

## CPR is Obsolete and it's Time for the Peaceful Death

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In 1974, in response to an ongoing epidemic of middle-aged men dying from coronary artery diseases (CAD), the Standards of Cardio-pulmonary Resuscitation (CPR) and Emergency Cardiac Care (ECC) were first published. At that time, medical therapies, coronary care units (CCU), coronary artery catheterization and coronary artery bypass grafting (CABG) for CAD management were being developed and promulgated. These circumstances resulted in the widespread training of the general public in Basic Life Support (BLS) and universal training of clinicians in Advanced Cardiovascular Life Support (ACLS) encountering unresponsive patients. According to this training as a standard of care CPR must be initiated by default for all unresponsive patients unless an 'order not to resuscitate', a.k.a., 'DNR order', was written.

Paradoxically, even though developed for middle-aged men with coronary artery disease, CPR was and is provided to all unresponsive patients without DNR orders regardless of age and diseases even though there was and is no evidence of its benefits for their non-CAD conditions. Most all of these unresponsive non-CAD patients are pronounced dead after the 'violence' of CPR and those who responded continued experiencing 'violence' in ICU's before being allowed to die (frequently by 'pulling the plug') from their non-CAD diseases. Only a few who experience CPR ever leave the hospital alive and even fewer are well when they leave.

In an early attempt to mitigate these conditions, an alternative to DNR orders [1] was published and demonstrated to significantly reduced CPR rates without increases in mortality [2] but its use never become widespread. In practice and in the absence of DNR orders, CPR became and remains a 'rite of passage' for most unresponsive, dying patients.

Unfortunately, at that time medical themed television programs misinformed the public by showing CPR as a few minute event occurring before a commercial and showing a fully recovered patient after the commercial. They rarely, if ever portrayed, real clinical CPR which is long, chaotic, violent, gruesome and largely ineffective.

Eventually, it was shown that the benefits of CPR were dismal even in patients with CAD and sudden cardiac death and the 'Standards for CPR became 'Guidelines.' Instead, emergency cardiac defibrillation and Emergency Department (ED) to catheterization laboratory transfers within 45 minutes for interventions for acute heart attacks are now the standard of care.

Yet, CPR remains mandatory in all unresponsive patients unless there is a DNR order. Regrettably, since clinician and patient end-of-life discussions are rare, DNR orders are frequently missing and patients are receiving CPR even when it is obviously medically ineffective and of no medical benefit. Fortunately, from their past experiences with their parents and families, the ineffectiveness of CPR and subsequent futile care has not escaped notice by current patients and their surrogates resulting in their ready acceptance or requests for DNR orders and resulting in a lot less futile care.

Ironically, most physicians rarely see heart attacks nowadays. In fact, the majority of CAD patients have medical management and interventions like stents even before they have a heart attack. These have become the norm and are great advancements in the management of CAD. Currently, most patients dying of cardiovascular disease are dying from recalcitrant-to-treatment, advanced disease.

So, CPR for all unresponsive patients is now obsolete. CPR should be restricted to very specific and rare circumstances such as known heart attack patients awaiting interventions or induced cardiac arrests in catheterization laboratories. It should no longer be a 'right of passage' for all dying patients especially for those dying of recalcitrant-to-treatment, advanced cardiovascular diseases.

Death is the only prerequisite for life! If it cannot die, it is not alive. So, the question is not 'if' death will occur but 'when' will it occur and under what circumstances. Albeit mostly passive, the good death, i.e. euthanasia, is almost universally desired. For some in States where it is legal, active euthanasia is available in very restricted situations. Hospices' and Palliative Care whole bases for being is to provide for the passive good death. Done right, death can be peaceful and should always be the goal of end-of-life care.

In this day and age, the default clinical status should be 'No CPR' for all patients in whom death is not unexpected. When medically appropriate and deemed medically effective, an order to 'Do CPR' should be written.

Just desiring or demanding CPR is not justification for its provision when it is medically ineffective and futile. It is key to remember that a patient or surrogate 'Do Everything!' directive means 'Do Everything That Will Help!' Very rarely do patients or their surrogates want or demand medically ineffective interventions that will not help.

Universal CPR training for all clinicians should be stopped since it is time consuming, wasteful and few clinicians do enough CPRs to remain proficient. Instead a 'CPR Team' for the facility should be trained and a 'CPR Team' identified and readily available as needed on a 24/7 basis.

In summary, many believe that CPR is a medically effective intervention and yet it is in only a very few of limited clinical circumstances. Yet, in most circumstances it is a medically ineffective intervention and medically inappropriate. Clinicians should only recommend and provide interventions that are medically appropriate and effective. Thus, CPR should NOT be routinely offered when it is considered medically inappropriate. Instead, a peaceful and, if possible, a meaningful death for the patient and their family should be the goal of care.

### Bibliography

1. Davila F, *et al.* "Patient care categories: an approach to 'do-not-resuscitate' decisions in a public teaching hospital". *Critical Care Medicine* 14.12 (1986): 1066-1067.
2. Davila F. "The Impact of Patient Care Categories on Cardiopulmonary Resuscitation and Ventilator Support". *Archives of Internal Medicine* 156.4 (1996): 405-408.

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