# Ethical attitudes of non–intensive care unit clinicians upon end-of-life issue: more training is necessary

*To the Editor*—We read with interest the article by Yap et al,[1] comparing the ethical attitudes of intensive care physicians in Hong Kong with that of European countries. We have also conducted a questionnaire survey in January 2004 on the ethical attitudes on 'do-not-resuscitate' (DNR) orders of clinicians outside intensive care unit (ICU), including both physicians and surgeons, in our hospital. That was carried out to examine their views and existing practice, particularly on their willingness in using a DNR form developed in accordance with the guidelines of the Hospital Authority.[2] Totally, 86 completed questionnaires were received, with an overall response rate of slightly above 50%.

One of the major findings from our survey is that more clinicians from medical specialties than surgical specialties have ever used the form and issued DNR orders (surgical 58.3% vs medical 90.2%, $\chi^2(3)=16$, $P<0.001$). Compared with the finding of Yap et al,[1] where 95% of ICU physicians gave verbal or written DNR orders, it seems that the practice of DNR for medical non-ICU clinicians is similar to that for ICU physicians. Another interesting finding is that clinicians of Department of Medicine with experience of 8 years or more are more successful in convincing the relatives to accept DNR ($\chi^2(3)=7.93$, $P<0.05$), though that was unrelated to their ranks. The respondents widely accepted that when managing patients decided for DNR, morphine can be administered for the relief of respiratory distress (82%), with no further invasive procedures (78%) or intubation (100%). However, the degrees of acceptance for administering broad-spectrum antibiotics (21%) and blood product transfusion (32%) are more divided in these scenarios. Clinicians with less than 8 years' experience had less agreement with regard to the giving of antibiotics to patients decided for DNR ($\chi^2(4)=17.8$, $P<0.001$), while more medical clinicians agreed with regard to blood transfusion ($\chi^2(4)=11.9$, $P<0.05$).

In our survey, 34% of respondents had experienced unhappy encounters during their discussion with relatives of patients over the DNR issue, the percentage was not associated with clinical experience and specialty. Fifty percent of respondents would refrain from using the form if relatives were demanding. The difficulty has also been discussed by Yap et al[1] and our findings have echoed their identified importance of family involvement in such decision-making in Hong Kong. That also highlighted the importance of communication skills in this area, and it was found that 73% of respondents suggested that more training was necessary for junior staff and 38.5% would actually prefer to have more training themselves.

'Do-not-resuscitate' orders are not just a clinical decision for intensivists. Our study has also illustrated the views and practice of a group of non-intensivists working in general wards. Another study on internists showed that clinicians were more likely to give order on withdrawal of support if they had more time in clinical practice, more contact with ICU patients, or were specialists.[3] As a result, we totally agree with Yap et al[1] that more ethical training in end-of-life issues is necessary.

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2. Hospital Authority Working Group on Clinical Ethics. HA guidelines on life-sustaining treatment in the terminally ill. Hong Kong: Hospital Authority; 2002.
3. Christakis NA, Asch DA. Physician characteristics associated with decisions to withdraw life support. Am J Public Health 1995; 85:367-72.

# Prescribing information for medicines containing codeine for use in infants

*To the Editor*—This letter is in response to a case report published in the *Hong Kong Medical Journal* titled "A case of probable codeine poisoning in a young infant after the use of a proprietary cough and cold medicine".[1] The infant in this case was 3 months old.