Purely Performative Resuscitation: Treating the Patient as an Object

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Abstract: Despite its prevalence today, the practice of purely performative resuscitation (PPR)—paradigmatically, the 'slow code'—has attracted more critics in bioethics than defenders. The most common criticism of the slow code is that it's fundamentally deceptive or harmful, while the most common justification offered is that it may benefit the patient's loved ones, by symbolically honoring the patient or the care team's relationship with the family. I argue that critics and defenders of the slow code each have a point. Advocates of the slow code are right that not all PPR is wrongly deceptive or harmful to the patient or his family, and that the symbolic aspect of medicine is itself morally significant. But the critics are also correct: slow codes are *prima facie* wrong. I argue that pursuing a slow code amounts to treating the patient as a tool for others' benefit—hence, treating him as an object—and that this instrumentalizing quality constitutes one core *prima facie* wrong of the practice. I also build a case for the idea that the slow code may not always be all-things-considered wrong, specifying certain limited conditions under which acts of PPR might ultimately be permissible. Thus, the symbolic dimension of medical treatment is indeed morally important, both in morally favorable and in morally problematic respects—namely, in its symbolic denial of the patient's humanity.

Key words: slow code, dehumanization, objectification, instrumentalization, medical futility

1. Introduction: Toward an Ethics of PPR

The practice of purely performative resuscitation (PPR) enjoys a prevalence in clinical medicine that would surprise anyone familiar with the bioethical literature on the topic. I define PPR as an attempt at resuscitative medical treatment that the care team reasonably believes to be physiologically futile yet that is undertaken for performative or symbolic effect, for the benefit of an audience—paradigmatically, the patient's family. The most salient example of PPR—and the

primary target of moral opprobrium in the literature—is the 'slow code', which I shall define as purely performative CPR that is administered with less time or effort than is standard.[1]

While the practice remains controversial, a recent study found that 69% of care providers had treated a patient on whom a slow code was performed, that a narrow majority (52%) maintained that it was not wrong to do so, and that a comparable number (53%) held that care providers were *obligated* to pursue a slow code at the request of the patient's loved ones.[2] Thus, the convictions of bioethicists may simply be out of step with those of many care providers. And in that case, a closer look at the ethics of PPR—and the slow code in particular—is needed.

Critics of the slow code tend to argue that it's impermissible because it involves deception or manipulation, harm to the patient and his family, harm to the care team (in the form of moral distress or communicative inefficiency), and/or violation of professional standards. Defenders of the slow code, on the other hand, emphasize that it need not be wrongly deceptive, that it can help the patient's loved ones begin the grieving process, and that it symbolically communicates the care team's (and the patient's own) commitment to his survival. They have urged critics to reconsider the importance of medical treatment's symbolic dimension generally.[3]

I argue that critics and defenders of the slow code (and other PPR) each have a point. Advocates of the slow code are right that not all PPR is wrongly deceptive or harmful to the patient and his family, and that the symbolic aspect of medicine is morally significant in its own right. But, crucially, the critics are also correct: slow codes are *prima facie* wrong. Where I part ways with most critics, however, is in my diagnosis of the wrong in play. In my view, PPR

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[1] Thus, my definition therefore differs from common definitions of a slow code as an act of CPR that involved a significantly delayed response to the patient's undergoing cardiac arrest.

[2] Piscitello, G.M., Kapania, E.M., Kanelidis A., Siegler M., & Parker, W.F. (2021). The use of slow codes and medically futile codes in practice. *Journal of Pain Symptom Management*, 62(2), 326–335.

[3] See, e.g., John Lantos's closing discussion in Frader, J., Kodish, E., & Lantos, J. (2010). Symbolic resuscitation, medical futility, and parental rights. *Pediatrics*, 126(4), 769–772.

amounts to treating the patient as a tool or instrument for others' benefit, and this instrumentalizing quality constitutes one core *prima facie* wrong of PPR, slow codes included. To subject a patient to PPR for the reasons typically given is, then, to treat him as an object.

