REPORTS

Code Krishna: an innovative practice respecting death, dying and beyond

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Abstract

In moments of grief, human beings seek solace and attempt to discover the meaning of life and death by reaching out to wider and deeper dimensions of existence that stem from their religious, cultural and spiritual beliefs. Conventional patient care fails to consider this vital aspect of our lives. Many hold the view that life and its experiences do not end with death; the body is but a sheath which holds the soul that inhabits it. The use of a protocol-based practice to create a solemn atmosphere around the departed individual can bridge the gap between the materialistic and non-materialistic perceptions of the dimensions of care. The innovative practice, "Code Krishna", is aimed at institutionalising a practice which sensitises and empowers the treating team to address the grief of the relatives of deceased patients, and respect the departed in consonance with the family's cultural, religious and spiritual beliefs. The practice entails the creation of a solemn atmosphere amidst the action-packed environment of the critical care unit at the time of the patient's death, offering of collective prayer and floral tributes, and observation of silence both by the healthcare team and family members. Code Krishna attempts to blend current care practices with spirituality, ensuring that the treating team is the first to commiserate with the grieving family, with warmth and openness. In this piece, we briefly report our first-hand experiences of practising Code Krishna in our hospital [Shree Krishna Hospital, Karamsad, Central Gujarat]

Introduction

Death is the only predictable event in the unpredictable course of human life. The extent of suffering and fear that death entails is phenomenal. Though issues related to death and dying are relevant to health professionals, they are avoided. The typical non-abandonment response, defined as "open-ended, long-term, caring commitment to joint problem-solving" (1), has been considered an all-important obligation of physicians. It consists of providing continuity of expertise and a therapeutic relationship, and facilitating closure of that therapeutic relationship (2). This response has been observed to be consistently inadequate across various specialties, although some differences do exist in attitudes towards death, depending on the clinical branch and duration of clinical practice (3).

Death does not have only a visible component, ie biological demise; it also has social, cultural, religious and spiritual connotations, which describe the reality of death from different perspectives. Almost all religions describe death both as an event and a process. Almost all medical professionals view death as a defeat and avoid exploring the phenomenon as a process. If healthcare professionals were better sensitised to aspects of the natural, inevitable occurrence of death and, therefore, the care of the dying, it would have important implications for counselling.

Since the process of dying and death fall in an area where medical treatment comes to an end, the incorporation of the spiritual dimension is of the utmost relevance. While adding the term "spiritual dimension" in its definition of health in 1968, the World Health Assembly mentioned that this dimension pertains to social beliefs, customs, traditions, rituals, religion and culture, and enables peoples to develop and maintain a positive attitude towards health. It would be very useful to create an awareness of various religious/ spiritual convictions among the treating team, and for medical facilities to incorporate a code of practice that respects these convictions.

An analysis of the contexts of care is crucial to the fulfillment of the expectations of the society we serve during terminal events. The concept of care tenor, defined as the attitudes and behaviours of those interacting with the patient, includes the physical, emotional as well as spiritual care tenors. The physical care tenor is aimed at enhancing physical comfort, and the emotional care tenor at providing emotional support to patients and treating all patients with compassion. The spiritual care tenor aims to provide patients with access to spiritual support, and has been perceived as a vital factor in fostering the patient's dignity and supporting the culturally driven wishes of patients and their families in end-of-life situations (4,5).

Code Krishna: driving philosophy and elements

Code Krishna was designed to establish a protocol that (i) sensitises the treating team to the need to address the grief

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To cite: Vaishnav B, Nimbalkar S, Desai S, Vaishnav S. Code Krishna: an innovative practice respecting death, dying and beyond. *Indian J Med Ethics*. 2017 Oct-Dec;2(4)NS:289-92. DOI: 10.20529/IJME.2017.059

Published online on June 6, 2017.

Manuscript Editor: Sunita VS Bandewar

of the relatives of deceased patients; (ii) expresses empathy and gives loving care to the bereaved family; (iii) extends homage to the departed in consonance with the family's cultural, religious and spiritual beliefs regarding "death, dying and beyond"; and (iv) symbolises institutional commitment to whole-person care and healing.

Code Krishna is a practice aimed at offering the grieving family emotional support in a culturally and spiritually appropriate manner. The treating team is to pay its respects and homage to the departed soul in the critical care unit itself, where the patient dies. The "outward" or "visible" components of the practice include the following: members of the treating team assemble at the bedside of the patient who has expired; team members and patient's relatives offer floral tributes to the deceased; and a prayer is recited /played according to the family's religious faith, following a few minutes of meditative silence. The "inward", "non-visible" or implicit components of the practice are: showing respect for the deceased, attempting to share the bereaved family's grief, and creating a solemn environment and a "silent space" amidst the action-packed environment of the critical care unit.

