Foreword

> The father of the bride entered our emergency department face up on a gurney, with one paramedic pumping on his chest and another squeezing oxygen into his lungs through an endotracheal tube. Although his perfectly shined shoes were still laced, his tuxedo had been carelessly torn open to make way for electrocardiographic electrodes, defibrillation pads, and IVs. Trailing him were his wife and son. He had been dead for 45 minutes, yet we stood poised in the resuscitation room, about to spend another hour trying to bring him back to life.

THIS BOOK examines a topic that has received surprisingly scant attention, despite the roughly 400,000 sudden deaths per year in the United States. How is it that a whole industry has grown up around cardiopulmonary resuscitation (CPR) when it seems to be so rarely successful? In exploring the answer, Stefan Timmermans meets the difficult challenge of articulating a common ground of interest for emergency medical staff, basic researchers, ethicists, sociologists, anthropologists, policy wonks, and that large and important constituency lumped under the inadequate rubric "lay readers."

Those who work in emergency medicine—first responders, paramedics, nurses, physicians, social workers, respiratory therapists, radiology techs, pharmacists, clergy, and others—will find, as I did, the full spectrum of emotional responses portrayed here, from a neophyte's unbridled enthusiasm to a veteran's more ambivalent stance. But the book goes beyond simple portrayal; it encourages us to examine our emotional responses in depth, a luxury we're rarely allowed during actual resuscitations.

Researchers and historians of medicine will appreciate Timmermans' detailed and careful outline of the evolution of CPR, which includes material from interviews with several of the field's leaders. Social scientists and health policy analysts will find a stimulating, somewhat contrary portrayal of what has become one of the pillars of Western biomedical practice, a portrayal in which Timmermans highlights the

distinction between saving life and coping with death. Throughout the book, he disentangles and explores the complex knot of medical, social, and ethical issues with care and compassion.

The first three chapters provide an historical overview of social and medical attitudes toward dying, of the evolution of resuscitative techniques, and of the development of an emergency medicine infrastructure in the United States, including a widespread network of emergency transport and mass training of lay persons in basic life support. This overview sets the stage for the next three chapters, which summarize, with vivid vignettes, Timmermans' year-long ethnographic observations in two emergency departments. Along the way, Timmermans explicates social and emotional issues underlying CPR, such as patient and professional identity, the relationship between the rescuer and the rescued, the dynamics of the resuscitation team, the demystification of death for members of the resuscitation team, and the meanings of the CPR ritual. In addition, he analyzes decision making during resuscitations, including when to start and stop, and deciding—and decoding—when a person is dead and what makes for a "good," "bad," or "tragic" resuscitation. In the final chapter, Timmermans explores policy issues and potential nonbiomedical improvements to current CPR practice, such as allowing family members to be present during resuscitation efforts or paying more explicit attention to the needs of the survivors.

Readers will find that this book stimulates further biomedical, social, and ethical questions. In the biomedical sphere, how might medical research help CPR fulfill more of its historical promise? Perhaps detections of T-wave alternans or possibly beat-to-beat variability might lead to better prediction of susceptibility to sudden death. If we get better at predicting who might be at higher risk for sudden death, perhaps more patients will survive with intact neurological function. Are there opportunities for health care information technology to strengthen the "chain of survival"— for example, by automatic dispatch of medics or by more rapid retrieval of a patient's medical record?

In the social sphere, are there ways other than CPR to fulfill some of the nonmedical functions of seemingly futile resuscitations? For example, could public education possibly change societal attitudes toward death, or toward death in the home as opposed to death in the hospital? In what ways might sudden death and resuscitation be viewed differently in other cultures, both in the United States and abroad? And what about the experiences of the patients and their families? Unfortu-

nately, constrained by the institutional review boards of the hospitals in which he did his observations, Timmermans was forced to focus on the experiences of the staff rather than of the patients.

In the ethical arena, a growing body of literature has developed around questions of what constitutes "futile" care, and the concept of a "good death." Are there ways to maximize the chance that a sudden death will be a good death? What are the pros and cons of trying to eliminate all disparities in how different patients are resuscitated? Are there ethical costs to the reification of CPR as a pillar of modern emergency medicine? What might be the consequences if managed care treatment protocols begin to specify when resuscitation efforts will and will not be reimbursed?