By using one well-known conceptual tool of feminist theory, then, I strive to show that PPR is morally problematic even when it's not, strictly speaking, deceptive or harmful to anyone. At the same time, by conceiving PPR as a kind of objectification, I also intend to build a case for the idea that it may not always be all-things-considered wrong, and I specify certain limited conditions under which PPR might ultimately be permissible. Thus, the symbolic dimension of medical treatment is indeed morally important, both in morally favorable and in morally problematic respects—namely, in its symbolic denial of the patient's humanity.

2. Standard Moral Objections to PPR (and Their Limits)

I begin by revisiting a rare, well-known defense of the 'slow code' mounted by John Lantos and William Meadow.[4] Lantos and Meadow argue that slow codes are permissible in cases where (a) CPR would be ineffective, 'the family decision makers truly understand and even accept that death is inevitable', and 'those family members cannot bring themselves [to] agree to a… DNR order.'[5] In such situations, they claim, clinicians may discuss options for end-of-life care with the dying patient's family in the spirit of strategic, compassionate ambiguity, then pursue a slow code.[6]

Per Lantos and Meadow, the two-part alternative that they endorse can benefit the family in various ways. It may spare them the feeling of complicity in the patient's death or honor him

[4] Lantos, J. & Meadow, W. (2011). Should the "slow code" be resuscitated?. *American Journal of Bioethics*, 11(11), 8–12.
[5] Ibid: 8.
[6] Ibid.

by conveying that he 'was not a "quitter" and did not "give up"'[7]; express the care team's 'sympathy, love, and respect for the family'[8]; and give the family wiggle room ('illusory refuge') to allow him to die.[9] There can thus be a ritualistic element to CPR: it can function as 'a symbolic expression of a complex set of commitments', toward the patient and his loved ones.[10]

Most commentators on Lantos and Meadow's article were quick to condemn their proposal and to challenge the reasons offered in support of it. A majority of critics alleged that prefaced by compassionate ambiguity, slow coding involves deception, centrally of the patient's family, or that it amounts to manipulating them, breaking a promise to them, or violating their trust.[11] Some commentators, however, objected to it on the grounds that it causes the patient's family psychological harm[12] or inflicts bodily damage on the patient.[13] Others attended to the risks to care providers (or the medical profession) and claimed that the practice undermines training needed for full codes[14]; compromises communication between members of the care

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[7] Ibid: 9.
[8] Lantos and Meadow, op. cit., p. 11.
[9] Ibid.
[10] Ibid.
[11] For the point that slow coding is deceptive, see, e.g., Weinacker, A. (2011). The "slow code" should be a "no code". *American Journal of Bioethics*, 11(11), 27–29, p. 28; Paris, J.J. & Moore, M.P. (2011). The resuscitation of "slow codes": Fraud, lies, and deception. *American Journal of Bioethics*, 11(11), 13–14; Morrison, W. & Feudtner, C. (2011). Quick and limited is better than slow, sloppy, or sly. *American Journal of Bioethics*, 11(11), 15–16; Mercurio, M. (2011). Faking it: Unnecessary deceptions and the slow code. *American Journal of Bioethics*, 11(11), 17; Clark, J.D. & Dudzinski, D.M. The false dichotomy: Do "everything" or give up. *American Journal of Bioethics*, 11(11), 26–27, p. 26. For the point that slow coding involves manipulation and the reinforcement of a false belief on the family's part, see Allen, W.L. (2011). Let's do not resuscitate placebo cardiopulmonary resuscitation. *American Journal of Bioethics*, 11(11), 24–25, p. 24. Indeed, even in the call for papers for this special issue of *Bioethics*, we find similar language: 'After all, a slow code is fundamentally dishonest.' See: https://onlinelibrary.wiley.com/pb-assets/assets/14678519/Bioethics_SLOW%20CODE_CFP%202023-24-1690921414.pdf
[12] According to Jeffrey Berger, among the effects of slow coding are that it precludes the family's 'intimacy with their dying relative', yielding 'final memories that are traumatic, not peaceful'; see Berger, J. (2011). Misadventures in CPR: neglecting nonmaleficent and advocacy obligations. *American Journal of Bioethics*, 11(11), 20–21, p. 20.
[13] See Weinacker, op. cit.; Berger, op. cit., p. 20; and Kon, A.A. (2011). Informed non-dissent: A better option than slow codes when families cannot bear to say "let her die"'. *American Journal of Bioethics*, 11(11), 22–23, p. 23.
[14] Janvier, A. & Barrington, K. What is an "appropriate code"?' *American Journal of Bioethics*, 11(11), 18–20, p. 19; see also Morrison and Feudtner, op. cit., p. 15.

