

It is Not OK to Die (With Dignity) in America: An Analysis of the United States' Denaturalization of Death and its Intimate Relationship with the SARS-CoV-2 Pandemic

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ABSTRACT

The SARS-CoV-2 pandemic (COVID) transformed the everyday life of millions around the globe; however, many Americans never believed the virus—or the threat of death—was real to begin with. This research analyzes a systemic denaturalization of death and its processes within the United States, and subsequently identifies a public health crisis stemming from the biomedicalization of aging, illusory expectations of end-of-life care, and a generational pursuit to achieve a ‘good death’ within a capitalist economy. Informed by over 1,300 hours of first-hand participant observation in two public health institutions in Indiana and interviews with medical providers discussing the impact their own (de)naturalization of death on patient care, this paper dissects American’s social and cultural behavior regarding death, its processes, and its intimate connection to the SARS-CoV-2 pandemic. While most Americans describe their worst nightmare for end of life, they are most often suffering and dying exactly as they fear: institutionalized and isolated. This explores why this is so.

Keywords: death; denaturalization; SARS-CoV-2; biomedicalization of aging; structural violence

Two Health Institutions, One Systemic Parallel

In June of 2019, while entering “Room 12” of the rural ED in my hometown with my colleague and close-friend, Kris, a Registered Nurse, we introduced ourselves to Unidentified Nevada (UN, a pseudonym), who had just arrived from a local nursing home by ambulance. According to nursing home staff, UN was an 87-year-old white male who had lived at their facility for the last year-and-a-half, and he had far from a good bill of health. UN was bed-ridden, mute, had zero limb mobility, his eyes glazed over when they were not sealed shut, and his skin was clammy, jaundiced, and riddled with bruises from failed IVs. The chief complaint was hypotension. UN’s family seldomly visited him in the nursing home, stated the nursing home staff, and UN lacked a living legal document that granted him a pass to die with the little dignity he had remaining. After recognizing the nursing home’s effort to restore UN’s blood pressure had previously failed, my main concern was that UN would go into cardiac arrest, and I would have to be the one on top of UN, an 87-year-old male, gravely ill and frail, performing chest compressions to “save” UN from the ostensible medical failure of death. After making UN comfortable and attempting to restore some of his dignity before the attending physician came in to give his assessment, Kris closed the curtain upon exiting, looked me in the eyes, and said “Creighton, it is not OK to die in America.”

Fast forward to September 2019, just a few months prior to the arrival of SARS-CoV-2 to the United States, I anxiously arrived at the level-one trauma center in Indianapolis for my first shift as a student intern. I quickly began to be acquainted with the rooms, the environment, and the staff I would be working with for the remainder of my shift. Hours went by, and it

was quiet—a word never to be spoken aloud due to healthcare superstition—with zero patient intakes in the trauma bay following my arrival. Finally, five hours into the shift, a trauma alert came in: an incoming 58-year-old female found unresponsive along the roadside, cardiopulmonary resuscitation (CPR) ongoing with no success. “Nothing further, see you in twenty minutes” ended the call. Holly (pseudonym), Registered Nurse, was assigned to this patient. Holly sprang into action preparing “Shock Room 1” for the incoming cardiac arrest ensuring the room had plentiful supplies, and the necessary medications were out and ready for immediate use — all ensuring that the incoming patient would receive the highest standard of care. “So, are you ready?” I asked Holly. After a sigh, “yes I am” she responded. “It’s still so different from [nursing] school, but we have a great team tonight” Holly added. Moments later, the patient, “Unidentified Wyoming (UW),” arrived in the trauma bay with paramedics actively performing CPR. “Shock Room 1” (Figure 1) soon occupied nearly fifteen medical personnel, all working together to “save” UW. Amidst the chaos, I observed the life-altering scene with the new lens of “it’s not OK to die in America” weighing on my mind. UW looked rough; matted hair infested with lice, unbathed and pale white skin, feet plagued with thick, dead, black skin, bed bugs crawling all over her lifeless body, two IVs in each arm and one in the neck tasked with quickly administering medications, bodily fluids soaking her clothes and bed sheets, thick tubes down her throat delivering oxygen to her lungs, and numerous personnel and their entire body weight taking turns delivering two inch chest compressions at a staggering two compressions per second. This horrific scene, with UW’s condition deteriorating every second despite depleting two trauma bays of their epinephrine supply, went on for two and a half hours. Resuscitation efforts continued in the intensive care unit upstairs, as attending physicians urged their colleagues to “continue doing everything you can,” to “not give up.” UW was transported to the intensive care unit mid-code, where her heart stopped again enroute to the elevator. UW was officially pronounced deceased an hour later. The aftermath (Figure 2) left medical personnel

physically and emotionally exhausted and UW died alone, intubated, and robbed of any dignity she had remaining.

This contemporary reality shared by Unidentified Nevada and Unidentified Wyoming—dying alone, intubated, and no longer in control—foreshadowed the reality thousands of Americans would face during the deadly SARS-CoV-2 pandemic in the following years, and served as examples demonstrating the way in which elderly populations were dying already within US healthcare regimes.

The experiences detailed above of UN and



Figure 1: "Shock Room 1" Before UW's Arrival (17:18). Photograph by author.