I feel triply implicated in this discussion of CPR: as an emergency physician with nearly two decades of prehospital and emergency department work, both in the United States and abroad; as a student of one of the pioneers of modern CPR—Dr. Peter Safar; and as the widower of a wife who was not, and could not have been, saved from a sudden death by resuscitative efforts. Like many readers, I've confronted the sudden death of individuals and its ripple effects on their families, caregivers, and the broader social network. As a physician, I've both rejoiced at "good saves" and felt disquiet at "failures" or, even worse, "bad saves," without fully being able to delineate crisply the boundaries of these categories. Perhaps for some readers, for Timmermans, and for myself, the loss of a loved one has raised important questions about our attitudes toward death and toward technologies designed to thwart it.

This book invites us to think more deeply about healing, even in the face of sudden death, and about resuscitation, not only of the patient but also of the survivors and caregivers. I hope this book will help all of us, including the family of the father of the bride, find some measure of wisdom and peace in our society's rituals surrounding CPR.

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Preface

THIS BOOK is for everyone who has taken a cardiopulmonary resuscitation (CPR) course and wondered what would happen if he or she actually had to use CPR. Should you resuscitate or not? How likely are you to save a life? What happens if you don't save a life? Should you resuscitate even if is very unlikely that you will save a life? This book is also for the survivors of CPR, who are exceptionally lucky to have survived. I hope as well to provide answers to the many questions of bereaved relatives and friends who have been haunted by concerns about what went wrong when a loved one did not survive a resuscitative effort. In addition, this book is for the many health-care providers in emergency medicine who wonder how we can improve resuscitative care. I observed your resuscitative efforts and listened carefully to your stories of caring for people during sudden death. I hope that, after reading this book, you will be inspired to change resuscitative care in your departments. Finally, this book is for social scientists interested in the medicalization of sudden death.

At the core of this book is the paradox that people living in the United States and other Western societies resuscitate and keep resuscitating although these efforts rarely save lives. I explain the gap between the purpose of the technique and its actual result by looking at the development of resuscitation techniques and at the construction of an aggressive interventionist emergency system. After providing an overview of the historical and structural factors behind the current emergency medical infrastructure, I describe the emergency department, where most resuscitation efforts takes place, and I explain how professional staff make sense of routine resuscitation. This analysis points to the different purposes resuscitative efforts serve besides saving lives, and it identifies the problems with the current system of resuscitative care. In the end, my goal is to highlight ways to turn sudden death into a more compassionate and dignified passing.

I feel privileged to have received the support of many while researching and writing this book. Some people's contributions are especially visible. I am especially grateful to Leigh Star, Andy Pickering,

Norm Denzin, Peter Conrad, Marc Berg, Laura Neumann, Ruth Baxter, Debi Osnowitz, Michael Ames, my relatives in Belgium, and Anselm Strauss. Leigh generously offered me her mentorship throughout all the colorful tribulations of the research process and gently invited me to cross disciplinary boundaries. Andy pointed me to the "so what?" question. Norm encouraged me to leave the safe haven of classical ethnographic writing. Peter reminded me of a well-defined body of medical sociology. Marc kept me on my toes with his warm friendship, collaboration, and insightful remarks. Laura helped me transcribe some of the interviews and provided thoughtful comments on an earlier version of this book. Ruth convinced me that there is more to life and death than sociology and kept me smiling through the writing process. Debi offered a superb editing job. Mike was a patient critic and editor in the rewriting and publishing process. My relatives in Belgium encouraged me from a distance. Finally, I am grateful to the late Anselm Strauss, my academic "grandfather," whose theory, method, and friendly reminders permeate this work.

I am also much indebted to all the nurses, physicians, technicians, paramedics, respiratory therapists, social workers, and chaplains who allowed me to witness their lifesaving efforts and shared their stories in interviews. I especially want to thank "Ruth Berns" (all names of resuscitation staff and patients are pseudonyms), who, more than anyone else, shared her story and her friendship with me. For the historical part of this book, I am very grateful for the help of the archivists Crawford Keenan, Gerard Shorb, and Ms. Cavagnero at the Alan Mason Chesney Medical Archives of the Johns Hopkins Medical Institutions and for the help of the librarians of the medical library at the University of Illinois. I also would like to thank Drs. Bahnson, Isaacs, Jude, Safar, and Knickerbocker for sharing their views about the history of CPR.

