TALKING ABOUT: CODE STATUS

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How we discuss code status with our patients has everything to do with how we see the issue:

Do we think that everyone has a right to choose a full code?

Do we think that by giving an opinion about code status we might be paternalistic and inappropriately influence the patient's decision?

Or, do we think that an attempt at resuscitation is a medical procedure that has major risks and is contraindicated in certain people who would not benefit from the procedure?

If it is the latter, then it is our obligation as a matter of informed consent to explain as well as we are able when we feel it would be harmful to allow us to try resuscitation. As with any other medical intervention, such as the use of antibiotics, transfusions, or surgical procedures, we should share our expertise with the patient regarding the benefits and burdens of intervention. We are also obligated to decide whether the intervention is appropriate.

We know that some people would have no benefit, and plenty of harm, if resuscitation is tried. Certain groups are unlikely to survive attempts at resuscitation: those more than 80 years old; those who are declining with chronic illness or metastatic cancer; and those who are elderly and on hemodialysis. Trying to resuscitate such people will complicate the end of their lives. If the attempt is "successful," it will only increase the risk of their dying on a machine in the ICU. If resuscitation is offered as a reasonable procedure in their plan of care, it offers false hope and complicates end of life planning. It will not serve their goal of living longer and better. These people will likely not make it out of the hospital if a Code Blue is called.

So here are some words, some script, if you will, that may help in talking about code status, when you feel it would be a contraindicated medical procedure:

We are going to try everything we can to help you with your current illness. However, if for some reason, things change suddenly and you are dying, without an order on the chart, we are obligated to try to bring you back. From what we know about people with health problems like yours, this would not be successful. Therefore I am going to put a Do Not Resuscitate order on your chart that so that we don't try to do something that we know won't help, and would cause you more harm.

Note that the patient can still object. The family may see the purple band and become upset. It is an admission that their loved one is seriously ill and could die. Also people often feel that a DNR order means that the providers are giving up. Even that sentiment can be found in medical staff attitudes. We have to use our skills as physicians to explain why for some people a resuscitation attempt is a medical intervention for which the burden exceeds the benefit. A DNR order can be a preventive that keeps us from doing something we know would be useless and harmful to the patient and distressing to all involved. The patient can still object and stay Full Code.

But then we *have* done our informed consent.

REFERENCES

1. Ehlenbach, Wm, et al. Epidemiologic Study of In-Hospital Cardiopulmonary Resuscitation in the Elderly. NEJM 2009, 361: 22-31.
2. Girota, Shet, et al. Trends in Survival after In-Hospital Cardiac Arrest. NEJM 2012; 367: 1912-20.