

End of Life Rituals: The Beneficence of Futile Cardiopulmonary Resuscitation

YAŞAM RİTÜELLERİNİN SONU: BOŞUNA KARDİYOPULMONER RESÜSİTASYONUN YARARI

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Summary

Since the Enlightenment, medical culture has been progressively transformed by new science, a medical industrial revolution, and the emergence of a modern medical technocracy in many parts of the world. As physicians don the miter of this technocracy, they may trivialize the cultural, medical, and religious rituals that were once the mainstay of the healer's art. In the wake of discarded ritual, a monotonic focus on science has stifled healing and nearly eclipsed humanistic and religious acts of caring. Since the Art of medicine has become the Science of medicine, patients also see technology as a normative and integral component of the medical encounter, especially at the extremes of life. In addition to its obvious role in preserving and enhancing human physiology, resuscitative technology itself may have a transcendent and as of yet largely unrealized role in the healing process. While the archetypal performance of cardiopulmonary resuscitation (CPR) may parallel many older rituals, such technology is only a surrogate for true caring. As occasional cleric and scientist, the consummate clinician must promote their patient's interest first, and ultimately, balance the bivalent utility of CPR by recognizing both the value of its art and the limits of its science.

Key Words: CPR, ritual, ethics, resuscitation, beneficence

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Özet

Aydınlanmadan beri, dünyanın birçok yerinde tıp kültürü; yeni bilim, tıbbi endüstri devrimi ve modern tıbbi teknokrasinin aciliyeti tarafından gittikçe artan biçimde değiştirilmektedir. Bu teknokrasinin baş tacı olan hekimler, hekimlik sanatının kültürel, tıbbi ve dini ritüellerini önemsizleştirebilirler. Ritüellerin atılması sonucunda bilimde tekdüze odaklanma, iyileştirmeyi engellemekte ve bakımın insancıl ve dini yönlerini hemen hemen gölgede bırakmaktadır. Tıp sanatı tıp bilimi haline geldiğinden beri, özellikle hayatın uç noktalarında hastalar da teknolojiyi tıbbi zorlukların normatif ve bir bütünün ayrılmaz parçası olan bir unsur olarak görürler. İnsan psikolojisini koruma ve yükseltmedeki bu açık rolüne ek olarak, resüstativ teknolojinin kendi başına, iyileştirme sürecinde doğaüstü ve çoğunlukla hala gerçek dışı bir rolü olabilmektedir. Kardiyopulmoner resüstasyonun (CPR) arketipik performansı, doğru bakımda sadece başkasının yerine kullanılan teknolojiye olduğu gibi bir çok eski ritüellerle benzerlik gösterir. Bazı zamanlarda bir papaz ve bilim adamı olarak kanımca, mükemmel bir klinisyen, hastasının yararına öncelik tanımalı ve eninde sonunda hem sanat değeri, hem de bilimdeki sınırlarını göreberek kardiyopulmoner resüstasyonun yararını dengelemelidir.

Anahtar Kelimeler : CPR, ritüel, etik, resüstasyon, yararlılık

*"Tantum ergo sacramentum **

Veneremur cernui;

Et antiquum documentum

Novo cedat ritui."

Introduction

Caring rituals have been an essential component of life in the animal kingdom since the beginning of time. Cats lick each others wounds, primates groom one another, and

and *homo sapiens* bury their dead. Before death, of course, there are many guidepost rituals performed across the human lifespan that signal important life events from the cradle to puberty, to marriage, to the grave. The cultural significance of ritual is varied and depends greatly upon the meaning humans bring to their world. Civic, religious, and social structure connects to existential notions of life's meaning and purpose.¹ Certain rituals may provide a sense of comfort and constancy amid change, an emotional guarantee of future well-being,² and may serve to relax participants during times of upheaval or social or physical transformation.³ New Age thinkers have argued for a return to ritual, arguing that rituals may serve to "animate life with a certain level of enchantment."⁴ There is great symbolism in archetypal rituals, especially those at the end of life that are often conserved across cultures.

* Attributed to St. Thomas Aquinas, 1225-1274. Translation:

We come before him bending,
This great sacrament reverse;
We have filed the old,
Now the newer ritual is here.

