Transcript for Sunita Puri's Podcast – to publish on Nov. 1, 2023

Palliative care expert Sunita Puri, MD, associate professor of medicine, delves into the complexities surrounding cardiopulmonary resuscitation, or CPR. Drawing from her extensive experience in the field of palliative care, Dr. Puri sheds light on the hidden harms of CPR and challenges prevailing beliefs.

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Voice over artist

Thank you for listening to the Voices of UMass Chan, featuring the people, ideas and advances of UMass Chan Medical School.

Sunita Puri reads an excerpt from her article published in *The New Yorker*

Shortly after his sixty-seventh birthday, Ernesto Chavez retired from his job at a Los Angeles food warehouse. Sara, his wife of forty-five years, told me that he meticulously took his medications for high blood pressure and cholesterol, hoping to enjoy his time with his grandchildren. But one morning in January 2021, Ernesto burned with fever, his chest heaving as though he were once again lifting heavy boxes. At the hospital, he tested positive for COVID-19. His oxygen levels plummeted, and he was quickly intubated. Ten days later, his lungs were failing, his face was bloated from liters of intravenous fluid, and his hands and feet had begun to cool. As his chances of survival waned, I arranged to speak with his family about a subject inseparable from death itself: cardiopulmonary resuscitation, or CPR. For decades, physicians have debated whether CPR should be offered to people who suffer from the final blows of incurable illness, be it heart failure, advanced cancer, or dementia. Although CPR has become synonymous with medical heroism, nearly eighty-five per cent of those who receive it in a hospital die, their last moments marked by pain and chaos. The pandemic only deepened the risks: every chest compression spewed contagious particles into the air, and intubation, which often follows compressions, exposed doctors to virus-laden saliva. Hospitals in Michigan and Georgia reported that no covid patient survived the procedure. An old question acquired new urgency: Why was CPR a default treatment, even for people as sick as Ernesto?

Jennifer Berryman
So that is the voice and the writing of palliative physician Dr. Sunita Puri, reading from her recent article published in *The New Yorker.* Here at UMass Chan Medical school, Dr. Puri is an associate professor of medicine and program director of the hospice and palliative care medicine fellowship. We're fortunate that she is our today's guest for this episode of the voices of UMass Chan. Dr. Puri, welcome.

Sunita Puri
Thank you so much for having me.

Jennifer Berryman
So, we just got the very slightest taste of it. But you are, I think it goes without saying, an accomplished writer. You've penned pieces on palliative care and the end of life, or mainstream news outlets like *The New York Times*, *The Atlantic*, *The New Yorker*, and you authored the book, "That Good Night: Life and

Medicine in the Eleventh hour," which is a memoir about your journey to the practice of palliative medicine. For you, what is the connection between providing palliative care to patients and their families, and writing about it?

Sunita Puri
So, I think, in general, there's a very interesting relationship between being a physician and being a writer, because both things really boil down to something very simple and everyday, which is the art of observation. So, in medicine, we are from the moment we enter a patient's room we are observing, we're looking at how they look overall at how they're breathing, whether they're grimacing, and discomfort, or sweating, and what all of those things can indicate. And as a writer, what I enjoy thinking about and observing is human nature. So why do people act the way they do? How do they act when nobody's looking? What is the way that they make sense of the world? And in palliative care these are some of the questions are especially that last one that I have to kind of dig into, because a person's lens on the world is often their lens on their disease. And I have to understand that perspective in order to try to get them to see the perspective from the medical standpoint or the medical reality that might or might not kind of clash with their hopes and their perspective on their life and illness. And so much of palliative care, at least the way I practice it is very linguistic in nature. So that's also a place where writing informs palliative practice for me and also a way that my palliative practice informs my writing. So, if someone says to me, I'm a fighter. My job is not to just take that at face value, but to kind of push for what they mean by that. So, help me understand what being a fighter means to you helped me understand what you mean when you say you want everything done. And it means really being willing to kind of go layer by layer into what someone is actually trying to tell me because I can't help them in the ways I want to, unless I really know what they mean. And what I and for me, getting at the core of that meaning or what they're trying to communicate, ultimately tells me so much about their nature. And I observe the nature of the other physicians and healthcare providers involved in the field. What are they saying or editing out of what they're telling a patient? And I really do think like a writer in those conversations that what is the subtext? And what is the text? And how can I bring out the subtext in order to have a more informed conversation with people? So, I think medicine and palliative are natural bedfellows, but also palliative medicines relationship to language for, for me as a writer is a very exciting space to be in.

Jennifer Berryman
And those are complex, sensitive, challenging conversations, right? I'm sure you didn't mention family dynamics. But I'm sure that you're reading the family members who are in the room as

Sunita Puri
I was telling my learners that when I'm running a family meeting, and they're observing, that I am, I almost it's almost like a meditative space, because I am so focused on exactly what you said, reading the patient, reading the relationships in the room, reading my colleagues, managing the dynamics, calling things out when I need to understanding when to pull back. So, if we think about communication as a procedure, it's kind of like a sort of the surgeon's art of surgery, where I have a bunch of tools available to me in terms of words and observations of other people. And I have to decide which tool am I going to pick up? Is it going to be a blunt tool? Is it going to be a sharp tool? And to what end? Am I saying the sentences I'm saying, how is it going to advance this conversation? And how is this conversation going to advance that patient's care?