Code Krishna – conceptualised and introduced by a group of volunteering doctors –was soon adopted as an institutional practice and is now followed after every death that takes place in all wards of the hospital. Before its implementation, sensitisation and training sessions were held for the doctors, nurses and other staff members. Further, the undergraduate and postgraduate students were sensitised to the need to handle the emotionally traumatic event of death with the requisite sensitivity. When the entire medical team gathers at the bedside of the deceased patient, it can help the bereaved family to derive strength and solace in the philosophical domain in its time of grief. This forms the core of Code Krishna. It is aimed at shortening the period of grief and helping the bereaved family move to more stable mental stages of grief management.

Experiential anecdotes

We have not evaluated Code Krishna with rigour and we present it as an innovative practice in the field of death and dying. Our personal experiences have been gratifying. According to some family members, "The practice provides the much-needed humane touch in the era of high-tech medicine, and the solace it offers is very deeply touching." The relative of a deceased patient said, "It far exceeds expectations in the most crucial moments of hospitalisation, and is very rare to find anywhere." One relative mentioned that it was beyond her wildest imagination that the treating team would stand with them in silence in the critical care unit and solemnly recite a prayer observing the moment of death. Another said that she "was deeply moved by the spontaneity with which the whole team gathered quickly", and "the care of the dead should always be like this". One of the relatives said, "The practice reflects an altogether different paradigm." Describing her response to the practice, a family member said, "The practice meant a lot to me as a soothing experience, which will go a long way in healing."

The nurses felt that the practice gives rise to a stillness, which brings peace. A nurse said, "The silence is so unique!" Another opined that the practice gives one a sense of accomplishment or makes one feel that one has fulfilled one's duty of treating a human being to the end. The postgraduate students were awestruck. Those who were involved in initiating the practice observed that the implementation of Code Krishna helped to align the orientation of the treating team to the care of the whole person and his/her family. They also observed that the spontaneity with which everyone participated in Code Krishna revealed that even medical persons are, after all, human beings sharing beliefs and sentiments with others. It was also felt that it helped to de-stress the intensive care unit (ICU) staff. The students appreciated the fact that the practice served the non-materialistic, yet tangible and deep-rooted needs of society, thereby helping the institution honour its commitment to culturally synchronous, value-based humane care.

The perspectives of the patients are only one aspect of the documentation. We suggest that the next step in taking the project forward should be to capture the objectivity of the observations and reflections in a more structured and reflective manner, so that the practice helps to strengthen the holistic attitude through objectivity. We intend to further study and document the responses of the relatives of patients, doctors, nursing staff and other healthcare personnel.

Reflections

Code Krishna enables healthcare professionals to fulfil one of their well-recognised responsibilities, ie to provide the appropriate support and care to grieving families. Despite the normative nature of this obligation, it is known that clinicians mostly fail to do what is required of them (6). The culture of avoiding death and dying in acute care hospitals remains a significant barrier to the provision of end-of-life care, even when the tools are available and accepted by the staff, due to attitudinal issues (7). Our experiences should encourage others to come up with similar practices that are in line with the cultural milieu in which care is being provided.

Healthcare professionals provide care which is known to cure and/or extend life, as we know it. The medical team sees the end of life as a defeat, or at the least, as a termination of the patient–doctor relationship. However, sociocultural beliefs about existence often do not draw the final line at death and extend the phenomenon of existence to a realm beyond death. Thus, relatives may believe that the patient has gone into another life. Whatever the personal beliefs or concepts of the healthcare professionals, Code Krishna should be considered an extended aspect of the relationship with the family and/or departed individual. Since all healthcare professionals may not have the ability to provide this aspect of care or the attitude required to do so, including a clearly outlined protocol of care among their professional duties would give them a framework

to adhere to. Code Krishna is unique in that it encourages healthcare professionals to express care for the departed soul (for the believers), while at the same time, eases the grief of the bereaved family.

Our model is unique also because it does not rely on influences that are external to the hospital environment; the attempt is to provide components of the spiritual tenor through the involvement of the entire treating team. Traditionally, the responsibility of providing healing care and emotional support to the bereaved family has been entrusted to spiritual caregivers, such as chaplains and nursing staff, in the case of institutional deaths. As for deaths that take place in the community, traditional healers shoulder this responsibility. The medical team, however, is not called upon to play this role (4,8,9). In an environment in which resources are scarce or individuals such as chaplains and nurses are unavailable or unwilling to provide healing care, a process that emanates from the medical team may have the same, or even better, influence. Not only does this help the bereaved family cope better with its loss, it may also have beneficial effects on the caregivers, who may have been under stress or formed strong emotional bonds with the deceased.

