

## "Do You Want Everything Done?": Clarifying Code Status

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### Case Objectives

- Recognize the importance of a comprehensive, personalized discussion of code status with all hospitalized patients.
- Differentiate among terms associated with advance care planning and code status.
- Identify at least four tools available for clinicians and patients related to advance care planning and code status.
- Determine systems approaches that facilitate advance care planning between the healthcare team, patient, and family to include the designated surrogate.

### The Case

A 63-year-old woman with a history of liver transplantation secondary to hepatitis C, low back pain, and depression presented to the emergency department with hematemesis. Despite her chronic conditions, she was generally quite healthy, working as an office manager and frequently traveling to see her children and grandchildren. She was admitted by a second-year medical resident who ordered the appropriate

diagnostic and therapeutic interventions for her upper gastrointestinal (GI) bleeding.

As asking about code status is a normal part of the admission process, the resident asked the patient if "she would want everything done" if she were to get sicker. The patient paused and replied, "You know, I don't think I'd want to be kept alive on machines, that's for sure." The resident interpreted this to mean the patient would not want resuscitation under any circumstances, and thus felt that her code status should be do not resuscitate and do not intubate (DNR/DNI). Unfortunately, the resident did not enter this order into the computer, although he mentioned it in his progress note. So, per the admission orders, the patient was listed as a "full code" by default.

In the morning, the admitting resident presented the case to the daytime medical team, including the DNR/DNI code status. The team was somewhat surprised by the code status given the patient's general good health. Early in the afternoon, the attending physician and intern on the team met with the patient to discuss her wishes. In a longer conversation, the patient clarified that she would not want chest compressions (as she had seen her husband receive these in the past when he died) but would accept short-term mechanical ventilation for reversible causes. She repeated that she would not want prolonged mechanical ventilation. Based on this, they deemed her code status to be "partial code."

The patient was taken for an endoscopy for the upper gastrointestinal bleeding about that same time and was intubated for the procedure. In parallel, the intern placed the order to change the patient's code status from "full" to "partial" code. Right after intubation in the endoscopy suite, the anesthesiologist and gastroenterologist noticed the change in code status. They were no longer comfortable proceeding with the endoscopy, because they lacked the ability to respond fully with resuscitation if something were to go wrong during the procedure. Yet, the patient was already intubated and sedated.

They urgently contacted the daytime medical team, and the teams met briefly in the endoscopy suite. Under the circumstances, they realized they had three options: (a) proceed with the procedure without changing the code status and assume the risk that, if something went wrong with the procedure, the patient could not receive chest compressions and may die; (b) extubate without performing the procedure, discuss the decision with the patient, and potentially reintubate if that was consistent with her wishes; or (c) change the code status without the patient's explicit consent and proceed with the procedure.

In the end, they believed the third option from above best respected the patient's wishes and minimized harm, so they temporarily changed her code status to "full code," completed the procedure, and then discussed the situation with the patient afterward. The endoscopy was performed without any complications and the patient was extubated afterward.

## **The Commentary**

by Karl Steinberg, MD, CMD, HMDC, and Thaddeus Mason Pope, JD, PhD

There were several errors in this case scenario revealing multiple opportunities for improvement, which will be discussed in the next section; thankfully, no harm befell the patient. Three key issues will be addressed in this commentary. First, advance care planning and determination of specific treatment wishes are extremely important tasks of the health care team, because without knowing what the patient wants, it's

impossible to provide care concordant with those wishes. Along with this discussion, the health care team must provide appropriate discussions of risks, benefits and alternatives so that the patient (or surrogate) can make informed decisions. Second, there should be a named surrogate who can make decisions if the patient is unable. Third, orders for care preferences must be entered in the patient's record, so everybody on the team is aware of them in the event the patient's condition deteriorates.

### Opportunities for Improvement

In this case, the first identified error was the poor quality of the admitting resident's "discussion" with the patient about her treatment preferences. With recent increased attention to advance care planning and increased importance of defining individual patients' wishes, no medical professionals should use the language, "Do everything" or "Do nothing" when discussing treatment preferences with patients and families. Nor should they use facile terminology such as "If your heart stops, do you want us to restart it?" Using such simplistic language in the interest of expediency or because of our own biases about treatment options is an injustice to our patients and does not afford them the opportunity to explore what "do everything" or "do nothing" means. A busy medicine resident doing one of many admissions on an evening may not be best situated to have a complex and nuanced conversation about treatment preferences, particularly if this is the first time a medical professional has discussed the issue with the patient. Yet, these are life-and-death matters that must be discussed promptly, especially with a situation like upper GI bleeding that can result in rapid decompensation. Clear and concise communication about the meaning of each decision and ensuring the patient understands what they have decided is critical so that their preferences are correctly communicated to everyone on the healthcare team.

