lar, the excellent editorial in the *New England Journal of Medicine* suggests, after reviewing the other articles to which he refers, that we should not rely on the possibility of false-positive results as an argument against mandatory HIV antibody testing, because even if the rate were acceptably low such testing is not justified. The editorial concludes: "At present . . . voluntary testing, accompanied by counselling . . . is the approach most consistent with the information at hand". Parker has either not read or misconstrued the arguments in this editorial — and, indeed, in my article. One can only hazard a guess as to why this would occur, and I do not wish to attribute motives to Parker. However, it is not uncommon for us to allow personal values, attitudes and beliefs to colour our responses to AIDS and, for example, to read an article as stating what we would like it to state rather than what it does state. It is not enough that we act in "good faith" in entering the debate surrounding AIDS: we must also act non-negligently. But, most importantly, we must enter with open-mindedness and a spirit and approach of active tolerance.

Parker is correct that some of my propositions (for example, the suggestion that HIV-antibody-positive immigrants could contribute more to the economy than they would cost in terms of health care) cannot be ascertained with any accuracy. But neither can propositions to the contrary. When faced with such uncertainty we must choose which of the two alternative propositions should form the basic presumption from which we work. This proposition will then govern until displaced by proof that it is not accurate. Parker proposes a presumption against allowing the entry of HIV-antibody-positive people. I propose the opposite presumption, on the basis that it does not appear to involve undue harms, risks or costs and, most importantly, best promotes a position of humanity and respect for human rights.

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Reference

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Resuscitation of the terminally ill

In her recent article[1] Dr. Françoise E. Baylis takes issue with Drs. Robert Buckman and John Senn's recommendations on eligibility for cardiopulmonary resuscitation (CPR).[2]

Buckman and Senn argued that if no benefit is expected from therapies such as CPR in a specific group of patients, such as those with terminal irreversible illnesses, then the treatment should not be provided or offered. They suggested that patients suffering from irreversible, fatal conditions who are receiving palliative care and in whom no curative intervention is being carried out or planned fit into this category. Baylis challenges this concept and argues that even if the chance of CPR's being successful is infinitesimally small, and even if death may be postponed only for a very short period, the decision to have CPR belongs to the competent patient, regardless of whether the patient is receiving palliative care.

Although Baylis raises the issue of allocation of scarce resources, she appears to feel that physicians should have no say in this but must blindly follow the wishes of the patient. It is of interest that she agrees that a physician is not required to provide therapy contraindicated on medical grounds. However, the only contraindications she appears to accept for CPR are "a seriously ruptured myocardium, a pulmonary artery completely filled by embolic material or a seriously ruptured abdominal or thoracic aortic aneurysm". She ignores the fact that CPR was introduced as an emergency treatment for acute cardiac insults, and she does not seem to accept the very real distinction between a cardiac arrest that can respond to CPR and death occurring in terminal progressive illnesses with multiorgan failure.

Of most concern is her lack of understanding of palliative care. Palliative care consists of a multidisciplinary approach to the provision of care, with comfort and support provided through excellent symptom control. It avoids injudicious invasive investigations or treatments that will have no measurable benefit for the patient. In discussion of the prognosis of a terminal illness with patients and families the goals of such palliative treatment can be clearly outlined and acceptance of these goals obtained. However, Baylis insists on discussion of inappropriate treatment in all cases, which, as Buckman and Senn rightly said, is both inhumane and unconscionable.

Baylis seems to feel that physicians, nurses and other health care professionals have no rights in these matters but must perform interventions at a patient's request even when they regard these as inappropriate both medically and ethically. She also does not seem to understand that physicians have to make decisions regarding allocation of resources on a daily basis. If these resources are used inappropriately, patients with reversible and remedial conditions will die.

The real issue is the appropriateness of "Do not resuscitate" (DNR) orders, which are as much for the medicolegal protection of staff as for the benefit of patients. I have argued that these are not applicable to institutions providing long-term care, and in view of this current discussion their role in acute care hospitals requires careful re-examination.[3]

The management of terminally ill patients can be much improved. Such improvement will be hampered if credence is given to Baylis's recommendations.

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Dr. Baylis seems to suggest that DNR orders be discussed with terminally ill patients such as the one described by Buckman and Senn. She states that if there is any chance that CPR may be effective, even if that chance is infinitesimally small, the decision about resuscitation rightly belongs to the patient or a legal guardian. One could take this argument to its logical extreme and ask whether one should discuss with a 90-year-old patient who has end-stage heart disease whether he or she would like to have a cardiac transplant. Another example would be discussing liver transplantation with someone who has malignant disease metastatic to the liver only. In both cases the chances of survival would be very small, but as death may be postponed for a little while should transplantation therefore be offered? My feeling is that most physicians would not discuss those particular options with such patients.

My other concern is that there is now a widespread feeling that patients who die in hospital do not die but have cardiac arrests. If the patient described by Buckman and Senn were in a nursing home or other treatment facility he would have been allowed to die without any such discussion. Many patients with terminal illnesses are admitted to hospital because the family or the patient cannot cope at home; management in these cases is designed to ease suffering. If it were possible to manage these patients at home should CPR be discussed? If our answer is Yes and the patient would like to have CPR, should we then abandon home care and have the patient admitted to hospital so that this form of therapy could be applied?

For those few patients Baylis has described who may want to live a little longer so that, for example, they might attend a daughter's wedding, my experience is that they would discuss this with their primary care physician, and that is the time I think it appropriate to have a frank discussion about the benefit, if any, of CPR.

Although I agree with Buckman and Senn, I do feel that if a DNR order is written without discussion with the patient it should only be done by a physician having some relationship with the patient and after treatment options have been discussed. If these discussions are held periodically with the patient during the preterminal phase it is my experience that the issue of resuscitation is never raised by patients or relatives.

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[Dr. Baylis responds:]

Dr. Fisher objects to the idea that physicians "must blindly follow the wishes of the patient". I object to the idea that patients must blindly follow the wishes of the physician. The compromise I suggest is that physicians discuss with competent patients, or the legal guardians of incompetent patients, the benefits and harms of all available therapeutic options (including CPR) that are not medically contraindicated and that physicians obtain informed consent for the patient's or guardian's treatment of choice. I am concerned that this option seems unpalatable to some.

As to the specific criticisms Fisher raises, I do not, as he suggests, maintain that the only contraindications for CPR are "a seriously ruptured myocardium, a pulmonary artery completely filled by embolic material or a seriously ruptured abdominal or thoracic aortic aneurysm". This is a serious misreading of my article: these instances were listed as *examples* of situations in which CPR would be medically contraindicated.

Fisher also expresses some concern regarding my lack of understanding of palliative care. I well understand that the overriding objectives of palliative care are the enhancement of the last days of living and the provision of a good death. Pursuit of these objectives could, of course, mean no resuscitation. My concern is that some patients in palliative care may not understand this. Fisher writes that "in discussion of the prognosis of a terminal illness with patients and families the goals of such palliative treatment can be clearly outlined and acceptance of these goals obtained". I maintain that if palliative care precludes CPR, then the informing process for palliative care must include a discussion of, and consent to, a DNR order.

Finally, contrary to what Fisher implies, I am very aware of the problem of resource allocation. I do not believe, however, that physicians "have to" or even should be deciding which lives to save on economic, as opposed to medical, grounds. These are decisions for society to make. On this point, I repeat that "until and unless society . . . decides that