Several people commented on at least one chapter of this book. I thank Amy Agigian, Madeleine Akrich, Renée Anspach, Amber Ault, Isabel Baszanger, Margaret Baxter, Oliver Benoit, Nancy Berns, Geof Bowker, Perry Bridger, Maryellen Burke, Monica Casper, Clifford Christians, Adele Clarke, Claire Cummings, Antoinette de Bont, Elaine Draper, Steven Epstein, Gary Alan Fine, the late Diana Forsythe, Joan Fujimura, Emilie Gomart, Judy Hanley, Karen Hansen, Joe Hopper, Niranjan Karnik, Susan Kahn, Christa Kelleher, John Kelly, Katrin Kriz, Sarah Lamb, Valerie Leiter, Tim Liao, John Lie, Mike Lynch, Evan Melhado, Madonna Harrington Meyer, Annemarie Mol, Jessica Muller,

Buddy Peshkin, Victoria Pitts, Jude Preissle, Eli Sagan, David Schweingruber, Steve Shapin, Maury Stein, Reya Stevens, Mindy Stombler, Veerle Stroobants, Kari Thoresen, Alexandra Todd, Jef Verhoeven, Paul Vernon, Kath Weston, Jack Whalen, Angela Yancik, and Barbara Zang.

I thank the Program of Ethics and Values at the University of Illinois for its financial support, the sociology department of the University of Illinois for the Geisert dissertation writing fellowship, and Brandeis University for the Mazer award to finish this book. Parts of Chapter 4 were published as "Saving Lives or Identities? The Double Dynamic of Technoscientific Scripts," in *Social Studies of Science* (1996) 26 (4): 769–99; an early version of Chapter 5 was published as "Social Death as a Self-Fulfilling Prophecy: David Sudnow's 'Passing On' Revisited," in *The Sociological Quarterly* (1998) 39 (3): 453–72; and a more elaborate version of Chapter 7 was published as "High Tech in High Touch: The Presence of Relatives and Friends During Resuscitative Efforts," in *Scholarly Inquiry for Nursing Practice* (1997) 11 (2): 152–67.

I dedicate this book to the memory of three strong women from three generations who all died in 1990–91, when I first began thinking about this project: my grandmother Augusta, or "Moeke," the warm center of the Timmermans family; my mother, Marthe, whom I probably resemble most; and my favorite cousin, Ann, for whom the technique I will follow in the next pages failed to fulfill its promise.

Introduction

What They Didn't Tell You in Your CPR Course

It is 9:35 on a Thursday evening in February. The weather forecast predicts sleet and maybe an ice storm. Ruth Berns,[1] an emergency department (ED) nurse, shivers when she pulls the curtain around a patient's bed. She thinks of her husband, a firefighter and avid motorcycle rider. "I hope he'll be safe tonight," she prays. When she walks back to the nursing station, she quickly glances at the patient board. With the weather forecast, this could be a busy night in the ED. Until now it has been rather quiet: a nursing-home patient's broken finger, a child with a sore throat, a regular patient with benign chest pain, two minor motor-vehicle accidents, and a woman who needs a rabies shot. Berns walks to the computer, orders the rabies vaccine, and prepares the five injections that precede it. While she calculates the exact dosage on the basis of the patient's weight, a radio call comes in. Lisa Lopez, her colleague, takes the call.

Shortly, Lopez comes over to Berns and says, "It was Bow ambulance. They have a code—a guy, 56 years old. Can you take him in room six?" When Berns nods, Lopez fills her in: "It was a witnessed arrest. They started CPR after about five minutes. Extensive cardiac history. The paramedics gave him epinephrine, lidocaine, shocked him at least four times. They should be here in about five minutes." Lopez then asks the department secretary to page the respiratory therapists, the nurse supervisor, and the social worker while she gives Dr. Michael Sears the same synopsis that she gave Berns. Berns motions Derrick Tovey, the ED technician, to follow her and tells him that a code is on the way. Together they ready the drugs and switch on the EKG monitor. The respiratory therapists, Lopez, and the nurse supervisor join them. They wait for the patient to arrive.