UW were by no means exceptions to the observed paradigm shift of death being the new, and ultimate, medical failure — they were the epitome of this new era identified by this research, an era where lack of proximity to death causes death to be prolonged and violent, and death has evolved into the new "quantifiable" medical failure.

This research explores a public health crisis instigated by systemic death-denying culture within the United States as the mentality promotes unnecessary suffering among those who are deathly ill, and among healthcare professionals tasked with aggressively prolonging treatment to overcome the contemporary medical failure of death. Specifically, this research sought to answer the following questions: When did death culturally evolve from a natural phenomenon to a medical failure in United States? When is it

acceptable to view death no longer as a medical failure but rather as a natural process? When is enough treatment *enough*?

I used three forms of data collection: semi-structured interviews with medical staff, participant and institutional observation, and in-depth engagement with literature. Real patient and provider encounters are detailed throughout this essay and the names of all patients and some medical staff have been replaced with pseudonyms to be compliant with The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and/or to



Figure 2: "Shock Room 1" After UW's Transport to the ICU (22:58). Photograph by author.

protect the privacy of interviewees, as requested. Patient names with the format of "Unidentified State" were naming methodology used within the emergency department as it allowed patients to receive immediate care under a name already in the system, rather than waiting for patients' identities to be verified for record-keeping and billing purposes. I have kept that trend alive within this essay and named all patients as such for uniformity purposes. Additionally, I use the word "American" throughout this essay to describe the local and greater population in which these death and dying phenomena were observed to exist within geopolitical boundaries. I understand "American" incorporates a wide array of experiences, cultural norms, and a diverse set of factors I cannot address in the limited scope of this paper, including racism, ageism, sexism, and other institutional forms of inequality that

affect how lives—and deaths—are valued different within this broad category. Future research exploring these forms of institutional inequality, however, is strongly encouraged. All other details included within this essay, unless noted otherwise, were first-hand patient encounters I experienced between two distinct settings in Indiana: a stand-alone emergency department (ED) in my rural, 12,000 person hometown of Connersville, and the “Shock Rooms” of the emergency department at one of two level-one trauma centers in Indianapolis. I gained access to these health institutions through an internship program designed to make connections with medical staff and aid in patient care. Details from patient encounters were recalled from memory and written reflections after each shift, and I was careful in respecting patients’ death experiences, obtaining permission from medical staff to take notes and observe each case, and addressing any practical dilemmas with medical staff following applicable patient encounters. Formal interviews, some audio recorded with permission, were conducted with two critical care physicians and four ED and ICU nurses, and informal interviews were collected from additional nurses, respiratory assistants, medical technicians, and healthcare volunteers throughout debriefs of patient encounters or by casual conversation. Despite the stark differences in levels of care and accessible resources between the two institutions, one systemic parallel remained: death and its processes—its untimeliness and its denaturalization by patients and providers—all were recognized prior to, but magnified by, the onset of the SARS-CoV-2 pandemic. By “denaturalization,” I mean making or viewing something (in this case, death) as an unnatural phenomenon (Merriam-Webster 2022).

The Politics of Death and the ‘American Way’ of Dying

In the United States, the politics of death—when, how, where, and the social circumstances by which one dies—raises crucial questions about the cultural and political values placed upon people’s lives. As is evident by certain political attempts to dismiss Covid-related

deaths, or by cultural norms that minimize the visibility of death and dying, the American way of contending with death seems to center around delay and evasion. As stated in *Warehouses for the Dying*, Dr. Paul Merik, a critical care physician at Sentara Norfolk General hospital, stated “Americans not only don’t want to die, but they are also unwilling to accept the reality of death” (Whoriskey 2019). This phenomenon, American’s unwillingness to accept death and its realities, gained significant momentum during the SARS-CoV-2 pandemic as Americans’ intent to evade death while being in a state of ‘ignorance is bliss’ became ever so apparent. When SARS-COV-2 first came to the United States, the Centers for Disease Control (CDC) advised Americans that the virus may be one’s death sentence, particularly if the patient was elderly or suffering from a pre-existing condition that had compromised one’s immune response. In order the slow the spread of the virus and to protect oneself and their neighbor from being infected, the CDC recommended the combination of mask wearing and social distancing. Both recommendations were highly refuted and politicized by nearly half of the United States’ population. Despite the CDC’s warning of the high transmissibility of the virus and the higher death rate when compared to the common strains of influenza, a large portion of the American population and elected government representatives continued to downplay the severity of the threat, and, as a result, Americans were (are) dying institutionalized, intubated, isolated, and no longer in control. The cultural response to SARS-CoV-2 should not register as such a surprise; this is the way many elderly Americans are dying already. Whether denying the severe threat of death by SARS-CoV-2, or not allowing death to happen “naturally” when it is time, evading the realities of death leads to untimely death—whether over-extending and prolonging life, or in the case of SARS-CoV-2, shortening lifespans.

Due to ground-breaking research and discovery, medical advancements have prolonged the lives of those living with chronic illnesses (Kaufman 2006, 22). In return, these advancements created an increased burden on healthcare resources backed by an increase in challenging discussions and attentive treatment

near the end of one's life, resulting in patients and their surrogates arriving to health institutions with illusory expectations of the kind of care administered (The Lancet Respiratory Medicine 2016). Death is not portrayed as an enemy in need of defeat within solely the ICU ward, however. As Hannig (2017) articulates:

[L]ook at the plethora of contemporary fantasies of immortality, which range from anti-aging creams to efforts to download a person's brain so he or she can continue to live virtually, to cryonics, the practice of freezing and storing bodies or body parts in the hope that future scientists will thaw them and bring them back to life.