It is known that those working in ICUs have repeated exposure to death and grief. While most of the staff may view caring for the dying as just one part of their duty to rationalise events, such exposure can lead to occupational stress, disenfranchised grief and ultimately, burnout. Emotional disengagement from caring for the dying may have an impact on the quality of care, both for the dying patient and his/her family (10). The processes evolved by us may have long-term implications when it comes to reducing stressful outcomes among the staff. Practices such as those which form a part of Code Krishna help the members of the treating team to overcome their own suppressed grief, reflect on the meaning of life, improve the quality of the care provided by them, and show greater compassion. Further, they prevent desensitisation to events related to death. Additionally, they play a part in assuring the relatives that the institution is committed to humane care based on religious or spiritual beliefs. The benefits of practices of grief management have been documented for both the treating team and the bereaved family (11).

Our innovative practice is also aimed at enhancing the spiritual tenor, which is of the utmost relevance in situations in which medical treatment has come to an end. Various religious, cultural and spiritual belief systems have different views on the event of death, the process of dying and phenomena beyond death. The humanists, including atheists and agnostics, believe that death is the end (12). However, a majority of people seek succour in religion when they lose their near and dear ones since it is a common human tendency to look to non-biological, existential considerations to derive solace and relief from the suffering inflicted by the event of death (13). Religion has a strong influence on grieving and death rituals.

Hindus believe that while death is the end of this life, it is also the beginning of a new cycle. According to Hindu beliefs, the concept of life extends beyond the two polarities of physical birth and death, and much consideration has been given to the latter. It is held that while the physical body has a limited span of life, the underlying principle of life – the *atman* or supreme spirit – is eternal and, therefore, is not subjected to the same laws which govern the perishable physiological body. End-of-life rituals, such as creating a peaceful and solemn environment around the deceased person, chanting prayers, putting *tulsi* leaves and water from the Ganges into the mouth of the dead person, are considered important for the soul's purity and peaceful transition from this life (14). Christians believe that death is the beginning of an everlasting life with God. Among Christians, the care of the dying involves prayer and anointment of the body with holy oils. The dying person confesses his/her sins in the presence of a priest to obtain forgiveness and receives holy water (15). In Islam, it is considered that submission to suffering is submission to God. Great importance is given to participation in prayers and rituals in the final moments of life (16).

We named our model Code Krishna for two reasons. First, conventionally, terms such as "Code Blue" and "Code Red" convey that a duty should be performed urgently, responsibly and assiduously. While "Code Blue" refers to resuscitating a patient and "Code Red" indicates urgency in case of fire, "Code Krishna" is a call to fulfil one's obligation to deal with the death of a patient in a humane way. Second, the name of our hospital is Shree Krishna Hospital. We introduced Code Krishna as a signature practice of our institution, reflective of its commitment to offer truly humane and integrative care to patients/ their families in end-of-life situations by incorporating a spiritual component into the existing conventional healthcare practices.

Considering that a hospital is a place of healing, Code Krishna aims to offer quality care that facilitates the sharing of deeper individual and collective feelings arising from the event of death. The words, actions and gestures involved are intended to help everyone find meanings in the larger dimensions of life and death.

While introducing Code Krishna, we ran into several implementation-related difficulties. For example, we had to convince the healthcare team about the practice, persuade it to participate whole-heartedly and try to make it consider the practice as a priority in the totality of care. Constraints of time, eg due to the need to attend to other patients, was another important obstacle. Incorporating this practice in the standard operating procedure (SOP) for end-of-life care helped in overcoming these difficulties to a great extent. We hope that our innovation will foster introspection among all those concerned with providing humane care to patients, whether living, dying or deceased. We also hope it encourages them to evolve practices appropriate to their own setting to achieve the same goal.

Epilogue

In the light of our experience with Code Krishna, we would like to make the following observations.

First, recognising the fact that death is an event as well as a process with deep-rooted emotional, behavioural and spiritual elements, every effort should be made to address the physical, emotional and spiritual components of care. Second, the task of addressing that which lies beyond death should not be assigned to a team of spiritual support givers or chaplains; the entire healthcare team should be involved. Third, since holistic end-of-life care is essentially attitude- and behaviour-centric, systematic training and sensitisation of the staff are necessary to raise the standards of such care. Finally, there is growing recognition of collaborative wisdom in care, based on a scientific, social, spiritual and cultural understanding of the process of death. Collaborative wisdom should be used as a framework to bring about a paradigm shift in the care of patients.

To sum up, we have made a small beginning and aim to go further by making end-of-life care an integral part of holistic healthcare, as a continuation of the critical care component.

***Competing Interests**: None declared*

***Funding support**: None*

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