etry saturation of 97%. The patient’s family visited shortly thereafter and noted that the nursing staff had posted a patriotic red, white, and blue sign over his bed:

“Danny was liberated from the ventilator on Independence Day, July 4, 1996 at 4:00 P.M.!”

Credit must be given to the nurses in their recognition of the positive spirit of “liberation,” rather than “weaning” from a ventilator. The word liberation hits the mark better, adds enthusiasm to the cause, and supplements the vigorous efforts in caring for a difficult group of patients. Indeed, Danny’s fight for life on Independence Day can be equated to the courage of our forefathers in their struggle for freedom. Our country and Danny were liberated, both are strong, and hopefully as with our homeland, Danny’s future will be as promising.

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REFERENCE

1 Brandstetter RD, Tamarin F. Weaning is demeaning. It’s time for liberation. Chest 1992; 101:1488

From CPR to DNR

The Return of Death With Dignity

To the Editor:

Today, in hospitals, it seems no one ever faints anymore. They suffer either respiratory or cardiac arrest and a “code” is called. The hospital is galvanized into furious activity and CPR (cardiopulmonary resuscitation) begins on the hapless victim.

However, this is an improvement over what used to happen about 25 years ago. The medical profession was then zealously trying to prevent patients (and also presumably healthy people) from dying suddenly. Sudden death was taken as an affront, a sign of disrespect to the medical profession. Patients were supposed to die with medical consent and supervision—not suddenly, on their own.

This medical attitude spawned an extensive national educational campaign encouraging and exhorting physicians to immediately open the chest and “massage” the heart of anyone who “died” suddenly. This assault on the chest usually was carried out in hospitals but occasionally a television screen showed an ambulance intern busy doing open-chest cardiac “massaging.”

In those dangerous days, fainting when in a hospital became extremely hazardous. One might awaken to find his or her chest wide open with a tube in their windpipe. As a precaution, at that time, I had tattooed on my chest (in five languages), “DO NOT OPEN: I HAVE ONLY FAINTED.”

Just previous to this “open” era, a needle with adrenalin was sometimes stuck into the heart—a not so Draconian therapy—and occasionally it worked.

Fortunately, however, after some years, the chest was no longer opened, but instead, as at present, it was pounced upon and rhythmically compressed, together with mouth-to-mouth ventilation—so-called “closed” CPR. This relatively mild assault (compared to the open-chest maneuver) became so fashionable and widespread that no one in a hospital could die without these medical last rites. Not only those who fainted were “coded,” but much worse, also those who were dying reasonably comfortably and quickly of a terminal illness. Due to medico-legal technicalities, nurses and physicians were forced to participate in this frenetic medical tour de force. Sometimes, a terminally ill patient had to die two or three times before being allowed to do so permanently. Even Ann Landers received a letter from a bereaved widow complaining about the assault on her late husband. She wrote, “While a patient in the hospital, my husband’s heart stopped. An emergency team rushed in and worked feverishly to resuscitate him. They succeeded. Sounds wonderful? Well, not exactly. The dear man was 86 years old and had terminal cancer. He lived another three days in agony.” (September 1, 1980)

Recently, however, help has arrived with the warning of DNR (Do Not Resuscitate). This command has been made possible by some changes in the medico-legal pressures and by some clearer, deeper, compassionate thinking. It is now possible once again to die peacefully and quickly, in some hospitals, provided the patient or the responsible family member has made the situation clear with the nurses, the doctors, the hospital administrators and the commissars in Albany. Another factor may be that some astute lawyers, in cases of unauthorized CPR, may claim that this is assault and battery.

Televised has influenced the public with its dramatic versions of ER, Rescue 911, and Chicago Hope programs. The New England Journal of Medicine, June 13, 1996,3,5 carried two articles—one stating that the results of CPR on television are portrayed and presented as much better than the actual results as reported in the medical literature. A somewhat dissenting opinion was given in the accompanying article which stated, “Physicians need to make a concerted effort to discuss this difficult topic openly with all their patients.”

And, in the same month of June, CHEST carried an editorial entitled, “CPR or DNR?” with the subtitle, “Lessons from Buddha.”4 This is an excellent editorial and presents another endorsement of DNR when appropriate.

In conclusion, today, in the hospital or even on the streets, it may still be difficult to die a peaceful, quick, dignified death. The medical profession and the laity are still reluctant to accept death (and even old age) as a natural, inevitable phenomenon, and not as a challenge to the medical and nursing profession.

Incidently, I now wear a metal bracelet on my wrist with the inscription, “Do Not Resuscitate,” and soon I may add, “Or Resuscitate.”

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REFERENCES

1 Landers, Ann. Living wills are more discussed than used. Utica Observer Dispatch, Sept. 1, 1990

Cervical Collar in Sleep Apnea

To the Editor:

We report the case of a woman with severe obstructive sleep