The dedication to evading death is more prominent within the United States than it is to confront, prepare for, and accept the inevitable despite death being the one universal phenomenon known to exist among all living organisms. Why is this the case, particularly within the United States?

According to Anita Hannig (2017), anthropologist and associate professor at Brandeis University, Americans did not begin avoiding death until the end of the 19th century. Up until that point, Americans were comfortable with the aspects of death as most individuals lived their final days within their home, and families took care of their own dead. Jones et al. (2014), authors of *Extending Life or Prolonging Death*, claim the biomedicalization of aging initiated a new form of medical care where complex and expensive care became routine without contemplation of what was being accomplished with the goal of viewing the aging process as an entity capable of being controlled with modern medicine. This new form of medical care, where aging is viewed as a medical issue, has been studied extensively by Dr. Sharon Kaufman, medical anthropologist and Emeritus professor at UC San Francisco, as biomedicalization of aging has laid the foundation for widespread utilization of aggressive prolongation of life treatments in the present day (Jones et al. 2014; Kaufman, 2013). In other words, the biomedicalization of aging has resulted in life being so highly medicalized

that aging is viewed as a procedural failure rather than as an expected stage of life. Cardiopulmonary resuscitation (CPR), for example, is performed today on every applicable patient unless otherwise noted via the form of an advanced directive or 'do not resuscitate' (DNR) status; however, when CPR became widespread in the 1960s, it was not considered ethical to be performed on those unlikely to recover, typically those with previous chronic illnesses and older in age (Hillman 2012; Kaufman 2006, 118).

These themes of rationing care and allocating medical resources among those most likely to survive (and contribute to the economy) draw parallels prevalent in organ transplantation, where the paradigms of organ transplantation and the biomedicalization of aging overlap, and tensions between "fairness and the tyranny of potential" in an aging society clash, as described in Kaufman's (2013) scholarship. Throughout hundreds of hours being around healthcare workers, of whom share years of experience on the front lines, many conversations were made about death, dying, and the gruesome process death becomes once institutionalized. Medical professionals spoken with throughout my fieldwork shared a common understanding regarding naturalization and acceptance of death, and expressed strong conviction of not wanting to be institutionalized during their final days. Throughout these conversations, Kris often told me "Creighton, if my children have me in the hospital on life support, do me a favor and stick a piece of gum down [the ventilator tube]." This perspective shared among medical staff is similar to the perspective of the US population in the 19th century, as Hannig (2017) describes, where individuals were routinely exposed to the stages of death and dying among their loved ones within their own homes, and therefore were comfortable with the natural stages of dying. However, these profound preferences shared by medical staff are far from the views and mentality of the average American and the system by which they live. It was not until healthcare became mass-institutionalized that the remainder of Americans underwent a systemic change regarding viewing and coping with death. In similar ways the

biomedicalization of aging and discussions of resource allocation brought systemic changes to US healthcare regimes, I observed throughout my fieldwork the similar extent and consequence this new era of medical care, where aging as a medical failure, evolves to death being the new medical failure.

The critical and emergency care specialties have developed the ability to prolong the lives of thousands, if not millions, of Americans each year (Kaufman 2006, 22). In return, the aging population will develop chronic illnesses associated with 'normal aging' (Alzheimer's, cardiovascular disease, cancers, diabetes, etc.) many of which are not amendable to the interventions offered within the intensive care unit (Kaufman 2006, 22). Nevertheless, individuals with these chronic illnesses can be kept alive with the aid of modern-day machinery and pharmaceuticals (Hillman 2012). These patients and the like, including UN and UW, were referred by medical staff as "circling the drain." This phrase was often said in passing between healthcare providers, and the meaning it held was the end-all-be-all: someone was on the verge of death and being kept alive strictly with medical intervention. "Circling the drain" was rooted in the open secret of the (inevitable) dying process: infection, septic shock, and hypotension, followed by pneumonia, organ failure, and the infamous death rattle. However, the contemporary dying process is not adequately represented by the phrase as it fails to fully contextualize how Americans are dying in present time: institutionalized, intubated, and stripped of one's dignity and autonomy. By "dignity," I mean the maintenance of one's own physical and spiritual value that supports the individual's idea of self-respect, and recognizes one's ambitions and capacities with how to be treated, particularly when it comes to end-of-life. This definition was inspired by Social Care Institute for Excellence, but with some slight modifications to address the practical dilemmas during whose death experiences informed this essay (SCIE 2022). Neither the desire to have one's life prolonged nor the ability to prolong the lives of others are necessarily what consumers and medical teams are asking for; however, health institutions and their aggressive life-prolonging medical practices are a major contributor to the unsustainable cost of

healthcare, and further fuel the contemporary medical failure of death (Hillman 2012).

