Ask or Tell?
Code Status Conversations in the Hospital

Katy Hicks, MD
Susan Merel, MD, FACP

October 31, 2019
Learning Objectives

• Describe the historical and current context of the code status question in the hospital
• Identify best practices in asking seriously ill patients about code status
What’s different about the code status decision?

• Default is treatment, despite cardiac resuscitation not being a helpful intervention for all patients
• This is not how we ask patients to make other decisions!
How did we get here?

CLOSED-CHEST CARDIAC MASSAGE

W. B. Kouwenhoven, Dr. Ing., James R. Jude, M.D.

and

G. Guy Knickerbocker, M.S.E., Baltimore

When cardiac arrest occurs, either as standstill or as ventricular fibrillation, the circulation must be restored promptly; otherwise anoxia will result in irreversible damage. There are two techniques that may be used to meet the emergency: one is to open the chest and massage the heart directly and the other is to accomplish the same end by a new method of closed-chest cardiac massage. The latter method is described in this communication. The closed-chest alternating current defibrillator that was developed in our laboratories has proved to be an effective and reliable means of arresting ventricular fibrillation. Its counter-shock must be sent through the chest promptly, or else cardiac anoxia will have developed to such a degree that the heart will no longer be able to resume forceable contractions without assistance. Our experience has indicated that external defibrillation is not likely to be successful if attempted at a later stage of cardiac arrest.

Cardiac resuscitation after cardiac arrest or ventricular fibrillation has been limited by the need for open thoracotomy and direct cardiac massage. As a result of exhaustive animal experimentation a method of external transthoracic cardiac massage has been developed. Immediate resuscitative measures can now be initiated to give not only mouth-to-nose artificial respiration but also adequate cardiac massage without thoracotomy. The use of this technique on 20 patients has given an over-all permanent survival rate of 70%. Anyone, anywhere, can now initiate cardiac resuscitative procedures. All that is needed are two hands.
Early code team

RECOGNITION of arrest stirs immediate action. Here, one nurse notifies telephone operator, another begins chest massage, while an anesthetist introduces endotracheal tube.

C.P.R. TEAM ARRIVES to find orderly and aides removing furniture from room to facilitate resuscitation efforts. The team brings resuscitation and monitoring equipment with them.

Fields MJ Am J Nursing 1966
Early survivor of in-hospital cardiac arrest

IN CARDIAC ARREST for 35 minutes 14 months ago, this woman was revived by C.P.R. team. Fine today, she has three children, works part time.

Fields MJ
Am J Nursing
1966
Orders Not to Resuscitate

The purpose of cardiopulmonary resuscitation is the prevention of sudden, unexpected death. Cardiopulmonary resuscitation is not indicated in certain situations, such as in cases of terminal irreversible illness where death is not unexpected or where prolonged cardiac arrest dictates the futility of resuscitation efforts. Resuscitation in these circumstances may represent a positive violation of an individual's right to die with dignity. When CPR is considered to be contraindicated for hospital patients, it is appropriate to indicate this in the patient's progress notes. It also is appropriate to indicate this on the physician's order sheet for the benefit of nurses and other personnel who may be called upon to initiate or participate in cardiopulmonary resuscitation.
How we got to default paradigm

• CPR was a miraculous intervention
• By 1962, AHA/Red Cross publically acknowledging limitations
• By mid-1970’s, DNAR orders are codified in literature and at individual hospitals
• But the “default” paradigm had been set.
Survival of in-hospital cardiac arrest

• 15% or less survive to hospital discharge
  – Less than 5% of patients with cancer
  – Only about half discharged home
  – Many will have new disability

• Predicting failure to survive to discharge:
  – Sepsis
  – Serum Cr >1.5
  – Metastatic cancer
  – Dementia
  – Functional dependence

Ehlenbach et al NEJM 2009; Ramenofsky and Weissman, “CPR survival in the hospital setting”
Ebell et al JGIM 1998
Cardiac Arrest on TV

<table>
<thead>
<tr>
<th>Series</th>
<th>Episodes</th>
<th>Episodes w/ CPR</th>
<th>Survival to discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grey’s Anatomy</td>
<td>46</td>
<td>35</td>
<td>15 (62.5%)</td>
</tr>
<tr>
<td>House</td>
<td>45</td>
<td>11</td>
<td>8 (100%)</td>
</tr>
<tr>
<td>Total</td>
<td>91</td>
<td>46</td>
<td>23 (72%)</td>
</tr>
</tbody>
</table>

About 40% of older adults in one study cited TV as a major source of health information!

Portanova et al J Resuscitation 2015
How much does code status matter?

• In-hospital cardiac arrest relatively rare: 0.58/1000 bed days or 0.06% chance per day
• For seriously ill patients, usually still not the most important issue about their care, BUT:
• We should asking/recommend in a way that helps patients understand the true risks, benefits and alternatives (“informed assent”)

Perman SM et al, Journal of the American Heart Association 2016
Your words
Our Framework

1. Establish if patient has had prior conversations about their preferences; check for POLST/AD
2. Categorize patients to tailor language
3. Allow for follow-up conversations if needed to clarify goals and revisit code status during admission
4. For all patients, clarify surrogate decision maker
The Healthy Patient (low risk)

- Default "Full Code"
- Normalize question
- Goal of asking is to ensure we respect preferences

https://www.thewrap.com/greys-anatomy-10-times-the-surgeons-at-grey-sloan-memorial-had-to-have-surgery-photos/
The Very Sick Patient (*unlikely to survive*)

- Offer a recommendation
- “If you die despite our treatments, we will let you die peacefully and won’t attempt to revive you”
- "If your condition worsens and it appears you are dying, I recommend that we do everything possible to focus on your comfort and not use artificial or heroic means to keep you alive."

Chittendon et al 2006

Sick but not dying
(preference driven)

• Patient-centered decision making:
  • Assess patient/family's understanding: "What have the doctors told you about your condition?"
  • "If you were to die..."
• Does not need to be completed in initial meeting
• Consider including outpatient providers

https://www.thewrap.com/greys-anatomy-10-times-the-surgeons-at-grey-sloan-memorial-had-to-have-surgery-photos/
What about “medical futility”? 

- Not allowed at all hospitals
- Most appropriate in ICU setting
- Should be used rarely

https://www.buzzfeed.com/ehisosifo1/memorable-patients-greys-anatomy-sad-cry
Troubleshooting

- "Do you want us to do everything?"
- "If your heart were to stop, would you want us to break ribs with chest compressions?"
- "I just don’t want to be a vegetable”
- “I want you to do everything if there’s a chance”
What to say when you're stuck?

- "Can you tell me more about your decision?"
- "May I share some concerns with you?"
- "I'm worried..."
- "Would it be OK if we talk more about this later in your hospital stay?"
- Pause to reflect on whether patient's choice is in conflict with their preferences or your own
Time to practice!