team, placing an undue burden on some members[15]; or harms providers by causing them moral distress.[16] This taxonomy of moral objections, while representative, is far from exhaustive.

At any rate, one curious feature of the above taxonomy is that many of these objections—particularly the charge of wrongful deception—don't necessarily rule out slow codes (still less all PPR) *as such*. Indeed, many of them are more plausibly directed at the compassionately ambiguous discussion advocated by Lantos and Meadow.[17] But PPR could be pursued without it, and then it needn't involve deceiving the patient's family, manipulating them, breaking a promise to them (or to the patient), or violating their trust.[18] The family could truly accept that CPR will likely be ineffective and that death is inevitable but want PPR as, say, a symbol of the patient's indomitable spirit or the care team's commitment to his recovery.

Similarly, consider the allegation that the slow code is harmful to the patient's family or to the patient himself. Because some families explicitly request CPR despite acknowledging the vanishingly small odds of clinical benefit, it's reasonable to conjecture that they would take solace in a slow code and may well be more distressed by the care team's refusal to perform it. So, a slow code need not be psychologically harmful to the family, or at least not more so than alternatives. Nor does a slow code necessarily inflict suffering or bodily damage on the patient. It needn't be painful if the patient has proper pain control or, indeed, if he is so neurologically

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15 Morrison and Feudtner, op. cit.; Kon, op. cit.

16 Kon, op. cit.; Berger, op. cit. For the point that symbolic acts are incompatible with the physician's role, see Janvier and Barrington, op. cit.

17 Even some critics of Lantos and Meadow's proposal don't object to purely performative resuscitation as such, just to (e.g.) its lack of transparency or paternalistic overtones. See, e.g., Morrison and Feudtner, op. cit,; Janvier and Barrington, op. cit.; and Ladd, R.E. & Forman, E.N. (2011). Why not a transparent "slow code?". *American Journal of Bioethics*, 11(11), 18–20.

18 Cf. Frader, Kodish, & Lantos, op. cit., p. 772.

devastated that it's unlikely that he's conscious in the first place.[19] And it needn't damage his body if the code's time and vigor are limited, although some may be so frail that the risk is high.

What about the objection that slow codes undermine the training of residents, medical students, and other trainees, or that they hamper communication between different care teams? These charges, too, can be answered. For one, trainees will presumably receive plenty of training from performing CPR believed to be potentially effective, so training need not be compromised. Moreover, proper communication between teams can be facilitated by careful documentation of code status in the patient's chart as well as reiteration at daily rounds and sign-out. Snafus may still occur, of course, but the slow code does not seem to raise any *special* communication issues, beyond the ordinary challenges of communicating a patient's code status to another care team.[20] In any case, even if true, these charges also don't seem particularly forceful. Even if pursuing a slow code carries the above risks, it's hard to accept that they *alone* make it wrong to do so, particularly if the benefits to the family are great enough and the harm to the patient minimal. Similar replies may be given to the other moral objections to the slow code in the literature.[21]

So, standard moral objections to the slow code (and other PPR) have major limitations. At best, they identify morally significant risks of pursuing a slow code, not a feature of the practice that makes it wrong in itself. Shorn of the compassionate ambiguity recommended by

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[19] Moreover, awareness during CPR seems to be rare. See Lundsgaard, R.S. & Lundsgaard, K.S. (2019). BET 2: Pain management in patients who show awareness during CPR. *Emergency Medicine Journal*, 36(4): 249–250.