A prominent modern ritual today both inside and outside the medical- industrial complex is that of cardiopulmonary resuscitation or CPR. Rarely successful, CPR, like other end-of-life rituals, may serve a host of other important psycho-social, religious, and non-medical functions for both the dying patient and their loved ones present. In this paper, a connection between ancient healing rituals and the modern ritual of attempted resuscitation will be established and then compared; finally, the question of ethical justifications for using technology as a surrogate for caring will be explored.

Cardiopulmonary Resuscitation

In spite of 40 long years of resuscitation science, the outcomes remain dismal, as only 1% -20% survive an out-of-hospital arrest.⁵⁻¹⁰ Initiation or termination of resuscitation efforts, like all clinical decisions, connotes a multifactorial process that in turn, is dependent upon micro, meso, and macro influences.¹¹ At the micro level, provider comfort and experience as well as patient prognosis, desires, and prior expressed wishes and values all have a role.¹²⁻¹⁵ At the local or meso level, there are important hospital, EMS, and emergency department culture, protocol, and resource issues that come to bear on the resuscitation decision.^{16,17} Finally, at the global level, there are overarching guidelines promulgated by national and international bodies such as the American Heart Association, the European Resuscitation Council, the International Liaison Committee on Resuscitation and others that reflect changing standards of care, global interpretations of utility, resource availability, and the emerging science.¹⁸⁻²²

Frequently missing from the decisions to initiate or forego the resuscitation ritual are discussions of how patients and their families will be cared for on a more human level. All too often, orders are written that memorialize a decision not to initiate CPR and with these orders there is a common unspoken subtext that *nothing* need be done to or for the patient so marked. These DNAR-branded patients are also removed from ICU and generally left to languish with less nursing time and less caring altogether.

Decisions around the use, avoidance, or cessation of resuscitative technology have added meaning today and should not be taken lightly. *Decide* is from the old Latin, *decidere*, to cut off, to determine, as well as *caedere*, to cut. This etymology is revealing, as one is literally cutting off any chance of additional life when making the ultimate decision to withhold cardiopulmonary resuscitation (CPR). The decision to withhold CPR within the context of the latest recommendations from science fail to recognize unmeasured forces at the bedside and the consequences to families of a patient being “put out to pasture” that may also impact this decision.

When CPR is begun, the termination of resuscitative efforts is itself a momentous decision. Indeed, the word “termination” has grave connotations, defined by Merriam-Webster’s Collegiate Dictionary as “end in time or existence.” It is this sisterhood with death that makes termination an important cultural and social and religious event. Since all decisions to stop resuscitation, of course, end in death, they must directly or indirectly involve the only profession in Western society uniquely vested with the power to determine death: physicians. In spite of this endowment, physicians are often struggling, like William Faulkner’s Dr. Peabody in *As I Lay Dying* to understand death itself, and thereby better understand life.

“I can remember how when I was young,
I believed death to be a phenomenon of the body;
Now I know it to be merely a function of the mind-
--and that of the minds of the ones who suffer the be-
reavement.
The nihilists say it is the end, the fundamentalists the
beginning
When in reality it is no more than a single tenant or
family
Moving out of a tenement or town.”

Faulkner, Wm. 1930; *As I Lay Dying*

This is not to suggest that resuscitation efforts should not ever be withheld; to the contrary, since advance care planning may successfully incorporate other genuine forms of caring at the end of life, the ritual of CPR may have little utility in some circumstances. To date, however, meaningful palliation and caring have not been the norm in the wake of a Do Not Attempt Resuscitation (DNAR) order. The latter should be invoked when there are valid advance directives refusing such care or in the out of hospital setting when there are obvious signs of irreversibility (decapitation, hemi-corpectomy, rigor mortis, lividity, decomposition, etc). Many feel that poor prognostic indicators should dictate initiation, rather than termination, but others feel that all patients, young and old, deserve at least a trial of attempted cardiopulmonary resuscitation after a cardiac arrest.²³⁻²⁵ Science is required to inform resuscitation decisions whenever possible. However, CPR should generally not be withheld when it can add something important, either life to a “heart too good to die”²⁶ or perhaps even dignity to a patient bereft of other forms of caring.

Is CPR a Modern Ritual?