Breaking Down the Numbers – Before the SARS-CoV-2 Pandemic

Analysis of the 2016 fiscal healthcare data revealed the nation's medical bill added up to \$3.7 trillion — about 18 percent of the nation's total GDP (Reid 2017). As "one in every six dollars spent went to healthcare," financial experts concluded that approximately "five percent of the United States' population accounted for 50 percent of all medical costs" for the 2016 fiscal year (Reid 2017). More specifically, in the same \$3.7 trillion-year of 2016, one quarter of the Medicare budget was allocated toward strictly end-of-life care and ICU admissions. This may be attributed to the financial incentives built into the Medicare and Medicaid programs which encourage providers to render more services, particularly those more intensive in nature, than are necessary or beneficial (The Lancet Respiratory Medicine 2016). To visualize the magnitude of spending in terms of ICU beds, the United States has an average of 25 ICU beds per 100,000 people, whereas the UK allocates an average of 5 ICU beds per 100,000 (Hillman 2012). Despite the availability of more ICU beds and a much higher spending budget and rate, the United States and UK share similar patient outcomes upon comparison of the care received and the ailments treated and could indicate inappropriate ICU utilization within the United States (Hillman 2012). More specifically within the United States, a study compared patient data and longevity of those who opted for high-intensity treatment to those who did not undergo high-intensity treatment and found no significant contrast in patient outcomes (The Lancet Respiratory Medicine 2016). While one may view the additional spending and emphasis on end-of-life care as a sign of valuing the lives of elderly people, one may also view the excessive spending and emphasis on high intensity end-of-life care as enablers of a systemic capitalization on dying Americans and the quantifiable medical failures such as death.

Every health institution has one or more departments designated as the institution's top source of income, and, according to Dr. Joseph

Smith, a Pulmonary Critical Care physician at Eskenazi Health and a sub-internship associate for the Indiana University School of Medicine in Indianapolis, the Intensive Care Unit (ICU) is one of the top departments providing income to hospitals throughout the nation. Exploring fiscal data from 2011 among 1,882 hospitals in 29 states from Barrett et al. (2011), Healthcare Cost and Data Project, the highest proportion of ICU utilization came out to be \$5,914,560.23 per hospital, and the lowest proportion of ICU utilization came out to each hospital reaping \$725,082.74 for a grand total of each hospital of the 1,882 hospitals studied to have billed approximately \$6,639,642.97 for solely ICU utilization in 2011. The grand total assumes every hospital possesses and offers equal capabilities, which is untrue; however, if each hospital billed equally and had a proportionate number of patients in respect to each other, then each hospital of the 1,882 counted would reap the greater than \$6 million ICU utilization bill in 2011. The data provided demonstrates the magnitude of the billing if each institution was proportional to each other, and more importantly, demonstrates how the system profits off Americans during their inevitably most vulnerable times.

The data from 2011 and 2016 concludes a continual emphasis on providing high-intensity care within the United States, with little to no indication of slowing down. Most of the care resulted in the loss of life succeeding the initiation of care as “hundreds of billions of dollars are spent treating Americans who are within hours, days, or weeks from their death” (Reid 2017). While not all the patients referenced in the Healthcare Cost and Data Project died and treatment was not necessarily given to prolong their lives and evade death, many Americans will receive the most care ever received within the last hours of their life, with over one-third of Americans undergoing operations within the last month of their life (Reid 2017; Kaufman 2006, 1). This statistic supports the “pay-for-service” healthcare system within the United States which rewards institutions for additional treatment and investigation. In return, however, the “pay-for-service” system has increased the challenge of coding or quantifying a “good death” within the

United States (The Lancet Respiratory Medicine 2016; Jennings 2007).

While it may be intuitive to assume that the sicker one is the more care they will receive, the United States healthcare system has not undergone major structural change to exhibit the qualifications for a “good death,” especially among those subjected to dignity-compromising treatments to combat complications related to chronic illness(es). Instead, the US healthcare system evolved to be more efficient in combining morality and capital, all within the name of health, to gain the long-awaited profit from common and expensive end-of-life procedures that are nearly universally administered, regardless of if the patient is unlikely to recover from the administered treatments. Is a “good death” within the United States only achievable if the death is “good” for the economy?

The Search for a “Good Death” and Interviews with Dr. Smith and Dr. Carlos III

During an interview with Dr. Joseph Smith, Smith described what he qualifies as a ‘good death’ as being “surrounded with family, being at peace with the circumstances leading up to his death with acceptance of an end and being free of pain and suffering.” Similarly, Dr. Carlos III, a Pulmonary Critical Care physician at Eskenazi Health, described a “good death” for himself as being surrounded by his children, pain-free, and described the circumstances that constitute death as “points of no return” regarding the futility of the brain and circulatory flow. Upon comparison of Smith’s and Carlos’ viewpoints to a survey given to Americans about preparing and providing care for individuals nearing the end of life, 7 in 10 Americans (71 percent) share a common goal with Smith and Carlos as “helping people die without pain, discomfort, and stress” should be more important when it comes to healthcare at the end of individuals’ lives (Hamel et al. 2017). However, 4 in 10 (37 percent) Americans of the same group claim the system places “too little emphasis on helping people die without pain, discomfort, and stress” and 33 percent believe the United States places “too little emphasis on extending life” (Hamel et al. 2017).