[20] I hasten to add, though, that there is, in addition, the question of what the official designation for a slow code (i.e., in medical records, medical orders) should be. Because 'full code' would be misleading in this context (even in light of a tacit understanding among members of the care team that a slow code will be pursued), I believe that a separate official designation is warranted (e.g., 'terminal code').

[21] First, while it's true that slow coding causes some providers moral distress, in my experience some providers also experience moral distress when they perform a full code or refuse to administer CPR out of a belief that it would be medically inappropriate. So, it's unclear that performing a slow code produces the *most* distress of any of the available options. Second, it's not obvious why PPR conflicts with the physician's role: providers could permissibly pray with a family, hold a dying patient's hands, or close his eyelids out of respect for him once he had passed away. These actions, though performative or symbolic, don't seem inimical to the role of the physician, much less wrong. (I agree, however, that clinicians are, in general, not morally required to do these things.)

Lantos and Meadow, slow codes may be permissible, for all that's been said. But there's another curious feature of the above taxonomy of objections: they tend to focus on the potential effects of slow codes on the patient's loved ones, his care team, or the relationship between the two parties. *The patient himself* is largely left out of these criticisms of the slow code, making it especially difficult to see how (on these views) he is wronged by it, if at all.

This line of skepticism can be taken a step further. So long as there's no undue opacity in discussions with the family, the patient is subjected to little or no bodily harm or distress, and he wouldn't have—or couldn't have—objected, there's a strong moral argument for the permissibility of the slow code, one articulated by Robert Truog. Truog writes:

> Although the interests of the patient are always primary, at the end of life there are times when the interests of the patient begin to wane, while those of the family intensify. Family members may live for years with the psychological aftereffects and regrets of end-of-life decisions. In these situations, the interests of the surviving family members may take priority.[22]

Suppose that the family of a dying patient would find some relief in the slow code, as it would convey that he was a 'fighter' who 'never gives up', and that this feeling wasn't simply based on self-deception or the like. (If it seems incredible that a person could undergo a slow code without suffering, we can imagine—as in Truog's example—that the patient is neurologically devastated.) In that case, we may think that not only is pursuing a slow code *permissible*, under the circumstances, but that there are *positive moral reasons* for doing so. The harm to the patient is nonexistent after all, on this view, while the benefit to the family may be significant. If so,

[22] Truog, R. (2010). Is it always wrong to perform futile CPR?. *New England Journal of Medicine*, 362(6), 477–479, p. 479.

defenders of the slow code are, it turns out, on solid moral ground. The burden, then, is on critics to show that the practice is wrongful despite its potential for benefit.

I'll now proceed to argue that this burden of proof can, in fact, be discharged—that the slow code is morally objectionable as such, in virtue of its effect on the patient in particular. It will remain unclear why this is so as long as we continue to assume that the only patient-centered grounds for morally objecting to the slow code is that it somehow constitutes a setback to the patient's interests (e.g., in bodily integrity and freedom from suffering). Then, there'll be some cases in which the patient's interests don't seem unduly frustrated, and it will be plausible to claim that the needs of the patient's family carry greater moral weight. To get a grip on the relevant moral objection, we'll need to reject this assumption and to look at PPR through a lens recommended by defenders of the slow code—as a kind of symbolic act.

3. Slow Codes as *Prima Facie* Wrongful Instrumentalization

One critic of the slow code, Jeffrey Berger, anticipates the moral analysis that I elaborate here. Berger claims that 'respect for persons' constitutes a strong reason against slow coding dying patients, because this attitude 'prohibits using patients to assuage family members' grief or to satisfy their need for symbolism.'[23] He concludes: 'The use of ineffective CPR primarily for the benefit of the family risks dehumanizing the patient.' I agree. In this section, I offer an account of the moral valence of slow coding that is inspired by Berger's epigrammatic remarks.

My point of departure is the notion of *dehumanization*. I define dehumanization as regarding or treating someone as other than a human being or person.[24] Now, if it's alleged that a

[23] Berger, op. cit, p. 21.