The second and arguably most important significant error is the admitting resident's evident failure to have the patient designate an agent to make treatment decisions if she became incapacitated. This is the most important feature of advance care planning. Since no instructional advance directive can possibly predict the nuances of every possible scenario (even though some certainly attempt to), it is critically important to identify an agent who will consider specific clinical scenarios and make decisions for the patient. This would have been a vital piece of information for the resident to obtain and document on the initial encounter the night of admission. In this case, having a named agent and contact information in the record would have allowed for the procedural team to call the agent for guidance, instead of relying on the medical team to make a proxy decision to suspend the partial code status.

In this case, despite the reasonably good health and relatively young age of the patient, she did not want the most aggressive treatment under all circumstances. Unlike many patients, to her credit (and probably due to her own experiences and witnessing her husband's CPR), she was able to articulate her preferences, instead of merely acquiescing to the "do everything" suggestion of the resident.

Unfortunately, the resident failed to further explore what "I don't want to be kept alive on tubes and machines" meant. Instead, the resident considered the patient to be requesting "DNR" status. (Of note, DNR language is evolving and in many places is now stated as "Do Not Attempt Resuscitation [DNAR]" or "Allow Natural Death [AND].") [1-3](#) Not wanting to be kept alive on machines does not necessarily denote the patient would not want short-term aggressive life support, if there were a good prognosis for recovery. This is precisely the kind of discussion that is required to sort out these issues. For

example, did her statement mean she would never want to be on tubes and machines even briefly? Or did the patient mean that she would not want to be permanently dependent on this kind of technology?

It is important for health care providers and the lay public alike to understand that DN(A)R increasingly does not mean “just let me die.” Generally, as on the Physician Orders for Life-Sustaining Treatment (POLST) Paradigm (POLST document titles differ by state – e.g. Medical Orders for Life Sustaining Treatment or MOLST), orders are often completed outside the hospital setting and targeted toward patients who are most likely to experience a medical crisis but who may not want everything done to save their life.<sup>4</sup> DN(A)R only applies to situations of full cardiac and respiratory arrest. Similarly, a person can request DN(A)R status but still wish to receive other aggressive interventions, such as intubation and mechanical ventilation. Other patients may not wish intubation and mechanical ventilation but are fine with non-invasive respiratory support like BiPAP. Health care providers may sometimes erroneously interpret DN(A)R status to mean that a patient wants no efforts to prolong life, as observed in the TRIAD studies.<sup>5</sup> These studies found there was significant confusion in a cohort of emergency department physicians when asked to review the POLST document and determine code status and treatment decisions occurring in various patient scenarios. These studies emphasized the importance of ongoing education.

Some patients (and surrogates) reject DN(A)R status because of misconceptions. First, some fear that if the patient is in distress, the health care team will merely throw up their hands and not address acute changes in condition. Second, patients and surrogates often have a wild overestimation of the success rates of CPR. In fact, the rate of surviving in-hospital CPR for cardiac arrest to the endpoint of hospital discharge among all age groups and for every health status between 2000 and 2014 was less than 20%.<sup>6</sup> It is less than 5% in seriously ill or frail patients.<sup>7</sup>

The third significant error—and one that could also result in extreme and unfortunate consequences under different circumstances, including a preventable death, was the failure of the resident to enter the code status order into the record. The default code status in the absence of specific orders to the contrary is always to provide the most aggressive care, including CPR, defibrillation, intubation and ICU transfer. Unfortunately, as is often the case in teaching institutions where medical residents may cover evening shifts, this problem was not identified until the attending physician came in the following day. If there were a Chief Resident or Shift Leader available, this issue might have been caught sooner.

In a situation where a patient would not want aggressive or invasive interventions, failure to enter a DN(A)R order could obviously result in an unwanted resuscitation with extreme consequences, including CPR-related fractures, anoxic brain injury, prolonged disability, and the failure to abide by a patient’s known wishes—with potential and justifiable liability exposure.

Fortunately, when the patient’s case was discussed the morning after admission, the code status seemed irregular and the attending physician had a more careful conversation with the patient about her treatment preferences. It was determined that she wanted all ordinary measures and in fact would not object to being on a ventilator if necessary (at least short-term), but mainly did not want chest compressions. The intern who was working with the attending physician then entered appropriate orders for “partial code.” Different hospitals and different states may use varying language that reflects specific nuances about what treatment options are wanted in case of a deterioration in condition. To the extent

specific preferences can be determined ahead of time, it is best for orders to reflect explicit interventions—especially “do not” orders such as “do not intubate.”