Although most of the United States population, including the physicians interviewed for this research project, have profound preferences for how they would like to spend their final moments of life, 49 percent of Americans believe they have too little control over their medical decisions with that percentage rising to 63 percent among those who are in fair/poor health (Hamel et al. 2017). These statistics strongly correlate to the data point that 7 in 10 Americans would like to die within the comforts of their own home; however, only 4 in 10 believe they are likely to spend their final moments at home (Hamel et al. 2017). Despite this data coming from the consumers of the United States' healthcare system, a system where autonomy is allegedly valued, it is as though the fates of where and how Americans will spend their final days of life are predetermined given Americans' acceptance that their wishes will likely be neglected.

The ones providing the care, however, possess a different and stronger conviction for how and where they intend to spend their final days of life. According to a 2014 study conducted at Stanford University, 88 percent of physicians from a variety of specialties and backgrounds would not want invasive or intensive medical intervention at the end of their life and would opt for a do not resuscitate order for themselves if applicable (White et al. 2017). Similarly, the physicians interviewed for this project, Dr. Carlos and Dr. Smith, both stood with the 88 percent surveyed for the Stanford study, but Dr. Carlos made clear the contingency of his decision being persuaded by the circumstances leading up to his decision to withhold or continue treatment. The question was then raised as to why these physicians administer high-intensity care when they have decided to forego the same treatments for themselves; do the physicians not have faith in the medical interventions that they are providing to increase longevity and aid in one's quality of life? Have the physicians 'beat the system' and naturalized death whereas Americans tend to avoid the subject all together? When posed the question to Smith, his initial response was 'wow' and was followed by moments of silence as he formulated an answer. Smith then proceeded to explain how he finds comfort in providing the care he would

forego for himself by "consolidating with the council of the situation, such as the patient, their family, or surrogate if the patient is incapacitated." From there, he would "express the severity of the situation and what options, if any, there are for the next course of action within the treatment plan." He goes on to say, "If I do everything I am trained to do and I do so in a manner without compromising my own integrity, then that is sufficient for me to provide the care—the same care which I would forego for myself."

Smith continued his response describing the "very high bar set for physicians," preventing them from denying treatment without a solid legal basis and a holistic understanding of the situation. Smith began to elaborate on a case he had experienced recently where he felt the surrogate's wishes were not in the best interests of the patient; however, legal questions were raised by himself and his team on how they would prove the intent of the surrogate's wishes and disprove that the requests of the surrogate were in line with the patient's requests. Ultimately, physicians in the United States cannot implement the concept of futility very easily as that would eliminate the patient's autonomy rights—the autonomy rights that Dr. Carlos believes is a "driving home point" for the United States healthcare system. Dr. Sharon Kaufman, in *And a Time to Die* (2006, 117), wrote about the discourse autonomy rights have within the US healthcare setting, where some providers, like Dr. Carlos, believe autonomy rights is essential for reducing or eliminating pain, loneliness, and humiliation that commonly accompany patients during life-prolonging (or death-prolonging) treatments. Other providers, such as Dr. Smith, have a greater time choosing between treatments labeled "heroic" or "humane" (Kaufman 2006, 118). These tensions are prevalent in other healthcare systems around the globe, however, in some countries the handling of patients' autonomy rights is navigated by medical training rather than institutional policies.

Comparative Case Study of Doctors and Death: USA vs Netherlands

The United States' approach to providing healthcare possesses a significant difference regarding physicians making decisions to withhold treatment from critically ill patients in European countries such as the Netherlands. Citing A Nationwide Study of Decisions to Forego Life-Prolonging Treatment in Dutch Medical Practice, 17 percent (874 patients of 5,146) of decisions to withhold treatment were made by physicians without discussion with the patient and/or family, and with zero knowledge of the patients' wishes (Groenewoud et al. 2000). 42 percent of patients whose treatment were halted by the wishes and orders of the physician died within 24 hours or less, and 25 percent of those patients and families were not involved in the physician's decision to withhold treatment (Groenewoud et al. 2000). With lack of discussion being no exceptional finding given the structural and cultural difference in interpreting death within the Netherlands, "of the decisions to withhold cardiopulmonary resuscitation in incompetent patients admitted to a public teaching hospital, 21 percent had not been discussed with family members" (Groenewoud et al. 2000). More specifically, within the intensive care unit, 25 percent of physicians reported foregoing life-sustaining treatment without the consent of the patient and/or the relatives (Groenewoud et al. 2000). Breaking down the condition of the patients whose treatment decisions were made by the physician with and without discussion of others involved, 67 percent of patients were not fully competent and only 13 percent of those not fully competent had their wishes known and on file within their medical records (Groenewoud et al. 2000). The study indicated that the motives of the physicians were "practical" and resorted to removing autonomy in excruciating circumstances where "[the physicians] thought the decision (the halt of treatment) was clearly the best for the patient" (Groenewoud et al. 2000).

Despite the increase in compromised autonomy as observed in the Netherlands, the rate of death of those deemed critically and/or

terminally ill did not increase over time and did not appear to be significantly disproportionate to the population who were not battling critical and terminal illnesses. Upon comparison of the Netherlands to the United States, the only increased statistic noted was the Dutch ICU utilization and the number of individuals who succeeded death with their dignity intact. As stated previously, however, physicians in the United States do not have the power to withhold or discontinue treatment without some kind of legally backed consent and knowledge beforehand. Although US physicians possess the power to override a patient's decision due to the physician's medical knowledge of the circumstances at hand, the decisions made among the shareholders of the power dynamic must be evaluated and approval from a legal authority must be warranted. Due to the complexity of the United States' healthcare system and the fluidity of rights and legal actions between patients and providers, medical providers are often cornered in strengthening the longevity of this public health crisis within the United States while in constant search for a moral remedy.