[24] To regard someone as nonhuman is to hold an attitude toward her, whereas to treat someone as nonhuman is to perform an intentional action toward her. These two can come apart: people can be treated as nonhuman without

person has been the target of dehumanizing treatment, that allegation invites the question, 'What, then, has she been treated *as*?' Well, one paradigmatic mode of dehumanization, and the one suggested by Berger's remarks, is *objectification*: treating someone as a mere object. On one well-known view—articulated by Martha Nussbaum, Rae Langton, among others—to treat a person as an object is to treat her as (mindless) objects *as such* are appropriately treated[25] In this way, the objectifying treatment of persons is conceptually linked to our treatment of objects *qua* objects. What Berger is alluding to, then, is that slow code amounts to a particular form of objectification—namely, *instrumentalization*: treating someone as a tool for one's own purposes. I define instrumentalization or use as (a) acting on an individual (standardly, on her bodily or mental capacities) (b) in order to benefit someone other than that individual, and (c) in a way that risks disregarding how the action in question might affect that individual.

Tools are, by definition, to-be-used-for-our-purposes. This much is understood by anyone who possesses the concept of a tool. Tools are, therefore, *for us*, in that their value is exhausted by their capacity to further our aims or to satisfy our interests. Because instrumentalization is conceptually linked to our treatment of tools as such, to instrumentalize someone is, in principle, to treat her as to-be-used, to treat her as something whose value is tied to the purposes of others. In this respect, instrumentalizing someone has the potential to express a degrading social meaning about the individual so treated: that she has the value of an object, not that of a person.

Notice that this notion of instrumentalization is distinct from that of treating someone merely as a means, in Immanuel Kant's sense. Kant famously held that persons were ends-in-

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also being regarded as such, whereas people can be regarded as nonhuman yet treated as human. In what follows, I focus only on treating someone as nonhuman—in particular, as a kind of object (a tool).

[25] See, for instance, Nussbaum, M. (1995). Objectification. *Philosophy and Public Affairs* 24(4): 249–291; Langton, R. (2001). Autonomy denial in objectification. In *Sexual Solipsism: Philosophical Essays on Pornography and Objectification* (pp. 223–240). Oxford: Oxford University Press; Langton, R. (2001). Sexual solipsism. In *Sexual Solipsism* (pp. 311–356).

themselves, a status reflected in the second formulation of the Categorical Imperative, the Formula of Humanity: 'So act that you use humanity, whether in your own person or in the person of any other, always at the same time as an end, never merely as a means.'[26] While it's a matter of considerable interpretive difficulty how to spell out the conditions for treating a person merely as a means, we need only note that for Kant, such treatment is always wrong, all things considered. Instrumentalization, by contrast, is always *prima facie* wrong but not always wrong, all things considered; under certain circumstances, instrumentalizing treatment is permissible.

To borrow an example from Martha Nussbaum, it's permissible, all things considered, for a person to use her lover's stomach as a pillow so long as certain conditions are met—for instance, so long as he consents, he is not harmed, and the relationship is not instrumentalizing.[27] Nussbaum's point, as I understand it, is that contextual factors—crucially, the nature of the broader relationship between the two—determine the moral valence of her so using his body. Thus, even if the person's action is motivated by convenience or comfort rather than intimacy, it still doesn't constitute wrongful instrumentalization provided that these factors are in place.

With the above conceptual scaffolding in place, it should be clear why the practice of slow coding a dying patient for his family's sake amounts to instrumentalizing him. Slow coding a patient involves acting on him (e.g., giving chest compressions, administering medication, using an AED, etc.), for the benefit of others (e.g., the patient's loved ones), perhaps even with disregard for his perspective and while subjecting him to the risk of harm. Slow coding is

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[26] Kant, I. (1996). Groundwork of the metaphysics of morals. In M. J. Gregor (Ed.), *Practical philosophy* (pp. 37–108). Cambridge: Cambridge University Press, 4:429. For a Kantian criticism of the slow code, see Fine, RL. (2010). Is it always wrong to perform futile CPR?. *New England Journal of Medicine* 27;362(21): 2035–7, at p. 2035.