At 9:42 P.M., the paramedics wheel the stretcher into the resuscitation room. One of them is pushing an oxygen bag connected to a tube in the patient's mouth while the other steers the stretcher. A third person, wearing a sheriff's department T-shirt, stands on a bar under the

stretcher administering chest compressions. The patient is a middle-aged white man who seems to be wearing formal clothing. His shirt is torn open, and his tie has been cut loose. On his chest, three leads are connected to a portable defibrillator, which is placed on the stretcher between his legs. Quickly he is transferred from the stretcher to the ED bed. The respiratory therapists determine whether he is intubated correctly, detach the ventilation bag from the tubing, and attach the patient to their own oxygen and ventilation bag. At the same time, Tovey takes over the compressions. Berns checks the IV line established by the paramedics while she listens to their report.

Dr. Sears enters. He asks, "What do we have here?" The paramedic repeats: "We found him at the City Hotel. Full cardiac arrest. There was no ambulance available; firefighters got him first. After five minutes they started CPR. The firefighters shocked him seven times; we shocked him six times. We pumped him full of epinephrine. I think we gave him at least five and a couple of lidocaines, and he didn't respond. No pulse. He's had open-heart surgery." Berns tries to hook the patient up to the monitor in the room. She asks the team to stop the CPR. After a while, the monitor shows a very irregular rhythm; an occasional peak followed by a straight line.

Dr. Sears stares at the rhythm on the monitor. He says, "OK. We'll keep this nonsense up for ten minutes." One of the respiratory therapists repeats in disbelief, "Ten minutes?" She is new to the hospital. The doctor looks at her, annoyed, and gestures. "We have obviously already done everything: glucose, bicarb, epinephrine, defibrillation...." He then turns to the paramedics and says, "This man looks older than 50." The paramedic answers, "He's actually 71 years old. He's from out of town. He was a speaker at the City Hotel."

The respiratory therapists seem to have a problem. It appears the air is not going directly from their oxygen bag into the patient's tube. They argue about a possible leak. They pull and turn the tube and replace a piece. Berns asks Dr. Sears, "Do we need to give him anything?" "Yes, give him another epi," Sears answers. The second technician puts a blood-pressure cuff around the glucose bag to squeeze out the last drips. Dr. Sears leaves the room.

After the first rush, things become a little quieter. The paramedic walks to the nurse supervisor, who is taking notes, and tells her in detail what he administered to the patient on the way to the hospital. With some difficulty, Berns has been able to put the epinephrine in the IV line.

She starts talking about another case, in which the nurses in a nursing home thought that a patient had had a seizure, "He wasn't breathing anymore. He was blue for the last five minutes." She adds sarcastically, "They were so happy that the paramedics were there." The listeners shake their head in disbelief. Berns adds, "We got him back two times with bicarb, just enough to let him die in intensive care."

Everyone is now waiting out the time. One of the respiratory therapists mentions a cousin who was in his thirties when he was found slumped over in his truck. The technician asks what happened. "They think he had a cardiac arrest in an asthma attack, but I don't know. I know he was severely asthmatic. He had two children and a third on the way." The glucose bag is almost empty, and Derrick asks whether they should replace it. "No," answers Lopez. "It's only three more minutes, and the family will be charged enough." Tovey stops the compressions for a couple of seconds to check the monitor again, but there is no change.

Dr. Sears returns with the social worker and asks, "Any change after the epi?" He answers himself, "He's not responding to anything, is he?" The paramedic walks in to pick up the portable defibrillator and comments that the patient was at the City Hotel to be awarded Farmer of the Year. The nurses look at the patient and sigh. Observing the ripped clothes hanging off the patient, Derrick observes, "This was probably his only good suit." Lopez turns to the social worker. "What's his name?" she asks. "Richard Elmer" is the response. The technician wonders, "Did you know that he had a cousin with him?" The social worker answers, "There's a whole family over there. Two daughters and he lost his wife in September...." Ruth Berns interrupts, "Stop. I don't want to know anymore. I already start crying when I watch the Oprah show. Today they had two quadriplegics who married after their spouses left them, and they focused for what seemed like an hour on how they tried to put their rings on each other's fingers. I just had to leave the room." The physician is amused by the marriage of quadriplegics. He bends over the patient to look at the monitor and says, "I'm going to declare this patient dead." "Okay" says the nurse supervisor, "It's 9:56." "Make it 9:55. That's easier to remember." replies the doctor. The cardiac rhythm is still as irregular as it was when the patient entered. Most people leave. Berns waits to take a printout of the EKG monitor. She needs a straight line. Then she gently pushes with her thumbs on Richard Elmer's eyelids to keep them down.

