Did You Confirm Code Status?

Code Status Discussions as a Checkbox on Hospital Admission

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If you have admitted a patient to the hospital then you likely used a checklist, or bundle, as part of your care plan. This bundle involves what some refer to as “bottom of the list” items or tasks addressed for every patient: electrolyte repletion, diet, DVT prophylaxis, anticipated disposition, and code status. But one of these things is not like the others. Although clinicians usually are expected to have a code status discussion with patients who are admitted to the hospital (commonly conceived of as a “checkbox”), we have concern that relegating code status to a checkbox task actually does a disservice to patients.

Why is it expected that most hospital admissions include a code status discussion? In 1990, the passage of the Patient Self-Determination Act required hospitals to offer information about end-of-life decision-making to patients on hospital admission. Over time, satisfying this hospital-level requirement for information-sharing became wrongly associated with a perceived need for bedside code status discussions on admission.1

This checkbox mentality results in perfunctory and superficial discussions, suffering from a heavy use of medical jargon, lack of framing around the patient’s goals and values, and minimal depiction of individualized prognosis after arrest.3 At the end of the interview, with little preceding context, clinicians often raise blunt questions such as “If your heart stops beating would you want us to do chest compressions, electric shocks, and to put a breathing tube in your throat?” Although there are many potential reasons that code status discussions are done so poorly (including lack of training, incomplete prognostic information, and workload), we suspect that a checkbox mentality is a major contributor.

Conceiving of code status discussions as one of many admission tasks renders them intrinsically clinician centered. Rather than deliberately exploring the patient’s values and preferences, the goal becomes simply to complete a task. When clinicians feel obligated to discuss code status preferences on all admissions, regardless of clinical relevance, such trivialization is expected.

We also worry about the high risk for misinformation that arises from near-ubiquitous code status discussions on hospital admission for both clinicians and patients. First, clinicians may misunderstand patients’ wishes; rushed and ill-timed conversations with the acutely ill patient can lead to misinterpretation of preferences regarding resuscitation.5 Physicians may document patients as “Do Not Resuscitate” after a brief interview on admission, only to later discover that they would accept short-term interventions for reversible conditions. Abbreviated goals of care and code status discussions are prone to such inaccurate inferences and misunderstandings. Patients may also not know their own prognosis or risks and benefits of resuscitation.7

Code status discussions are complex and doing it well takes more time and attention than can be accomplished realistically with an abbreviated query at the end of the admission interview.

How can we do better as a medical community? The Institute for Healthcare Improvement has framed quality health care as appropriate care provided to the right patient, in the right setting, and at the right time.8

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Healthcare Improvement framework when deciding whether to offer bedside procedures such as bronchoscopies or arterial line placement, only doing so if indicated. We propose that the indication for a code status discussion must be more than admission to the hospital, but rather the individualized clinical and comorbid status of the patient.

For those who are critically ill or for whom there is concern for imminent cardiopulmonary decline clinicians should broach the issue promptly (Fig 1). Some patients who are otherwise clinically stable may benefit from code status discussions on admission at the clinician’s or patient’s discretion. We suggest considering code status discussions with patients who are in stable condition with progressive or incurable underlying organ failure or chronic disease, who are anticipated to have poor postarrest outcomes, in the context of larger discussions about advanced care planning. Although not an exhaustive list, such conditions include those who have metastatic cancer, severe chronic respiratory or liver failure, or advanced dementia.9-11 For other patients, we suggest that clinicians confirm existing documented wishes as available but otherwise not routinely initiate discussions about code status while admitting to the hospital. Patients in whom code status discussions are deferred should be documented as presumed full code (Fig 1). Of course, patients and families always have prerogative to initiate code status discussions with their care teams. The Veterans Health Administration has advocated for a similar approach to the one we have suggested.12

The status quo of code status discussions as a checkbox on hospital admission is harmful, particularly when detached from broader conversations about goals of care. Instead, clinicians should apply the framework of clinical indication (right patient, right setting, right time) when deciding whether to initiate this conversation.

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References


