Apropos of "The moment of death whilst in Internal Medicine hospitalization"

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The above-mentioned article, by Luísa Magalhães et al,[1] published recently in the journal, provides an important stimulus for reflection on some less attractive aspects of our hospital practice. Even so, we raise some questions. Firstly, the title refers to the "moment of death" but the text appears to concentrate on cardiorespiratory arrest (CA). Now, in many deaths in our wards, the doctor is called to ascertain the death, and this is not necessarily a CA, a situation in which immediate and coordinated action of the medical team could save the patient, albeit often for a very short and inglorious period.

The Authors (AA) reviewed 403 of the 438 deaths that occurred in a three-year period, but do not explain the exclusion of the remaining deaths. The high percentage of patients who, at the moment of death, already had a DNR (Do not Resuscitate) order in place (86.4%) is probably the result, in part, of cases where this order was added during a doctor's call due to deterioration of the patient's condition in the last hours of life. At any rate, it is a significant percentage compared, for example, with the reality of the hospital in which we work, where there appears to be no drama whatsoever caused by the absence of a DNR order in so many patients who obviously should not be resuscitated.

Curiously, the article does not clarify the proportion of cases in which there was no call for CPR by the emergency or residence doctors; we are merely told that in three cases with this indication, cardiopulmonary resuscitation (CPR) was attempted.

It seems to us authoritarian and somewhat gratuitous to state that 'In contemporary Medicine, it is not admissible that the possibility of death during hospitalization is not foreseen; the exact moment is not anticipated and its warning signals are not identified". In fact, the possibility of death of a patient admitted for a pathology or acute decompensation is always in the mind of any trained doctor; but it seems obvious that in many cases, the moment cannot be anticipated; finally, the identification of warning signals often does not lead to any attitude with the purpose of saving the patient's life, because the prognosis is not affected by this attitude, which could even lead to the onus of potential futility or "obstinacy". What is very clear, therefore, is that we agree on the need to identify the above-mentioned signs, because even in cases where there is a DNR order, the survival of some patients can depend on the immediate provision of competent medical care.

The AA state that "the low percentage of patients with indication for CPR manoeuvres is an indicator of the complexity of the patients". It is not "extreme clinical complexity" that leads to the indication of DNR, but rather, the convergence of extreme severity of the pathology, or complications, often in elderly patients, with multiple and advanced comorbidities, that leave them in a situation of extreme exhaustion of their capacity to resist, and often very close to multiple organ failure. The complexity, in itself, is a challenge for any internist, as the AA certainly demonstrate in their day-to-day clinical practice.

Finally, we give special emphasis to the near-perfect regularity/randomness of deaths over the 24 hours of the day and seven days of the week, which is in contrast with the majority of series published on this subject. It appears to us that these results accredit the quality and dedication of the internship program, as well as the nursing of the Service in which the AA work. ■

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References

Luísa Magalhães, Arlindo Guimas, Sofia Ferreira et al. O momento da morte no internamento de Medicina Interna. Medicina Interna 2009; 16: 205-210.