Centering the Margins

Perhaps the most overlooked and most affected population by this public health injustice are the medical providers (the "medical heroes" coined during the beginning of the pandemic) who devote their lives to the United States healthcare system and its consumers, but also face a moral conviction when the consumers can no longer be satisfied by the guidance and recommendations granted by the interpretation of medical data. After analyzing Smith's recent patient experience detailed during the interview, physicians and other medical personnel are obligated to be complicit in the systemic notion of prolonging life upon the requests of the patients or their appointed surrogates. In a study that was conducted in 2003 among critical care physicians, most of the respondents indicated "they were comfortable with making recommendations and viewed it as appropriate and part of a critical care physician's duty" (Yaguchi et al. 2005, 165). However, within the same study, "50 percent of the US critical care physicians surveyed stated "it was inappropriate to make a

recommendation if the surrogate did not request one," with only one-fifth of respondents reporting they always give surrogates recommendations (Yaguchi et. al 2005, 165). Although the results of this study display the limitations self-reporting studies possess; the data from the study provides insight to the way end-of-life care is administered within the United States from the views of those providing the care.

An explanation for why these physicians were hesitant to make recommendations regarding a patient's care may be due to their role as "patient ambassadors." While advocating for what is best for the patient, the duty of a physician in a highly demanding field, such as critical care and emergency medicine, often thrives on embracing uncertainty. One patient plan does not resemble another given different medical/family histories, ages, lifestyles, environments, etc., and as a result, it is nearly impossible for physicians to practice with full confidence within time-sensitive circumstances. Dr. Smith and Dr. Carlos also mentioned the limitations and legal pressures preventing them from "backing away" and solely allowing the decisions to be made about the patient by the patient-appointed surrogates. To do this, the physician assumes the surrogate understands all the complexities involved, such as the underlying medical condition, treatment options, and prognosis — which is less than ideal in an emotionally draining moment for a family member or representative who shares a personal relationship with the patient (Hillman 2012). This move is solemnly done within United States medicine, however, and as mentioned previously, there are many stakeholders in medical institutions whose consent is required for these seldom-made decisions. Nevertheless, the institutionalized end-of-life medicine practice remains to be nothing more than supermarket medicine for its consumers.

Medical providers possess a significant and direct role in the care Americans receive, meaning the medical staff and their complicities to the healthcare system's inability to accept death as a stage of life, but rather a medical failure, are committing acts of structural violence themselves. While it is inappropriate to

villainize medical providers, it is important to understand and assume that "good people do things for bad reasons," and to explore how medical providers are doing so on a national level (Rubaii 2020). As a result, patients often suffer a cruel and prolonged death because of the United States' lack of expertise in handling end-of-life care, and due to the perpetuated illusion that prolongation-of-life care correlates to a restored quality of life among the ill and dying (Hillman 2012). The culture of the Intensive Care Unit was founded upon restoring homeostasis in a rapid and effective manner; however, with the technological abilities to rectify the system's wishes to keep individuals alive for as long as possible, "medical providers feel like they are inflicting more harm on patients whose lives are compromised, but their last (awoken) wish, along with the wishes of the family, enforce you to continue efforts" (Koesel and Link 2014, 331). Consequently, end-of-life care and the utilization of aggressive measures have been cited as two of the most prevalent conflicts within the ICU, resulting in staff burnout and poor quality of care, and further inflicts additional suffering among the most vulnerable patients (Koesel and Link 2014, 331).

Unidentified Illinois (UI) was one patient who struck me the most regarding the conflict between the oath of "do no harm" and the legal barriers of "doing everything you can." UI, a 90-year-old white male from a nursing home in Indianapolis, was brought into the ED due to a rapidly deteriorating case of sepsis following a bacterial infection. Rather than being treated in the "Shock Rooms," providers sent him upstairs to the ICU, and I anxiously trailed behind. We arrived to "Room 52," greeted by a dozen medical personnel ready to assess UI and develop a patient care plan. Discussions were made about intubating Unidentified Illinois. UI was in-and-out of consciousness, with the periods of consciousness being ghostly in presence. Despite being irresponsive to commands, UI would respond with groans and slight physical resistance to those who touched him. Despite his conscious absence in the room, the fear between the attending physician and Unidentified Illinois was prevalent. The medical resident assigned to this patient, Dr. X (pseudonym), weighed the options with the

attending physician on staff: to intubate, or not to intubate? UI's vital signs were rapidly dropping, with oxygen levels hovering in the high 60s low 70s (out of 100), despite being on continuous oxygen. From a 'medical textbook stand-point,' intubation would be necessary, however, on a moral basis, the trauma induced to the patient would overshadow any benefits from the intubation. Ultimately, the decision was made by the resident and attending physician to intubate the patient as the patient was not on file for being a DNR, nor was there a legally appointed surrogate present. In other words, the medical staff were in a legal bearing to "maximize efforts to return the patients to their baseline levels" all while balancing the oath of "to do no harm"—common themes touched on during interviews with medical staff following the case.