THE MYTH OF CPR

Richard Elmer collapsed. His pulse and breathing disappeared. Not so long ago, this would have been the moment of his death. His relatives, friends, and colleagues might have reflected on the irony that he died at a banquet held in his honor, and they would have mourned his sudden passing. But at his collapse, Elmer was not immediately—or, at least, not officially—dead, and his relatives undertook some very specific actions to keep him alive. They dialed 911, extended his neck, and placed their mouths on his mouth and their hands on his chest. By performing these simple steps, they set into motion a vast emergency system aimed at reversing the dying process. Similar scenarios are played out daily, hundreds of times throughout the country, underscoring resuscitation as the routine response to sudden death.

The most striking aspect of Elmer's story is its outcome. The resuscitative efforts of first responders, paramedics, and an entire ED armed with drugs and defibrillators were insufficient to keep him alive. Few people know that death is by far the most common outcome of out-of-hospital cardiopulmonary resuscitation (CPR) and the advanced cardiac life-support (ACLS) protocols used in the ED. Survival rates for out-of-hospital resuscitative efforts are hard to come by, and estimates vary widely, but there now exists some consensus. In a document approved by the American Heart Association, medical researchers ask,

> What is the maximum practical survival rate? The number of people resuscitated from sudden death by emergency personnel is not known. Nor is it known how many people can be resuscitated with a reasonable chance of surviving and remaining neurologically intact.... Though no national averages are available on the proportion of people who survive out-of-hospital cardiac arrests, *current estimates suggest that no more than 1–3% of victims live to be discharged from the hospital. The true percentage is probably even less.*[2]

These low percentages mean that in the overwhelming majority of resuscitative efforts,[3] people die. Still, we keep teaching schoolchildren CPR; we portray overwhelmingly successful resuscitative attempts on TV; and we invest millions of dollars in a sprawling emergency-system infrastructure to create the expectation that with resuscitative care every death may be averted. The widespread use and availability of resuscitation techniques in American society means that sudden death equals premature death, a death that by definition comes too early. People act

as if death caused by heart attacks, strokes, and accidents is a treatable event, to be cured like a Strep throat infection with the right medical intervention. But if the purpose and expectation of CPR is to save human lives from sudden death, resuscitative interventions are largely failures. Their intended goal is rarely attained. Belief in resuscitation has the value of a revered cultural myth perpetuated by "real-life" television shows and the organizations promoting CPR. The techniques spin a tale of heroism, medical magic to overcome the adversity of death, and the holy grail of a prolonged life in everyone's reach. Unfortunately, the tale unravels—humans remain mortals—and the promise of saved lives remains mostly unfulfilled.

Even if very few lives are saved, the overuse of resuscitation defines people's experience with sudden death. For Richard Elmer's relatives, the outcome means the life or death of their loved one. For them, the resuscitative effort is a dramatic event. They did what they were supposed to do: they followed the CPR protocols, called 911, and saw how the paramedics transported Elmer to one of the best hospitals in the area. They rushed behind the ambulance, then waited in the ED's counseling room with a social worker. They told the social worker that Elmer had had heart problems, and the social worker explained to them that things did not look good. Still, family members were unprepared for the shock when Dr. Sears came into the room to inform them that Richard Elmer had died. Instead of dying among friends and relatives, Elmer died in the hospital among health-care personnel.

For the resuscitation team in the ED, the same reviving effort was a routine procedure. They did not expect the resuscitative effort to succeed in saving a life, but they still needed to continue resuscitating. There is an unspoken subtext in the attempt to revive Elmer to which only ED insiders are privy. The physician who considers the reviving procedure "nonsense" and his annoyance with the inexperienced respiratory therapist who expresses surprise at its duration, as well as the team's casual conversation about television shows, stories about other failed attempts, nonchalance about the time of death, and jokes about the ineffectiveness of CPR, all indicate that this resuscitative procedure is little more than a matter of going through the motions. Although health-care providers know that resuscitating is often futile, they continue the procedure because they perceive pressure from outside the ED.