Anthropologists to refer to “ritual” as “the performance of sequences of formal acts and utterances”.²⁷ A strict interpretation suggests that rituals must have the following elements: formality, invariance, performance, and encoding by other than performers.³ A dictionary definition of “ritual” refers to “ceremonies or formal, solemn acts or

procedures in accordance with prescribed rule or custom, as in religious use".²⁸

To ascertain whether chest compressions and artificial breathing meet the criteria for a "ritual," we need only consider a few facts. First, CPR has certainly become the customary standard response to pulselessness in most countries since it was invented by Jude, Knickerbocker, and Safar in the early 1960s. In the United States, for example, approximately 370,000 to 750,000 inpatients and over 225,000 outpatients have a cardiac arrest each year, resulting in approximately 350,000 deaths.²⁹⁻³² In addition, CRP is formally executed with code teams being summoned or EMS being called through formal dispatch networks. In addition, CPR is largely invariant in how it is conducted according to strict international guidelines promulgated by the Emergency Cardiac Care Committee of the American Heart Association and others. It is also face valid that CPR is "performed" and the performance is encoded and recorded by witnesses and other medical personnel. It is this last area, namely encoding by non-performers where modern CPR is less clearly a true ritual. In fact, many healthcare providers still ask families and loved ones to leave the room when CPR is in progress in hospital. This tradition of asking families to leave, however, is dying out in many places and hospitals increasingly have policies allowing families of loved ones to stay in the room during resuscitation attempts. In the out of hospital scenario, however, all the criterion for ritual are met since it is customary for the nonparticipants to witness the event directly and intimately.

In spite of these ritualistic considerations, CPR is still regarded more as a part of resuscitation science wherein its chief benefit is in prolonging life. Rarely successful in its scientific role of restarting the heart, CPR may give providers and families themselves the reassurance that we are correct to say goodbye to our loved ones. It is well known that resuscitation efforts longer than 30 minutes portend a poor prognosis, and most studies reveal that those undergoing longer than 15-20 minutes having a significantly increased risk of mortality.³³⁻³⁸ While standard CPR is in no way a form of "alternative medicine," its widespread implementation despite a relative lack of success may place it only a few notches above amulets on the science scale. Before the advent of modern medicine, nearly all end of life acts performed by physicians overlapped with those of priests, healers, and shaman and fit at least partially, into the definition of rituals.

As the science and public health have advanced, the average life expectancy worldwide has lengthened. But in some respects, by employing more invasive and drastic measures, we have sacrificed a great deal in the name of longevity. While our technological armamentarium has expanded, we still stand as helpless as ever at the threshold

of death. Perhaps we need to revisit the values at the end of life that are most relevant to patients and families if we are to respect their dignity, personhood, and autonomy. We can no longer afford either in human or economic terms to vilify death as the physician's archenemy.

Ironically, many advancements in technology have occurred during an era of increasing spiritual needs and humanistic longings of the general public. Although, by some measures, participation in organized religion has decreased, increasing numbers of people report belief in God or some spiritual force, and report prayer or other spiritual practices.³⁹⁻⁴² The indiscriminate and blind application of technology as a proxy for other care may in fact lead to negative consequences, such as the unintentional abandonment of subjective needs, such as comfort, pain control, communication, spirituality, or other significant values.⁴³

As the role of technology at the extremes of life increases, we must question whether chest compressions have replaced touching, adrenaline has replaced holy water, sterile gel has replaced sacred oil, and electric shocks have replaced prayers during the resuscitation exercise. In other modern contexts, Medic-Alert bracelets have replaced religious jewelry; automatic external defibrillators adorn the walls of public buildings in place of religious décor; "911" or EMS is dispatched to the death scene rather than religious clergy.

Despite the scientific progress and technologic advances of the past century, many patients are significantly disenchanted with modern medicine, as evidenced by the increased movement towards alternative medicine, towards which Americans pay over \$1 billion, out of pocket, annually.⁴⁴⁻⁴⁶ Increased participation in rituals may be an antidote for this dissatisfaction with modern medicine, through connections with the deeply rooted hopes and aspirations of patients. Although technology often fulfills physiologic goals, and at times serves to meet the expectations of some, it should not routinely be relied upon as a weak substitute for *caring* for the patient and loved ones. When appropriate, technology should be utilized as a portion of the overall care of the patient, which should include comfort, communication, compassion, empathy, respect for autonomy, and assistance in meeting other spiritual, cultural, religious, psychological, and emotional needs.