Jennifer Berryman

Let's frame an important piece of information for our listeners. Just before we continue with the conversation. Can you just remind us how palliative care differs from hospice?

Sunita Puri
Yes. So palliative care is a type of medical care that focuses on relieving suffering and improving the quality of life of people with serious illnesses. And that involves treating their physical pain, understanding and treating their emotional and spiritual pain and providing support to their family. And we do two big things, we manage symptoms, and we help our conversations about what people really want for themselves when they're very sick. And you can get palliative care right alongside other treatments. So, it's not dependent on how long you have to live. If you're getting chemo, you can get palliative care to support your symptoms and make sure you're having the right discussions about what matters to you. You can get palliative care if you're on dialysis. And the difference between palliative and hospice is that at the time of hospice, we're doing the same things as palliative care does in terms of the attention to suffering. But for hospice, we're not doing things like chemo or dialysis. We're parting ways with that in favor of managing the ways that cancer or renal failure affects the person. So as opposed to palliative, which you can get alongside other treatments. Hospice is the time where we think you have six months or less to live. And we're parting ways with some of those treatments to allow a natural process of dying to unfold a hospice.

Jennifer Berryman
You could say maybe as a phase of palliative care, it's a piece of the puzzle, but it's not the puzzle.

Sunita Puri
Yes, it's their sister specialties. Palliative care actually grew out of hospice, which was a movement that started in the 70s here. So, hospice kind of came first. And because hospice did so well for people, the thing naturally, folks wondered, why aren't we doing this earlier in a disease course. And that was really kind of the birth of palliative care.

Jennifer Berryman
You wrote so powerfully about Ernesto and his example and how it opens a door to the health care system. And so, I want to get back to that into his story. So, this, this New Yorker article that you read from is called, “The Hidden Harms of CPR,” and I think the average consumer or the average person doesn't know this. So, what did you want us to know by writing this article?

Sunita Puri
I have been fascinated by the history of CPR and the ways we use it for very long time ever since, as I eluded, as I wrote about in the article, ever since I was a resident and didn't know how to talk about this, and subjected people to CPR that they didn't need and filled their last moments with pain and suffering. And I had a lot of shame about that. And a lot of those memories stayed with me. And what I wanted to do in this piece was to help both the lay public, but also people in medicine, challenge their views and the beliefs around CPR. Because I think when we talk about it, we think both sides are thinking a lot about what it represents or symbolizes, and not actually what it is practically. So, I wanted to dispel some of them mythology around CPR, especially, as you know, this very heroic, this is the pinnacle of medical heroes, this is the way that medical teams show that they care about you. And for families, it is a show of advocacy, we are not going to let our loved one die unless we try quote unquote, everything. But I think what people miss is that the statistics don't lie around the success of CPR. And the history is fascinating because it was invented for people with acute, sudden reversible injuries who were otherwise pretty healthy. And so, you know, I wrote in the piece, and I can read from the section where I

talk about Damar Hamlin, and what his example showed us is what people think CPR achieves all the time, when it actually doesn't.

Jennifer Berryman
Yeah, tomorrow's the Buffalo Bills football player who collapsed suddenly on the field.

Sunita Puri
So, to read from that section, “It is an open secret in medicine that CPR is both brutal and rarely effective. The procedure begins at death when someone loses a pulse. This can happen because of heart problems, a blockage in a coronary artery or when other organs cause cardiac arrest. lung failure depriving the heart of oxygen, Kidney Failure call is causing a buildup of toxins. CPR is designed to keep blood flowing to the brain in these situations. It requires 100 chest compressions per minute, two inches deep to the beat of the song Stand alive on using a defibrillator to deliver an electric shock to the chest. In hospitals. It also includes IV medications to help the heartbeat and a ventilator to help the patient breathe. The result done correctly, is akin to assault. The force of compressions can shatter ribs and breast bones, puncture lungs, bruise the heart and cause major blood vessels to rupture. Repeated electrical shock can burn flesh. Even if a procedure restores a heartbeat, brain damage whether mild memory loss or a vegetative state occurs in 40 percent of hospitalized patients. There are times when these risks are worth taking. CPR can save lives when patients are relatively healthy and when the cause of their death is reversible or unclear. Damar Hamlin, the Buffalo Bills player whose heart stopped during a nationally televised game in January typifies the person for whom CPR was invented, young and fit and the victim of sudden treatable injury rather than a progressive disease. Still, less than 10 percent of people who receive CPR outside of hospitals survive. Inside hospitals where CPR begins quickly, the odds are slightly better, but only for those who aren't in the last stages of life, a mere 2 percent of adults over 67 with severe chronic disease, including cancer are alive six months after CPR, and they often deal with pain, physical disability and post-traumatic stress disorder. reversing a death is not the same as restoring a life.”