Resuscitation also defines sudden death on a broader cultural level. These interventions indicate more than anything else how people in

Western societies at the turn of the twenty-first century have turned away from personal, community-centered dying and embarked instead on an elusive search for the postponement of death. Instead of passing away among relatives and friends with whom we have shared long histories, we pay white-coated professionals to deal with the sudden-dying process. Their work is secluded behind closed doors, and their task is to keep death at bay. With resuscitation protocols spelling out the script during the last moments, death becomes the wrong outcome. When the doors open, a cold body reappears in its finality, cleaned and arranged. The dying process remains invisible, and the customary phrase, "We did everything we could, but...." once again underscores that death should not have occurred. A society that builds and supports an extensive resuscitative system opts for aggressive intervention, death defiance, and medicalization of the dying process.

HOW DIGNIFIED IS SUDDEN DEATH?

The observation that resuscitative efforts save lives only rarely raises the issue of the quality of such a dying process. If a person who was supposed to keep living dies at the end of a resuscitative attempt, how socially meaningful is that dying? How dignified was Richard Elmer's death? If Elmer had been diagnosed with an aggressive, terminal cancer six months earlier, he would have had the opportunity to reflect on his impending end. He could have chosen to put closure on some aspects of his life, and—if he had the resources—he, his relatives, and his friends could have opted during the last weeks for different forms of palliative or hospice care, or they might even have considered assisted suicide. But unlike expected, lingering deaths, in which all parties have days, even months, to reflect on a course of action, the possibility of turning sudden death into a "good" parting moment seems to be severely limited because time, access, and resources are lacking. In addition, the very use of resuscitation techniques focuses on an attempt at reviving, not a consideration of impending death. Thus, while most patients are deceased at the end of resuscitative efforts, their loved ones are unprepared. At the last moments, resuscitative techniques have intervened.

In different ways, Elisabeth Kübler-Ross and the death-awareness movement, Dame Cicely Saunders and the hospice movement, Jack Kevorkian and physician-assisted suicide, and the Hemlock Society ad-

vocate dignified dying at the end of an expected lingering-illness trajectory. These advocates have championed alternatives to customary hospital practice. But who writes about, speaks for, or wants to change sudden death? This book examines the quality of sudden death at the end of resuscitative efforts. As a sociologist, my purpose is to analyze how people use resuscitative techniques to make sense of sudden death. I therefore will investigate out-of-hospital resuscitative practice not as a set of interventions to save lives (which rarely happens anyway) but as a medical action that frames the dying experience. My investigation concentrates on the organization and actual experience of resuscitating in EDs. Like the neonatal intensive-care observer Renée Anspach, I am more interested in how decisions about life and death are made than about how they should be made.[4] My approach differs from the concerns of ethicists, who often use idealistic, extreme resuscitative scenarios to debate morally sound decision-making. I also diverge from legal scholars, who examine the legal ramifications of the decision to resuscitate or withhold resuscitative care. Finally, I differ from emergency physicians and researchers who have written extensively about improving survival rates by changing the emergency-care system, resuscitative protocols, or clinical decision-making. All these analysts provide recommendations about how or when one should resuscitate, but they are less concerned with how resuscitative care is accomplished in practice. Most also assume that the quick and proper use of resuscitative techniques regularly leads to saved lives.

If we want to understand how resuscitative technology might provide meaning to sudden death, we need to withhold judgment about these techniques. Ethicists and many social scientists often refer to resuscitative technology as an example of an excessively technology-driven medicine. They repeat the argument that advanced medical technology has corrupted the dying experience, making it somehow less "natural" (see Chapter 1). At the same time, physicians and some ethicists hail the same technology for saving lives that would otherwise be lost. This blame–hail reasoning isolates medical technology and ascribes to it too much power. In line with a recent wave of science and technology studies, I believe that the important task is to follow technology in action and show how it generates new meanings and changes our understanding about the finality of life.[5] Such an approach does not imply an uncritical stance, but, as I show, it ultimately can be directed toward evaluating the technology and improving the dying experience.

I address the dignity of sudden dying with a combination of historical material, observations, and interviews. In the historical chapters, I explore how, in one generation, American society invested heavily in an emergency medical system and fostered the belief that every sudden death is potentially reversible. Relying on primary archival sources and published medical studies, the historical chapters document the growing medicalization of sudden death, the "statisticulation" (Darrell Huff's term for the manipulation of people by the use of statistical material[6]) used by emergency-system policymakers, and the neglect of sudden death by the death-awareness community. The result is a vast emergency infrastructure centered on universally used resuscitation techniques that potentially enroll every American as a first responder and potential victim in the resuscitation project.