[27] Nussbaum, op. cit., p. 265: 'If I am lying around with my lover on the bed, and use his stomach as a pillow there seems to be nothing at all baneful about this, provided that I do so with his consent (or, if he is asleep, with a reasonable belief that he would not mind), and without causing him pain, provided, as well, that I do so in the context of a relationship in which he is generally treated as more than a pillow.'

therefore tantamount to using the patient—his body—as a tool for alleviating his loved ones' distress.[28] For this reason, the slow code is instrumentalizing, hence (at least) *prima facie* wrong.

I note two advantages of my view, which I call the *instrumentalization account*.

First, my view does not locate the wrong of wrongful slow coding in its alleged deceptiveness, the supposed fact that it causes the patient bodily damage or physical suffering, or its putative propensity to cause his family distress. This feature yields a significant advantage. As we saw, slow coding needn't involve deception or any straightforward setback to the patient's interests, and his family (who, after all, has requested it) may find some solace in it. Yet it still seems morally objectionable even if harmless and pursued without opacity. My view explains why: because even so, it amounts to treating a dying person's body as a tool to benefit others. On these grounds, slow coding is prima *facie wrong* in itself, not in virtue of some of its accidental features. So, my view handily answers the challenge adumbrated by Truog's discussion.

Second, the instrumentalization account also offers a *patient-centered* explanation of the wrong of wrongful slow codes. It follows from my view that wrongful slow codes are not only wrong but *wrong the patient* in particular. Recall that critics of the slow code seemed to have trouble obtaining this result, and that some even denied that slow codes were wrongful as such. On my view, by contrast, other things being equal, wrongful slow codes don't primarily wrong her family, other care teams, or the medical profession as a whole, nor do they simply violate a general professional norm. Rather, it's the patient *himself* who has been objectively degraded in that he has been treated as a tool for others' purposes—and, therefore, as an object, not a person.

[28] Thus, standardly, slow coding involves instrumentalization of a person—using her as a tool—rather than, say, of an action or practice. There's a sense in which the intervention may itself be used to alleviate the family's distress, of course, but by definition only individuals can be instrumentalized or used as tools, in my sense. Here the body specifically is the site of instrumentalization because slow coding consists of acting on, or doing things to, the body.

4. Is PPR Always Impermissible?

I've argued for two main claims. First, slow coding is, at least, *prima facie* wrong—indeed, *prima facie* wrong in itself, hence wrong even when harmless, free of deception, and the like. Second, slow coding is *prima facie* wrong because it amounts to treating the patient as a tool for the purposes of others, expressing the social message that she has the value of an object, not that of a person. In this way, wrongful slow coding isn't just wrong; it wrongs the patient.

In mounting this case, I've sought to vindicate a key insight of the critics of the slow code and other PPR. In this section, though, I'll shift gears, arguing that the defenders of the slow code and other PPR have a point, too: there are limited and not merely theoretical circumstances in which it's permissible. The instrumentalization account helps us see why.

On the view of instrumentalization articulated above, treating someone as a tool for one's purposes is, at least, *prima facie* wrong. Before, however, I noted that instrumentalization may not be wrong, all things considered. We can now revisit this point. In other work, I've proposed that *prima facie* wrongful instrumentalization can be fruitfully conceptualized as *morally risky*, in the sense of presenting a significant risk of doing wrong to the patient.[29] But, crucially, an instrumentalizing action can be morally risky yet not, on balance, wrong if certain conditions are in place that defuse or mitigate the moral risk involved. Let me explain.

Nussbaum's example of a person using her lover's stomach as a pillow illustrates this point: the background relational factors that she identifies arguably transform what would have been an act of wrongdoing into something permissible, even a salutary expression of intimacy. But examples from clinical practice aren't hard to come by. For instance, in harvesting a dead

[29] Tarasenko-Struc, A. (2021.) Objectification and domination. *Ergo* 8(14): 406–40, p. 411. A picture like the one that I articulate here is arguably suggested by Berger's language, as he claims that 'ineffective CPR primarily for the benefit of the family risks dehumanizing the patient'; see Berger, op. cit.

patient's organs so as to make them available for other patients who need them to survive, we treat the former as a tool for our own purposes, which is morally risky as well. Yet doing so can be made permissible if—*inter alia*—the dead patient's organs are harvested with his prior voluntary, informed consent (or with the authorization of a surrogate decision-maker who reasonably believes that the donation is in accordance with the patient's values), in the context of a regulatory framework that includes procedural guardrails to protect vulnerable patients from coercion, exploitation, and the like.

