Towards a definition of the dying patient: A response to Baylis

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In our article "Eligibility for CPR: Is every death a cardiac arrest?",[1] we suggested that it might be ethical for a physician to write a "Do not resuscitate" (DNR) order in a chart without discussing it with the patient if that person was expected to die because of irreversible and untreatable disease, and was not having a cardiac arrest. To that end, we proposed a set of criteria that might allow physicians to distinguish between a "dying patient" and a "patient suffering a cardiac arrest".

We drew this distinction because of the ineffectiveness of cardiopulmonary resuscitation (CPR) in the case of patients dying of terminal illness. We deliberately focused on objective, disease-related criteria and excluded from our discussion all mention of quality of life or financial cost.

Françoise Baylis,[2] PhD, has written an interesting response in *CMAJ*. She suggests that if there is any chance, however small, of life being restored to the patient, the patient has a right to the intervention, regardless of how brief and miserable that restored life may be. We do not disagree with this, and nothing in our article suggested that we did. However, as Baylis stated, if "specific treatments that in specific instances . . . are known to be completely ineffective — as when there is no chance of restoring cardiac output for a given patient by means of CPR — then it is certainly true that the physician is not required to provide such therapy".

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The latter point was, indeed, the sole and central point of our article. CPR was introduced as an emergency treatment for cardiac arrest and Baylis has failed to note our attempt to define "the dying patient". She states that we "failed to distinguish between a life that cannot be saved and a life that, in their opinion, is not worth saving". This is untrue. In fact, we are deliberately trying to make that distinction. We wish to define a group of patients for whom CPR is totally ineffective and for whom physicians should not be required to provide it.[3,4]

Baylis has fallen into the trap of regarding CPR as a treatment for all deaths, one capable of restoring life in any clinical setting, even if for only a brief period. CPR was not introduced for that purpose. Long-term follow-up series of patients who received CPR specifically exclude dying patients, and current American Medical Association guidelines for CPR state that the procedure should not be performed on patients whose deaths are expected within 14 days.[5]

We suspect Baylis may be responding to the time frame in which the death is expected. One of us (R.B.) mentioned at a con-

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ference that this period could be as long as 90 days, the maximum length of predicted survival allowed for patients applying for palliative care. However, we would not propose to use 90 days as a criterion for writing a DNR order. As a profession, we might feel more comfortable with 14 days, in line with the US guidelines, or even 3 days, in line with the views of certain religious groups. The exact definition of "a short time" can be a matter for debate or discussion — the ethical argument is not affected by this time limit.

Incidentally, Baylis introduced another element of confusion in her discussion of cardiovascular catastrophes such as ventricular rupture, massive embolus or ruptured aneurysm. Although it is true that the chance of restoring cardiac output in these circumstances is low, these patients suffer a clinical cardiac arrest — sudden and unexpected cessation of cardiac output. Since the cause cannot be determined before commencing CPR it would be unethical to withhold it. It may be stopped once it has proven ineffective, and there are well established guidelines for making this clinical decision.[6] There is, however, a great difference between stopping CPR that is known to be ineffective in a cardiac arrest, and not starting CPR for a patient who is dying. To confuse the two implies a remote understanding of the clinical situations in which CPR is, or is not, used in daily medical practice.

Finally, in our article we used the word "contraindicated" erroneously, and Baylis repeated and compounded our misuse. "Contraindicated" implies that a treatment worsens the patient's condition, while "not indicated" implies that it is of no benefit. Our view is that CPR is not indicated for the dying patient. We would like to see the medical profession attempt to define dying in order to identify the patients for whom CPR is not indicated.

We seem to be living in a society that has great difficulty in accepting death. Perhaps it would be healthier for society, and for our profession, to acknowledge that there is such a thing as death and that we do not have to and should not pretend to attempt the impossible.

References

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