Supplies were gathered for the resident to perform the intubation, however, the resident refused to do so until the patient was fully sedated—something the attending physician argued would take too much time. "I am not intubating this patient until [UI] is fully sedated!" The resident yelled out under the pressure. "Doc, the patient really should have more sedation medication before we do [the procedure]," Miranda, a Respiratory Therapist, added. "We do not want this patient to aspirate in the process." Miranda's comments struck me, not because of her objections, but rather because they exposed the shift in the treatment process: the intubation is necessary to "do no harm" by coinciding with the patient's requests (or lack thereof) to minimize the deteriorating conditions, while simultaneously running the risk of doing harm by prematurely intubating the patient before full sedation. It is this moral and legal conflict which fosters the idea of death being a medical failure. The worst possible outcome. The attending physician refuted the recommendations made by his colleagues, quoting the lack of time the patient has until UI's heart would stop completely. The scene was horrid. UI, not fully sedated but also not fully conscious, struggled and fought the intubation with the little energy he had remaining. Medical staff and I were then tasked with holding UI's arms and legs down so that the intubation process can occur more smoothly, while simultaneously, administering

sedation medication into UI. "Everything will be OK [UI]! We are helping you breathe!" One nurse reassured UI. Eventually, UI was sedated, but died several hours later in full code.

The treatment described above with UI was adopted by US healthcare regimes in the 1980s–1990s to treat aging as a medical issue, with the implication if someone inevitably reaches old age, the patients and their deaths would be deemed as a medical failure. This may seem counter-intuitive—why would the patient's death be deemed a medical failure if the treatment provided to them failed? Simply put, because the patient reached the inevitable old age and are dealing with the complications of the aging process, all of which are immediately followed by death, the patients are now out of scope with the capabilities modern medicine possesses, and the patient is left with nothing more for modern medicine to provide them. As stated by Kris during an interview: "because medications and treatments have altered the aging process, there is some hope that, despite [the patient's] comorbidities, we can optimize them enough to bring them back to the baseline they came in at." This point is important—and commonly highlighted within the ICU and ED—as it demonstrates the limitations modern medicine has when dealing with end-of-life care. Throughout observations made during my clinical experience and patient encounters detailed in interviews with medical staff, there is no "reversal" of ailments happening at the bedside when the patient reaches the inevitable state of "circling the drain." It is at this point that the treatment focus shifts from combating the aging process (the "circling") to combatting death itself (the "drain") and the paradigm shifts from aging as an amendable entity to death as a looming medical threat—the new "thing" to overcome. Patients and their families often arrive to the ICU with the illusory expectations that suddenly all comorbidities would be resolved given the magnitude of resources and machinery at the patient's disposal (let alone the financial burden these resources and machines cost to acquire and use by the patient). The reality is, however, most end-of-life treatments result in death becoming prolonged and violent, rather than providing patients the means to overcome their current circumstances. Death, therefore,

represents quantifiably and figuratively, the ultimate failure within US healthcare regimes, and this failure is at the expense of patients' dignities and livelihoods, and the medical providers' moralities.

American Self Reflection

The United States' healthcare system carries mixed reviews among the US population regarding end-of-life care. Citing a 2017 study titled "Views and Experiences with End-of-Life Medical Care in the US," 25 percent of respondents rated the care as "good," 27 percent rated "fair," and 22 percent rated "poor" (Hamel et al. 2017). In terms of autonomy, the majority (87 percent) believe that patients and their families should have the greater say regarding which treatment options to pursue for patients who are seriously ill and nearing the end of life, while just 8 percent believe doctors should have the greater say (Hamel et al. 2017). The data presented on autonomy currently reflects the system Dr. Carlos refers to. Dr. Carlos also falls within the majority who appreciates the autonomy of US medicine rather than the "paternal-led" medicine observed in other countries. Aside from autonomy, Americans state to also prefer honesty from their healthcare providers, no matter the prognosis (Hamel et al. 2017). Just 7 percent say that when a patient is seriously ill, it is more important for their doctors to emphasize hope, while the vast majority (88 percent) say it is more important for doctors express full honesty, even if there is little chance of recovery (Hamel et al. 2017). However, it has been observed in the past and present that when medical professionals present the objective information of a loved one's condition, trust is extracted from the science and medicine and is applied to one's faith or opinion (Field 1997; Schenker et al. 2012). In other words, while a significant portion of Americans desire honesty and bluntness, that desire does not correlate with acceptance of the circumstance, nor does it indicate that death is accepted and embraced. This phenomenon strongly correlates with the American response to mask-wearing, social distancing, and receiving the COVID vaccine during the SARS-CoV-2 pandemic.

Despite the autonomous nature of US

healthcare, the public sees room for improvement when it comes to giving patients control over end-of-life medical decisions. About half (49 percent) believe most people in the U.S. have too little control over decisions about their own medical care at the end of life, while four in ten (38 percent) feel patients have about the right amount of control (Hamel et al. 2017). Among those who identify with their own health as being fair or poor, an even higher share (63 percent) indicate feeling they have too little control over their medical decisions (Hamel et al. 2017). When discussing this data with Dr. Smith, Smith indicated that options are available; however, not many seek the alternative options until it is too late to have full control over the circumstance (McHugh et al. 2015). Given how options are currently on the market to remedy this public health crisis, resources remain under-utilized by many Americans (including by those who feel they have too little control over their fate). This reveals Americans not only deter death itself, but also the decisions about it.