Jennifer Berryman
Reversing death is not the same as restoring a life I mean, I think you paint a picture of backing up while you call CPR brutal, you say it can be brutal and that it has become an expectation rather than an exception. So, there's so much to explore here. So, should we continue to train and CPR? How does medical decision making come into this? How do you have these conversations with family should CPR or not to CPR be part of the patient's palliative care plan?

Sunita Puri
So yes, so to start with your first question about whether we should continue to train in CPR Absolutely. Yes, because when it works, it works really well. So, I'll tell you, if I was in a grocery store and someone keeled over and they lost a pulse, I would begin CPR immediately and send somebody to get the defibrillator in the store, and another person to call 911. And the reason being, I don't know what caused them to have a cardiac arrest, it could be something like a heart attack, where a coronary artery needs to be opened quickly. But we won't know that unless we make the efforts to keep them going until they get to the hospital. And again, CPR is mostly designed to keep blood flowing to the brain, which is I think, another thing people don't know, they don't know the severe neurologic consequences of having your body die. And having us try to keep your brain getting blood until we can figure out the cause. So, I definitely think CPR classes should continue for everyone. In workplaces, lifeguards, obviously, people who need to know it EMS within hospitals, because when it works, it works really well.

Jennifer Berryman
But you bring up this distinction between real world settings and a hospital setting.

Sunita Puri
So, in the real world, part of the reason that so few people survive is because they're not often found in time. So, somebody could have a cardiac arrest, and their spouse might be downstairs in the kitchen, and not come upon them for half an hour. And if you have been down for half an hour, the odds of you surviving are next to none, even with high quality, immediate CPR. So, outside the hospital, it's just a matter of luck. And even if somebody finds you quickly, can they do chest compressions correctly, because these are not easy to do. They require a tremendous amount of force, and you can get tired quickly. So those are some variables that make out of hospital CPR, less likely to help in the hospital, we know your problems. So, the first thing that we should be talking about with you is, is CPR going to help restore the life you want the quality of life you want? And is your underlying issue reversible, meaning do we have a reasonable chance of treating the cause of a potential arrest. And when somebody has end stage cancer and stage cirrhosis, heart failure, we have to be honest with patients and ourselves about the limits of what we can do, and the limits of the body. And I don't think we're good in our society in general, let alone in medicine, discussing limits, discussing the reality that our bodies are going to change and die. And if we can't become more comfortable with that idea, both within medicine and outside medicine, we're going to continue to have people have their deaths extended by CPR that will not help them survive.

Jennifer Berryman
So really is your article, a call to action for your fellow physicians and nurses and care teams?

Sunita Puri
It's a wakeup call is really kind of how I would think about it. And it's a wakeup call that's not a polemic. Because I have put the history in there and interviewed other people, and really situated it in the context of COVID, where everything we knew about CPR was now coming to the forefront. That you know, this does not work as much as we would like to live in a magical reality where it works all the time. So how do we shed our magical thinking about CPR about medical heroes, about what it means to advocate for what's right for our families or a patient's when what's right for them may not be fully informed, because we haven't explained to them that CPR is it, we invented it to reverse death, not necessarily to prolong survival. And that is a very, very different way of thinking about things, but that enables true informed consent. So, it's really about a wakeup call that advocates for informed consent and asking people whether what we can do is what we should do for them.

Jennifer Berryman
How do you integrate all of this into your role at UMass Chan?

Sunita Puri
So, my role at UMass Chan is that I direct the palliative care fellowship training program and, and I teach a lot of the rotators that come on to our service from internal medicine, anesthesia, critical care oncology and people who want to do electives, and the medical students, of course. And I really try, in my individual practice, to help people think very carefully about the language they're using, and to think about the language other people are using. So, I will often ask my students, or whoever's rotating and observing a meeting with me to write down what they're observing in the meeting. So, what are turns of phrase that I use or other people use that they found to help that meeting move forward? What were

things that were said or left unsaid, that didn't advance the goals of the meeting? Did they feel that the family left with a clearer sense of what's going on to enable them to make the right decisions for themselves or their loved ones. So, I try to draw a lot of attention to language. And to help people understand that these meetings are a lot like writing an essay, you have a couple of major points you want the family or the team to walk away with. So, like a writer, you are going to try to do your best in kitchen table language to lead the reader to understand your perspective. And you in writing the essay have to anticipate their perspectives to make it a balanced peace. Leading a family meeting is very similar, because we're going in with two maximum three big messages that we want them to take away and we shape those messages with the other members of the team. But in the meeting, we also as we go in, we have to think about what are the potential objections or things that are going to come up. I try to make them see that these conversations have a structure and a language that they need to learn to be effective communicators.

Jennifer Berryman
Dr. Sunita Perry, thank you so much for joining us today. So thought provoking. It makes me want to have conversations with my own loved ones.

Sunita Puri
Well, thank you so much for having me. It has been a pleasure.

Jennifer Berryman
Thank you. We will provide a link to Sunita's book and her recent article in *The New Yorker* in our show notes. If you like the *Voices of UMass Chan* podcast, and we hope you do, please subscribe so that you don't miss any new episodes. We also want you to know that you can now listen to the *Voices of UMass Chan* on our YouTube channel. Until next time, I'm Jennifer Berryman, have a great day.

Voice over artist

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