With respect to the endoscopist’s and/or anesthesiologist’s demand that the DN(A)R or partial code order be suspended during the procedure, this is an ethically fraught area. In this case, no harm was done by the somewhat utilitarian decision to suspend the patient’s partial code status intraoperatively, under the circumstances of her already being intubated and sedated. But there was certainly the potential to harm a patient in this situation by not respecting her wishes in the event of an unexpected complication. It is unknown whether the patient herself would have consented to full code status during the procedure, but the team appropriately disclosed the error to her after the procedure was completed.

While it is true that the success rates of CPR are better intraoperatively (probably at least in part due to very rapid identification of arrest and immediate access to ACLS protocols), it is also true that some patients do not wish to have CPR (or other specific interventions) under any circumstances and irrespective of their prognosis for recovery. Bioethics and/or palliative medicine consultation may be appropriate to attempt to reach consensus in cases where a patient will not agree to suspend DN(A)R status and the surgeon will not agree to perform a necessary surgery unless the patient is full code status.

Tracking of quality measures with respect to mortality can have a unnerving effect on a clinician’s willingness to perform procedures, as demonstrated by some orthopedists’ reluctance to perform surgery on unstable hip fractures in seriously ill patients, even when it is clearly a palliative intervention that would avoid severe pain with movement for weeks or months post-fracture.<sup>8</sup> Surgeons can easily convince patients and families that the patient is “not a surgical candidate” even in cases when it is clear that death on the operating table or due to postoperative complications would be a preferable patient-centered outcome.<sup>9</sup> Clinicians should not allow concerns about metrics to color their clinical decisions, although clearly they sometimes do, as in a recently publicized case where a transplant patient was kept on life support in a long-term acute care hospital seemingly to improve the hospital’s transplant program survival statistics.<sup>10</sup>

#### Systems Change Needed/Quality Improvement Approach

Appropriate training and supervision around advance care planning or goals-of-care conversations in medical school and postgraduate training along with systems-level designs would help “close the loop” to ensure that clinicians who care for the seriously ill are knowledgeable about the need for and adept at having these conversations. Other clinical skills are certainly important, but these conversations around advance care planning and treatment preferences are among the most important work we do.

Fortunately, since 2016, time spent discussing advance care planning is billable in 30-minute increments (except in the ICU).<sup>11</sup> There are many organizations with excellent tools for clinicians, including VITALTalk<sup>12</sup> and Ariadne Labs’ Serious Illness Program.<sup>13</sup> There are also decision aids for patients, including those from ACP Decisions<sup>14</sup> and the Coalition for Compassionate Care of California.<sup>15</sup> Both organizations offer videos or short informational brochures with low-health-literacy descriptions of benefits versus burdens of CPR, tube feeding, artificial hydration, intubation/mechanical ventilation, and many others. The Agency for Healthcare Research and Quality also has an [Advance Care Planning Decision Aids](#) evidence-based report available online.

While significant progress has been made in establishing more humane working hours during postgraduate training, residents are still often under great pressure with high patient loads and, consequently, their performances can suffer.<sup>16</sup> It is certainly possible that the resident in this case failed to take the necessary time to explore the patient's specific preferences because of other pending patient care commitments that night, and it is possible that fatigue and burnout contributed to the resident's failure to enter the orders promptly as happened in this case. Periodic assessments of residency hours and individual resident performance should attempt to determine whether residents are failing to timely enter orders or feeling so rushed that they cannot have complete and meaningful discussions with their patients. In this case, it is unknown whether fatigue or sleep deprivation played a role in the poor quality of the ACP discussion between the resident and the patient, but it is clear that the resident had a deficit in his ability to flesh out and accurately communicate the preferences of the patient. Improved attention in medical school and postgraduate training to the nuances of specific treatment preferences would have probably helped avoid this near-miss situation, where the health care team was placed in a decision where they essentially proceeded to cancel/suspend a DN(A)R order without informed consent.

Ideally, advance care planning discussions should include the patient and invited family members including the designated health care agent (sometimes also called surrogate, representative, decision-maker, or proxy; or erroneously referred to as "POA" or power of attorney, which is a document and not a person).

With respect to appropriate order entry on hospital EHR systems, it is important for individual clinicians to place and modify code status orders promptly, given their extreme significance. In this case, it seems that the anesthesiologist and endoscopy team sedated and intubated the patient thinking she was full code at the same time the intern was updating the code status; so when they looked at the record again, they found out she was "partial code" and did not desire CPR in the event of an arrest. Presumably, the conversation between the attending physician and the patient in which she expressed the preference had occurred sometime earlier that afternoon, and the corresponding order should have been apparent in the EHR—so, if it wasn't, that either reflected a failure to check code status prior to sedation and intubation on the part of the procedural team, or the attending physician failed to enter the order promptly. Again, because of the importance of knowing these life-and-death preferences, it is advisable for hospital and other EHR systems to make code status a prominent and easily-seen entry near or at the top of the screen.

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