Impact of SARS-CoV-2

The United States' healthcare system and the cultural views of death consist of direct and indirect acts of structural violence, the morality and economy of death, and the politics of death and dying. Death as an entity evolved from an accepted inevitable series of events to a feared, evaded, and violent demise capitalized upon via the trafficking of morality between the vulnerable and systemically complicit. With medical breakthroughs prolonging the lives of millions, Americans are living longer, thus leading to further complications and expenses throughout one's lifetime to which the thought of an "end" is repulsed by the living and the economy. Regardless of the kind of exchange done, through financial means or by morality, Americans are unnecessarily suffering; patients are suffering from a prolonged death given the system's lack of expertise and emphasis in end-of-life care, and medical staff are drowning in their own acts of structural violence. Amidst the onset of the SARS-CoV-2 pandemic, the CDC emphasized the danger SARS-CoV-2 may pose to those with pre-existing conditions—nearly three-fourths of the adult population within the United States—with ~30% of those with a

“deniable” pre-existing condition per the standards of the health insurance market (Reid 2017). This data demonstrates that medical breakthroughs stemming from biomedicalization of aging have curated the perfect storm for a pandemic, such as SARS-CoV-2, affecting the ever-vulnerable populations. After decades of treating aging as a medical issue and the curation of breakthrough treatment options for life-altering diseases, along with the systemic denaturalization of death and the American superiority and immortality complex, the United States suffered the worst possible outcome from the SARS-CoV-2 pandemic for a developed nation.

Years without a national public health crisis, such as SARS-CoV-2, passed which allowed the systemic denaturalization of death and the façade that Americans were indestructible to brew and spread into succeeding generations. In reality, however, Americans were dying within healthcare institutions in the same violent ways they are dying from Covid. Alas, a violent death wave hit by “unprecedented” means: over one million American lives taken from SARS-CoV-2 (CDC 2022). Perhaps, however, the SARS-CoV-2 pandemic is not directly responsible for the deaths of one million Americans, but rather is an opportunistic infection taking advantage of the United States’ weakened healthcare infrastructure and its illusive death-preventing capabilities and demonstrating the violent extent death is capable of the longer is it prolonged, avoided, and viewed as a medical failure, rather than a universal demise with violent capabilities.

Conclusion and Future Directions

As demonstrated throughout this research, death in the United States is taboo and viewed as a medical failure within US healthcare regimes. Thus, discussions regarding end-of-life preferences are dismissed with loved ones and medical personnel, and the fear of the “unknown” is comforted by the bliss of ignorance. Americans strengthen the magnitude of this two-fold public health crisis as their acceptance for a predetermined institutionalized fate is greater than their acceptance for the once universal truth of death. To restore the dignity of dying

Americans, death needs to be naturalized — something that has not been done on a structural level in the United States for hundreds of years. While many discussions have already taken place between patients and surrogates detailing preferences leading up to and following one’s death, the societal and cultural barriers of death being taboo need to be demolished for true resolution to take place —where prolonged suffering is no longer the accepted outcome for dying Americans (Kaufman 2006, 117). It is therefore the duty of the medical profession to foster these conversations about death and dying to Americans, and aid Americans in viewing death as a successive stage of life.

Given the profoundness of death, there is no simple or binary solution in naturalizing its existence, but rather systemic change needs to be undergone to restore Americans’ dignity during the dying process, and to minimize unnecessary suffering among the dying and the medical providers. There is no better time than now, amidst a global pandemic, to confront the relationship between SARS-CoV-2 denial and the politics of death-denial systemically. Rather than perpetuating the deceptive narrative that the United States possesses vast life-saving capabilities within the critical care specialty, and thereby forcing medical staff to compromise dignity of their own, healthcare institutions and stakeholders possess a moral obligation to reveal the open secret of the limitations within the critical care specialty regarding the lack of treatment for the inevitable. Healthcare providers across specialties must educate patients on the offerings of hospice and palliative care, and advocate for policy change to increase the accessibility of advanced-directives and DNRs for all individuals, regardless of health status and age. Palliative care is currently offered on the market; however, its services remain under-utilized and inaccessible by much of the public due to lack of education and lack of proximity to alternative end-of-life treatments (Kaufman 2006, 278). To increase accessibility, funding and expertise need to be allocated into the palliative care sector to allow for an increase in education to build a larger demand for the specialty, especially within rural and medically under-funded communities, and to foster a swift

transition of care from critical care specialties to at-home care. While this research explored the tension in which death is viewed as a medical failure within US healthcare regimes, future research is encouraged to explore other ways Americans are suffering and dying without dignity outside medical institutions, such as from the politics of environmental contamination, racism, police brutality, and gun violence.

One's quality of life and the restoration of dignity on one's deathbed have been missing focal points within the United States healthcare system for decades, and Americans have been 'circling the drain' while paying the consequences of the nation's inability to accept death, and view it as a legitimate entity, until it comes knocking on their door. Despite the overarching cultural belief within the United States, death is not a medical failure; however, the United States' inability to accept, prepare for, and naturalize death and its processes is the most detrimental failure of them all.

I have learned from my life in medicine that death is not always an enemy. Often it is good medical treatment. Often it achieves what medicine cannot achieve—it stops suffering.

—Christiaan Barnard (Good Life, Good Death 1980, 144)

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