I don't want to put too much weight on the details of these examples—on which exact conditions suffice for neutralizing the moral risk of the instrumentalization in play. They're meant only to suggest a strategy for locating the set of conditions that would render slow coding permissible. Consider the following case, in which those conditions are arguably present:

> Maria is a 78-year-old woman diagnosed with metastatic breast cancer four years ago. Given the extent of the cancer (she'd developed metastases in her lungs and liver) as well as her age, she wasn't expected to survive more than a few weeks when she was reexamined earlier this year. In fact, she's lived six months. But her prognosis remains poor, as her cancer appears increasingly resistant to chemotherapy and she's not a candidate for other therapies. Now she has been taken to the Medical ICU, and it's thought that she'll die within a day. Awake and alert, she tells her care team, 'If I go into cardiac arrest, please, for my family's sake, give me CPR, even if it won't save me. Just don't do it fully: I'm so weak that you'd really hurt me.' Later in the day, after Maria loses consciousness, her family is at her bedside. During a discussion about resuscitation, her son (and surrogate decision-maker) pulls the attending physician aside and says,

> ‘Look, we know that my mom is probably going to die. But none of us can sign a DNR, and she’d see that as giving up anyway. She’s a fighter: she beat cancer twice, and even if she can’t do it this time, I know that she’d want to be remembered as a fighter in her last moments. Even if you think CPR wouldn’t help, please give it to her—but don’t hurt her.’

I submit that it would be permissible for Maria’s care team to perform a slow code in this case, so long as care is taken to minimize harm to her. She has consented to resuscitative efforts fitting the description of a slow code, as has her surrogate decision-maker—albeit, perhaps, for different reasons (to spare the family grief and to honor the patient, respectively). Importantly, neither the patient nor the family is under any illusions, apparently, about the effectiveness of the slow code, so the risk of deception—or, indeed, of self-deception on the family’s part—appears to be minimal. Finally, the slow code is undertaken not only for the benefit of the family but also to express a distinctively humanizing message about the patient: that she’s ‘a fighter’ who ‘never gives up.’[30]

I therefore claim that PPR may be permissible when the following conditions obtain:

(1) Either (a) the patient gives voluntary, informed consent to PPR of that kind or

[30] In this context, a slow code is a properly symbolic action in that it has the potential to communicate a message about the patient by symbolically expressing that message. For example, in many (all?) cultures, it’s normally seen as disrespectful to dispose of a human corpse by simply throwing it on a heap with other refuse, because that symbolically expresses the idea that the person is on a par with trash. Rather, corpses are buried, burned, or the like, and these actions are seen as ways of symbolically honoring the dead person, by expressing the idea that their body has a value qualitatively different from that of trash. Similarly, in pursuing a slow code, a care team is symbolically expressing the idea that, say, the patient will not give up. There’s a sense, of course, in which this isn’t literally true—if the patient is (say) comatose, then they’re not really in a position to give up or stay the course—but the same could be said for burying the dead: human corpses are, at a material level, not very different from other kinds of refuse. This is why pursuing a slow code on Maria need not be deceptive: her family can authorize it on her behalf as a symbolic action—to symbolize her indomitable spirit—even though they know that Maria doesn’t really face the deliberative question of whether to give up or stay the course, given her current clinical condition.

(b) his surrogate decision-maker(s) give(s) voluntary, informed consent on his behalf, out of a reasonable belief that the patient (when decisionally capacitated) would have wanted PPR to be pursued, where this belief is based on what the surrogate decision-maker(s) know(s) about the patient's values.[31]

(2) The act of PPR causes the patient little to no physical or psychological harm.

(3) The act of PPR expresses a humanizing message about the patient's value as an individual, according to the system of shared social meanings internalized by him.

(4) The act of PPR benefits the family significantly, and their obtaining this benefit does not depend on their having any false belief about that act's physiological efficacy.

