Title

Response to Cohen and Germain: Defining a Good Death

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Response to Cohen and Germain: Defining a Good Death

TO THE EDITOR:

We appreciate the opportunity to respond to the points that Drs. Cohen and Germain have raised. First, we commend these investigators on their important work in end-stage renal disease and palliative medicine, highlighting the value of discontinuing dialysis earlier in a patient's treatment trajectory as a means of reducing suffering and thus allowing for a good death.[1,2] We applaud their prospective study design to determine whether dialysis discontinuation increased quality of life and decreased unnecessary suffering.[2] Additionally, we compliment these authors on their poignant case study of a patient who chose to discontinue his dialysis, seeking a good death, and preferring *quality* of life over *quantity* of life.[1]

The reason for our not including these articles in our review[3] was that they did not meet our selection criteria. As we stated in our article, ". . . there are far fewer studies that have specifically defined, rather than conceptualized, what a good death is according to patients, family members, and health care providers (HCPs). The goal of this paper is to review the literature that examined the definitions of a good death from the perspectives of such patients, their family members, and HCPs" (p.262). Of the three articles by these investigators that were cited in their letter, one is a description of the renal palliative care initiative[4] and one is a case study of a 73-year-old man who voluntarily decided to terminate his dialysis and died 11 days later.[1] As can be seen in Figure 1 of our article, we had chosen to exclude "10 clinical case reports" because these reports conceptualized components of a good death from the author's perspective but did not specifically define good death according to the individual. Similarly, the study of 11 patients who discontinued dialysis and died subsequently[2] was excluded because the definition of good death used therein was researcher-derived rather than provided specifically by patients, their family members, and HCPs. Nonetheless, we are pleased to note that several factors associated with good death in our review were common to those reported by Drs. Cohen and Germain, that is, being pain-free, process of death (brevity and place of death), existential factors, and presence of loved ones.

Drs. Cohen and Germain have conducted valuable research in end-stage renal disease and in developing tools such as the Dialysis Quality of Dying Apgar.[4] We share with them the goal of ensuring that patients have a good death by reducing unnecessary aggressive treatments that often prolong life but diminish quality of life. We too believe that further defining what constitutes a good death is an area of increasing importance for the medical community as well as for the general population.

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