Can Futile CPR be a Vector of Beneficence?

Since Neanderthal times, rituals have played an important role in the acceptance of death;⁴⁷ and even today, for both patients and survivors, rituals at the end of life continue to carry crucial religious, spiritual, emotional, and social significance. In developed countries, the role of emerging technology has in some ways replaced many rituals. Futile CPR itself, is not viewed as negatively by

most patients and in many cases it is a talisman that every possible chance of survival is being embraced. In some cases, the populace regards it as a proxy for a willingness to help, and in some cases CPR may even serve as surrogate for compassionate care. With a willing eclecticism, physicians may be able to combine certain elements of technology with the older rituals of laying on of hands, oils, therapeutic touch, words of comfort, and a spirit of compassionate caring that can help patients and their loved ones meet the plethora of challenges at the end of life without layering futile CPR on top of other caring.

For patients who are not candidates for CPR, less overall care is often provided. It is frequently forgotten that dying patients often suffer from numerous physical symptoms, as well as psychological, social, emotional, and spiritual challenges. Although great strides have been made in the medical management of physical symptoms (such as pain, insomnia, etc.), even greater challenges present themselves to the clinician who should also be skilled at managing such symptoms as depression, anger, denial, fear of the unknown, and worries regarding survivors. Additionally, the patient's loved ones also face significant challenges near the end of life, such as grief, anger, denial, and guilt. Unfortunately, the concerns of families, friends, and loved ones are sometimes neglected, as the primary focus of the physician is directed toward the dying patient.

Rituals can serve important functions in the relief of these symptoms for patients and loved ones, through a variety of mechanisms. At minimum, the placebo effect of rituals is well established. Additionally, rituals may serve to strengthen bonds between family and friends, to resolve guilt, to focus energies away from pain and other physical symptoms, and to provide spiritual, religious, and emotional fulfillment and comfort.

Religious beliefs regarding the significance of death and dying vary significantly. While certain religions practice complex end of life rituals, others allow significant freedom in the direction of the experience.⁴⁸ Some rituals allow physical relief of grief and suffering, such as the Jewish tradition of rending garments,⁴⁹ or the weeping and wailing of the Chinese.⁵⁰ Certain other rituals carry symbolic meaning, such as anointing. Many rituals carry spiritual significance, such as prayer, rites, chanting, or bedside services offered by clergy. Some religions place emphasis on repentance and the forgiveness of sins at the time near death. Some cultures, such as Hawaiians, celebrate death, as a happy occasion, with eating and dancing.²⁷ Some scientists will acknowledge only a placebo effect of rituals; however, even this rudimentary acknowledgement necessitates concession of a degree of power.⁵¹

Although the significance of cultural or religious rituals may not be fully appreciated by the health professional,

there should be respect for its significance to the patient and loved ones. Regardless of the religious beliefs of the physician, a supportive environment, which may include allowances to practice religious rituals, may serve an important function at the end of life. .

The Physician's Role at the End of Life

The role of the physician at the end of life is multifaceted. Only in modern times has the primary goal of the physician been to preserve or restore life. Because of this relatively modern duty, there is often a pervasive and penetrating feeling of pathos and defeat when patients die. This perverse worldview is at odds with the facts that all die, and our encounters with death make doctors more humanistic, allowing them to more empathically respond to the death-meaning crisis of patients. Physicians must not imperially medicalize death, and instead they should teach the acceptance of death as a natural part of life, to their patients, loved ones, and other health care providers.⁵²⁻⁵⁴ A physician's role in being a midwife through the dying process for patients should be revered and not feared.⁵⁵ By reconnecting to their own priestly roots as healers, physicians can be leaders who reject attempts to deconstruct medicine into a technocracy. Through improved communication and caring, modern physicians may be better prepared to provide valuable medical and ritualistic experiences that promote true healing in the lives of their dying patients, and help the patients own narrative of life's meaning take center stage.

Physicians must resist the temptation to use technology as a crutch, and offer interventions that are unlikely to be of physiologic benefit.⁵⁶ When curative therapies do not exist, the role of the physician may actually broaden, rather than diminish, as less tangible interventions and benefits attain greater significance. The physician should address the numerous physical, emotional, social, and spiritual challenges facing patients and loved ones. Many actions in modern medicine, including CPR itself, may serve some of the functions of rituals.

