Second Thoughts

CPR

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MUCH CONCERN has been expressed about the “dehumanizing” aspects of medical training in the United States. One aspect of the problem has been identified in the structure of medical education, with its packed curricula, excessive workloads, and authoritarian rigidities which have been accused of taking idealistic young men and women and turning them into cynical and jaded professionals. This concern has been responsible at least in part for the dramatic decrease in total workload and increase in financial compensation for physicians in postgraduate training programs. At most major teaching hospitals, the 80 hour week and every other night call schedule have been replaced by an every third or fourth night on call schedule, sometimes supplemented with a “night-float” system to insure that house officers are not chronically sleep deprived and that these individuals have time for normal out-of-hospital pursuits. While these recent changes in workload seem important and dramatic to an observer of medical education, it is not clear that the trainees’ subjective experience of the dehumanizing impact of medical education has been appreciably altered. The purpose of this paper is to discuss the possibility that the major dehumanizing forces in medical education have to do not with the amount of work or the attitudes of teachers but reflect something intrinsic to medical work and the medical identity required to perform medical work. Over the past 20 years, while the total amount of work required of house officers has decreased there has also been a shift in the type of work performed, to include procedures which must be experienced by trainees as alien to the comforting and well-worn paths trod by the majority of humankind. To illustrate this, we will focus on one medical procedure learned and performed by almost every trainee—cardiopulmonary resuscitation (CPR).

CPR is a relatively recent procedure. It was first described by Kouwenhoven et al. [1] in 1960 and achieved widespread use in hospitals by the mid to late 1960’s after several well documented reports of its success in maintaining perfusion over prolonged periods in patients with cardiopulmonary arrest [1–3]. The rate of success of CPR in hospital is low, reflecting no doubt the serious underlying illness of patients that suffer cardiac arrest while in hospital.

Depending on the series, between 5 and 20% of patients will survive CPR to be discharged from the hospital [2–5]. Patients with coronary artery disease of relatively young age are good risks, and the series with the highest success rates contain the most patients from this group. Older patients and patients with non cardiac disease rarely survive to leave the hospital, but may be “successfully” resuscitated, only to die after a
few days on a respirator. Often CPR is performed on patients with a quite hopeless diagnosis, because the house officer called on the arrest is not familiar with the case. About the only way for a patient to die in hospital without benefit of CPR, unless he has cancer, is to have specific “do not resuscitate” (DNR) orders written, or to die unmonitored and unnoticed. The recommended procedures to follow for writing DNR orders are difficult enough to discourage house officers from allowing this type of death. Improvements in monitoring technology have also reduced the number of patients found dead in bed. In short, most people who die in hospital get CPR.

What connection might CPR have with the disaffection, alienation and dehumanization so chronic to house officers. To answer that we would like to view CPR as an outsider, a fly on the wall, might see it. What actually happens in CPR?

A nurse is watching a monitor. She jumps up and runs to the patient's bedside and puts her fingers on his neck. Seconds later she will call out “call a code blue.” Within a minute, between 7 and 25 people have gathered around the bed. The dying man's clothes are ripped off, an intern has slammed her fist into his chest as hard as she can, and now she starts to push down on the dying man's breastbone, rhythmically breaking his ribs [4]. A medical resident sticks a metal hook in the man's mouth and lifts his head and neck off the table with the hook as he places a large tube in the man's throat. Another intern sticks a large needle in the dying man's chest, just below the collar bone; then, cursing, he pulls it out and sticks it in the dying man's neck. All the while there is shouting, maybe even some laughing. Can the dying man hear? CPR has been shown to maintain adequate cerebral perfusion to avoid permanent brain damage [2]. Can he feel his ribs breaking, the excruciating pain of someone pounding 60 times a minute on his battered chest? Soon, an intern places paddles on the dying man's chest, and sends him into a convulsive movement, his body rising off the bed. This is repeated several times during the next half hour. Different people are constantly sticking needles into the dying man's body—into his chest, his arms, his groin, even directly into his heart. As all of this activity progresses, the number of people around the bed diminishes. After 30 minutes of activity, perhaps four are left. They are sober, somewhat withdrawn. Then all activity ceases, and the physicians leave, the nurse remaining behind to prepare the dead man's body for viewing by his family.

How can performing CPR not be dehumanizing? CPR is an assurance that an individual will spend the last 10–30 minutes of his life in pain. In that respect it violates every religious and cultural precept on the care of the sick and dying. Ironically, one of the most common rationalizations given by battering parents for the multiple fractures and abrasions seen in these dead infants is that the parents were simply performing CPR.

How do house officers deal with this horrible contradiction, that they must subject their dying patients to the torture of CPR? We have found denial to be the most prevalent response, a refusal to consciously consider the effects of CPR on the dying patient. Indeed, most physicians reading this article have by now in all probability reacted violently to this characterization of CPR as torture. It is a powerfully unpleasant concept to confront, and denial can be a successful defense. Others may rationalize CPR by stating that the dying patients do not feel pain because of a massive release of endorphins. Perhaps that is correct. It is interesting how little is written on the subject, reflecting the taboo status of such a difficult and painful issue. Clearly, even leaving aside for a moment the question of the pain of CPR, the savaging of the dying patient by the CPR team still violates many basic concepts of humane care. Traditions from China to medieval Europe enjoin rituals to comfort the dying patient and to wash, dress and ornament the dying body in preparation for the sublime moment of death [6]. Even in cultures such as the Navajo where death is feared and the corpse is treated as an enemy, no attack may be made on the body until all signs of life have fled it.

Nonetheless, CPR saves lives [5]. Thousands of people are alive today because of CPR, and traditions asserting the supreme value of life are as abundant as those describing the sanctity of the moment of death. In the thirteenth century Thomas Aquinas addressed the question of what should be the price of continued existence and concurred with Aristotle
that existence is the greatest good. Camus has expressed the same idea in existential terms: "I would accept even worse, blindness, deprivation of all my senses, loss of the power of speech and of any contact with the external world—as long as I could feel within me this dark, burning flame which is me and me alive" [7].

But, as teachers and mentors, what can we say to the internal medicine resident who became a doctor because he wanted to help and comfort people and who has never held the hand of a dying patient? What does the practice of CPR do to this physician’s values and view of the self? What can we do? We do not have an answer. Denial is not working because it cannot be complete. Most physicians we have talked with about this say, “Of course this is the way it is. Everyone knows this.” We simply avoid talking about it or thinking it through. In one sense the whole of medical education can be understood as a progressive initiation into the breaking of taboos. Not only does the physician savage the sanctity of the dying, it is the physician who dissects the sacred dead, who approaches the raped virgin with the speculum, who rends the sick child from its mother, who pulls the plug of the respirator. It is perhaps no accident that so many of those taboo-breaking activities are relegated to the most junior of trainees, leaving more senior physicians to pursue more socially acceptable and comfortable medical procedures. Perhaps if more of us made our peace with this awe-full aspect of medicine in training, we would not flee from this taboo territory later on. In the end, it may be the conversations that we force ourselves to have with ourselves and with each other that determine whether these activities lead us to a numbing sense of lost empathy or to a broader, more objective, more executively effective view of our patients’ lives and of ourselves.

REFERENCES