community has tried and failed to reach consensus on any definition of “quantitative futility” or “qualitative futility.”²

Therefore, while conceptually attractive, Daly’s “indecent” proposal will remain extremely difficult to operationalize until we can adequately answer 3 very tough questions:

1. What is the threshold that defines “reasonable chance of success”?
2. Should CPR even be disclosed as an option to patients below the threshold?
3. Should CPR be provided, when demanded, to patients below the threshold?

Adequate responses to these questions are not imminently forthcoming. At bottom, Daly’s proposal is not so much about reversing the presumption of CPR as about eliminating the inappropriate use of CPR. The former objective is, at least in the short term, far more realistic than the latter.

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FINANCIAL DISCLOSURES
None reported.

REFERENCES

1. Daly BJ. An indecent proposal: withholding cardiopulmonary resuscitation. *Am J Crit Care*. 2008;17(4):377-380.
2. Pope TM. Medical futility statutes: no safe harbor to unilaterally refuse life-sustaining medical treatment. *Tenn Law Rev*. 2007;71(1):1-81.

Response:

I appreciate Dr Pope's thoughtful comments about my "indecent proposal."¹ I fully agree that making an actual change to the current default status of full attempts to resuscitate in every instance of cardiac arrest will indeed be "difficult to operationalize." However, I think the primary difficulty is in challenging the very deep-seated reluctance among health professionals to recognize the limits of technology and to engage in meaningful discussions with patients and families about goals of care and judgments about effective vs ineffective interventions.

The challenge of determining what constitutes a meaningful chance of success of CPR is no different than the task of every clinician who must decide when and if a high-risk procedure in life-threatening conditions should be recommended or even offered. Clinicians accomplish this every day, with varying degrees of certainty and comfort.

I do want to clarify that I do not propose "exempting" any patients from this proposal. Rather, the most important aspect of the proposal is simply the requirement that a decision to withhold CPR or to use CPR when cardiac arrest occurs be made explicit—with fully informed consent—for all patients.

The complexities of identifying acceptable outcomes and judging when and how to hold these discussions with patients and families, as well as how to respond to requests for ineffective therapies, are, as Dr Pope notes, daunting. But reversing the presumption for CPR would, at least, be a step in the right direction.

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FINANCIAL DISCLOSURES

None reported.

REFERENCE

1. Daly BJ. An indecent proposal: withholding cardiopulmonary resuscitation. *Am J Crit Care*. 2008;17(4):377-380.