

This is a resident case log of a patient encounter in which an “Aware Medicine topic” was central.

Code Status and Family Wishes

A little over a month ago we had a patient admitted to our service who brought up a number of challenges for our team. The patient was a middle-aged woman with a many long-standing medical problems including chronic pain and diabetes. She was extremely cachectic when she arrived on our service; clearly she had been malnourished for some time. While admitted to our service, she had an episode of severe hypoglycemia and ended up with profound neurological damage as a result. Although she was able to gain back some cognitive functioning to the point that she could mutter a few words, she did not regain the ability to really communicate or even follow commands during the weeks that followed.

Prior to the hypoglycemic episode, she had expressed to her family that she wished to have maximal medical treatment, that “everything be done to save her life.” And at first we did just that – we had a PEG tube inserted to feed her, we carefully monitored her sugars, we had an evaluation by neurology, we put her through a bunch of tests and we aggressively treated her other medical issues. Despite our efforts, she did not recover. The daily lab tests indicated that one by one, her organs were slowly beginning to fail. She had to be restrained in bed because she got up and fell unless constantly monitored and spent her days lying there, incontinent of urine and stool. She was no longer talking, eating or interacting with those around her.

As time progressed and she continued to get worse, we began to question the utility of our interventions. She was a full code and it seemed imminent that she was headed that direction. Our team wanted to make her DNR, stop her tube feeds and refer her to hospice. The family felt they needed to respect her last request and continued to push for maximal interventions. After a number of long discussions without resolution, we sought an ethics consult to support our decision to change her code status to DNR. The ethics physician determined that there was no reason to extend futile measures and we did end up changing her code status against the family’s request. When we held a family meeting to inform them of the change, they were upset but also somewhat relieved that the decision about her code status was something they no longer had to worry about.

She continued to decline and the family eventually began to agree with us that she would not get better, even with blood draws and PEG feeds. They finally agreed to transition to comfort measures and we transferred her to hospice. She only lived a few days there before she died.

As with this patient, the issue of code status comes up fairly often. It is not uncommon that the health care team feels a code is futile, but the patient requests to be full code anyway. Although it felt uncomfortable to change a patient’s code status against their wishes, I would have been more uncomfortable doing chest compressions and intubation on someone so frail and ill that had no chance of recovery. What I learned most from this was that as much as I try to give patients autonomy to make their own decisions about their health care, I also had a strong pull to stay consistent with my own values.