Some clarification is needed to make these conditions practicable. We might ask what the threshold is for sufficiently low harm (in [2]) or significant benefit (in [4]), a matter that is complicated by the lack of any uncontroversial measure of harm or benefit. To some extent, whether an intervention counts as harmless or beneficial enough depends on the patient's own values and preferences. But if slow coding causes the patient unbearable pain, then (2) is unmet; it's less clear, however, how much bodily damage would count as surpassing the threshold, and this may be a matter for individual judgment on the part of the attending physician. Likewise, the

[31] Per Gina Piscitello et al., however, 11% of the requests for a slow code came from patients. See Piscitello et al., op. cit., p. 328. Where the care team cannot obtain the patient's consent, as with other interventions it's appropriate to defer to his surrogate decision-maker's claim that he would have wanted it or that it's consistent with his known values. PPR raises no special issues here.

patient's family will benefit significantly from the slow code if (for example) it enables closure, helps them initiate the grieving process, or gives them solace by honoring the patient.[32]

Admittedly, it's uncommon for all of the above conditions to be met at the bedside. But when they are, clinicians are permitted to pursue PPR, despite its instrumentalizing character. So, slow coding has incipiently dehumanizing expressive content, yet it's not always wrongly dehumanizing. Fulfillment of the above conditions most fully obviates the risk of wrongdoing, although fulfillment of some subset of these—e.g., (1) and (4)—might also suffice for permissibility. Thus, defenders of the slow code are correct: performing it may be permissible.

I believe that it's to the credit of the instrumentalization account that it combines insights from both defenders and critics of the slow code (or other PPR), thereby respecting the divergent intuitions of bioethicists and clinicians on this topic. But I would also like to note a third advantage of my account: that it helps explain why *not all slow codes are (morally) equal*. Specifically, the instrumentalization account explains, in an intuitively satisfying way, why it is morally worse to slow code for some reasons than for others, other things being equal.

Suppose that in the above example a slow code had been performed without Maria's or her family's consent. Now imagine that instead of symbolically honoring her fortitude and courage, her care team had pursued a slow code in order to honor the team's relationship with the family, thereby expressing (e.g.) the providers' compassion, commitment, and concern. In expressing a recognition of the family's value (or of the value of the family's relationship with the providers), this sort of PPR does convey a humanizing message—unlike, say, slow coding in order to train medical students, which is clearly wrong. Yet slow coding for the former reason expresses no particular message concerning *the value of the individual patient*, but remains

[32] Thus, for the fourth condition to be met, there's no requirement that slow coding benefit the family *more* than other alternatives.

focused on communicating something about the providers instead. It therefore seems that slow coding for this reason is morally worse than doing so in order to honor the patient herself.

My discussion leaves many questions unaddressed. How does the prospective moral distress of residents and nurses affect the permissibility of slow coding? Should they be allowed to opt out on grounds of conscientious objection? Even if slow coding is sometimes permissible, might there be moral reasons not to explicitly offer it or to nudge the patient or his family in a different direction? Does slow coding pediatric patients present any special ethical issues? Might the practice of slow coding depend on, and reinforce, the widespread, problematic belief that CPR is always appropriate? Although I haven't answered these questions, I've at least sketched an ethic of PPR that will serve as a point of departure for a more complete, more nuanced theory.

5. Conclusion: Medicine and Its Symbols

I'd like to close by bringing out a broader lesson of my discussion: that the symbolic dimension of medical treatment morally matters. Defenders of the slow code have—in my view, aptly—urged critics to accept this point. I've offered additional reasons to believe that they're correct. Most importantly, slow coding (and PPR generally) has the potential to express humanizing messages about the patient as an individual person, which can sometimes make it permissible and even generate positive moral reasons to do it. Yet defenders (and some critics) of the slow code don't sufficiently appreciate its capacity to express dehumanizing messages about the patient as well, nor have they registered the fact that this feature of it makes it *prima facie* wrong even when it's relatively harmless and involves no deception. An ethics of PPR must begin with a recognition of how it might humanize, but also dehumanize, the patients in our care.