In the ethnographic chapters, I look at what it means to resuscitate on a daily basis when almost no one survives. Using interviews with forty-five ED staff and fourteen months of observations of out-of-hospital resuscitative efforts in two EDs in a Midwestern town (see Appendix), I map how the staff balances social and clinical patient characteristics to reach the "right" decision about life and death during a resuscitative effort. In addition, I explore how a health-care novice learns to evaluate a resuscitative effort on grounds other than its outcome. In the last chapter, I describe some possible avenues for change that would prepare people for impending death. Specifically, while the patient is hanging between life and death, relatives and friends could be given the opportunity to say goodbye to their loved one and be part of these very important last moments. For example, instead of discussing talk shows at the end of the resuscitative effort, a social worker or chaplain could have accompanied two of Richard Elmer's closest relatives into the resuscitation room. There they could have said the last things they regretted never having said; they could have touched his forehead or just witnessed with their own eyes the final moments of his life. In that case, a resuscitative effort would have been not only a lifesaving attempt but also a unique occasion to face the impending death and begin the mourning process. It would have become a parting ritual not in spite of, but because of, the available technology.

As an example of what could be retrieved with some adaptations in current resuscitative practice, I would like to contrast Richard Elmer's death to the anthropologist Barbara Myerhoff's account of the sudden death of a popular Jewish community leader and teacher, Jacob Koved,

at a party in honor of his ninety-fifth birthday.[9] Although firefighters transported Koved to the hospital, his friends and family resisted the interpretation that he did not die among them and dismissed the importance of the last-ditch reviving effort. After Koved was transferred to the hospital, a rabbi took center stage and spoke:

> We have had the honor of watching a circle come to its fullness and close as we rejoiced together. We have shared Jacob's wisdom and warmth and though the ways of God are mysterious, there is meaning in what happened today. I was with Jacob backstage and tried to administer external heart massage. In those few moments with him behind the curtain, I felt his strength. There was an electricity about him, but it was peaceful and I was filled with awe. When the firemen burst in, it felt wrong because they were big and forceful and Jacob was gentle and resolute. He was still directing his life, and he directed his death. We will say Kaddish, the mourner's prayer.

Myerhoff observed:

> People shuffled towards the stage, talking quietly in Yiddish. Many crossed the room to embrace friends. Among the old people, physical contact was usually very restrained, yet here they eagerly sought each other's arms. Several wept softly. As dictated by Jewish custom, no one approached the family, but only nodded to them as they left. There were many such spontaneous expressions of traditional Jewish mourning customs, performed individually, with the collective effect of transforming the celebration into a commemoration. Olga reached down and pulled out the hem of her dress, honoring the custom of rending one's garments on news of a death. Someone had draped her scarf over the mirror in the women's room as tradition required. Moshe poured his glass of tea into a saucer. Finally, the Center had emptied. People clustered together on the benches outside to continue talking and reviewing the events of the afternoon. Before long, all were in agreement that Jacob had certainly died among them. The call to the rescue squad was a formality, they agreed. Said Moshe, "You see, it is the Jewish way to die in your community. In the old days, it was an honor to wash the body of the dead. No one went away and died with strangers in a hospital. The finest people dressed the corpse and no one left him alone for a minute. So Jacob died like a good Yid. Not everybody is so lucky."

If we compare Richard Elmer's death with the death of Jacob Koved, the similarity is that neither could just die. Even a ninety-five-year-old man needed to be resuscitated. The difference is that in Koved's situation, the resuscitative attempt was secondary to the community mourning. Koved's death was socially meaningful in spite of

the reviving attempt. In Elmer's case, the resuscitative interventions prevailed, and the medical goal of saving a life overshadowed his passing. Elmer's relatives and friends were pushed aside by the paramedics and left in a counseling room in the ED. They left Elmer when he was somewhere in limbo between life and death, and when they saw him again, he was officially dead.

We need not fall back on the mourning rituals of a Jewish immigrant community to make sudden death meaningful. There are other ways to adapt the use of resuscitative interventions to the needs of relatives, friends, and all of us to put closure on sudden death. Resuscitative procedures rarely save lives, but with some modifications, we may be able to save sudden death.