At times it may be appropriate for the physician to actively participate in cultural or religious rituals, despite perhaps differing personal beliefs or convictions; this may include observation or participation in cultural or religious rituals, joining in prayer, attending a funeral, or a variety of other tasks

Respect for Patient Autonomy, Beliefs, and Preferences

Honoring patients autonomy does not imply aggressive resuscitation at any and all costs. Widespread public education and legislation regarding advance directives have had a significant impact on their development and use. However, although only 12-20% of Americans have

completed an advance directive,⁵⁷⁻⁵⁹ an overwhelming majority of people have definite opinions regarding resuscitation.⁶⁰ Therefore, even in the absence of an advance directive, *communication* with patients and families, prior to, and during, resuscitation attempts, regarding advance directives and patient preferences, is of paramount importance.^{61,62} Recognition of cultural beliefs and preferences can be of great significance to the end of life experience of patient and loved ones.⁶³ Careful consideration and application of the patient's wishes contribute greatly to the creation of an acceptable or "good" death. As patients approach mortality, rituals in medical treatment become increasingly important.

Meeting their expectation for ritual is part of the way in which we honor their dignity and autonomy. Placebos, for example, are largely effective due to the entire ritual that accompanies their administration: who gives the drug, the route, the touch of the doctor, the listening to the chest, the taking of the blood pressure, the drug's color, etc. are all significant covariates in the placebo response where the routine actions now become important. If you do the ritual, the patient and the family may feel better. An important caveat, however, is that if they don't expect or want the ritual, they may also feel worse. The expectation is also part of patient preference, and this also impacts the effect. As we strive to honor patient autonomy, however, we must not force decisions upon patients who are unable or unwilling to make them. Competent patients may also turn over their decisions to either a surrogate or to a doctor, but each case and medical subculture is different.

Communication

Effective communication with patients and loved ones is an essential component of end of life care, and may in fact serve some of the function of rituals. Even following the patient's death, when some physicians feel guilty or perceive their duty has been completely fulfilled, there exists a parallel and lasting duty to address needs of surviving loved ones as well. Vital components of empathic communication to the bereft include sitting down, maintaining eye contact, spending adequate time, use a quiet location, ask everyone their name and use it properly, speak in laymans term, use open ended questions, and touch and other nonverbal communication appropriately, use reassurance to resolve feelings of guilt or blame, and use allied health, social services, pastoral care, and psychiatry for added support when requested or necessary.⁶⁴⁻⁷²

"Death is inevitable in the case of the man who is born. Therefore one should not be happy at birth, nor mourn death. A creature comes from the unknown and goes to the unknown, so the wise regard birth and death as equal. Such being the fact, people give their dues to their mother,

father, preceptor, wife, son, disciples, cousin, maternal uncle, agnates, and cognates, and consecrate their cremation with proper sacrament."

(Ancient Hindu writing)⁷³

Conclusions

Physicians, who at one time could do little more than perform death bed rituals, may be wise to rediscover the importance and utility of combining compassion and empathic communication with resuscitation rituals at the end of life in order to optimize their interactions with dying patients and their loved ones. Sophisticated medical interventions, resuscitation protocols, and customary treatments can often be responsive to the many unspoken needs of medical consumers. Even when physiologically futile, the sweat on a professional's brow, the touch of a precordial thump, intravenous adrenaline, and other seemingly normative gestures may sometimes give testament to hope, compassion, and even a sort of beneficent caring—thereby legitimizing their therapeutic value to patients and their loved ones. What determines how such actions are interpreted, however, is in *how* they are executed and transmitted to the patient and their loved ones. Well-communicated resuscitative efforts may indeed yield measurable benefit when, for example, both families and providers are powerfully consoled that "everything had been done" in the case of pediatric cardiopulmonary arrest. On the other hand, technology in a vacuum cannot substitute for other important end of life caring, communication, counseling, pastoral care, or other spiritually or emotionally significant end of life activities. While the CPR ritual seems expensive, it may tap into a priceless component of caretaking that has remained important to patients since antiquity, and indeed, remains an essential prop in the modern passion play of dying into which all sooner or later play a cameo role.

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