

Discussions of “code status” on a family practice teaching ward: What barriers do family physicians face?

Betty Calam, Susan Far, Rodney Andrew

Abstract

Background: Patients want physicians to ascertain their wishes related to resuscitation, yet such discussions of “code status” are often delayed in the hospital setting, which compromises patient autonomy. Few studies have examined family physicians’ views on this topic. Our objectives were to explore the experiences of family physicians and family practice residents in establishing code status with their patients who had been admitted to hospital and to identify barriers to these discussions.

Methods: Semistructured, in-depth interviews were conducted with 5 family physicians and 5 family practice residents admitting patients to a family practice teaching ward in a university-affiliated urban tertiary care hospital. Interview transcripts were analysed inductively, and grounded theory was used to identify conceptual categories and recurring themes. Key findings were validated by means of member checking with participants, consensus meetings of the research team and consultation with qualitative researchers.

Results: Barriers to code-status discussions included personal discomfort with confronting mortality, fear of damaging the doctor–patient relationship or harming the patient by raising the topic of death, limited time to establish trust, and difficulty in managing complex family dynamics. In spite of these challenges, family physicians and residents viewed discussions of resuscitation as a significant part of their role.

Interpretation: Family physicians and residents need to develop personal awareness about difficulties in confronting mortality, enhance their communication strategies for broaching the topic of code status in the context of a trusting doctor–patient relationship and sharpen their skills in understanding and managing family dynamics related to end-of-life decisions. Awareness of the barriers to code-status discussions can inform research, education and hospital policy. Consultation with patients is needed to develop effective communication strategies.

Most people want their physicians to discuss resuscitation or “code status” with them,^{1,2} yet in the hospital setting, such discussions are fraught with difficulty and delay.^{1,3–7} When patients’ views on resuscitation are unclear, their autonomy may be compromised and hospital staff left in a state of uncertainty or distress.⁸ Family physicians often visit or care for their patients who have been admitted to hospital and would thus seem ideally situated to facilitate code-status discussions because of the existing doctor–patient relationship.

Over the past decade, the attitudes, knowledge and communication styles of health care providers with respect to code-status discussions and do-not-resuscitate (DNR) orders have been under scrutiny,^{9,10} and the effects of educational interventions, guidelines and policies to improve such discussions have been examined.^{11–15} Studies of family physicians’ experiences in establishing code status with their hospitalized patients are scarce. In one exploratory study in a hospital setting,¹⁶ it was unclear if the physicians interviewed were the patients’ own family physicians. In a survey on discussing advance directives in both hospital and outpatient settings, only 3% of the respondents were certified in family medicine.¹⁷

Research

Recherche

Dr. Calam is Assistant Professor in the Department of Family Practice, University of British Columbia, and Medical Director of the Family Practice Ward, St. Paul’s Hospital, Providence Health Care, Vancouver, BC; Ms. Far is a fourth-year medical student at Queen’s University, Kingston, Ont.; and Dr. Andrew is a Clinical Professor in the Department of Family Practice, University of British Columbia, and Director of Medical Education, St. Paul’s Hospital, Providence Health Care.

This article has been peer reviewed.

CMAJ 2000;163(10):1255-9

On a teaching hospital ward run by family physicians, we found that, of the 40% of patients who were judged on admission to be unlikely to benefit from resuscitation, just over half had DNR orders written in their charts in the first week,¹⁸ and only half of these orders were adequately documented (according to existing hospital policy¹⁹).

Our objectives were to explore the experience of practising and resident family physicians in establishing code status with their hospitalized patients and to identify barriers to these interactions.

Methods

We audiotaped semistructured in-depth interviews with 5 family physicians and 5 family practice residents. These key informants were men and women from a variety of cultures, age groups, practice structures and backgrounds, who could provide “expert inside information.”²⁰ They all had admitted patients to the Family Practice Ward of a university-affiliated urban tertiary care hospital in 1998/99 and were chosen to represent a spectrum of experience, from residents to seasoned practitioners.

We developed 2 open-ended questions to elicit rich stories from the interviewees.²¹ We asked participants to describe their experiences in code-status decision-making on the ward and to specify the factors that they believed could affect open discussions with their patients on this topic. After one practice interview we added a third open-ended question about the influences of personal background in the physicians’ approach to these discussions. Prompts were derived from a comprehensive literature review and from issues that emerged in the initial interviews.

We analyzed the interviews using a qualitative method called grounded theory,²² whereby interviews were scrutinized to identify and categorize all ideas presented. Each idea was given a code, and the codes were linked by hand to construct a conceptual framework explaining the collective experiences of those interviewed (“Rudiments in the process of conducting qualitative research: a working guide to the use of ‘grounded theory,’” unpublished manuscript by G.D. Grams, University of British Columbia Department of Family Practice, Vancouver) and the nature of the barriers to establishing code status. The interpretation of the data was thus inductive and “grounded in the words and experiences of the participants.”²³

We revised the framework over the course of the study by referring back to existing data as each interview was analyzed. No new themes or categories emerged in the final interviews, which meant that the data were “saturated.”²⁴ To ensure the accuracy of our interpretations, key findings were validated by member checking and triangulation of information.²⁵ The participants were asked to review our interpretations, and their comments were used to regroup some of the codes and to further develop the themes. Triangulation methods included meetings of the research team to corroborate findings and interpretations, as well as discussions with qualitative researchers to review the emerging framework, barriers and implications.

Results

Family physicians suggested that code-status discussions can be straightforward, particularly when the patient has made a decision about resuscitation before admission to the

hospital, the patient or the family raises the issue spontaneously or the patient is clearly terminally ill. In some cases, however, establishing code status is complex and difficult. Barriers to code-status discussions are summarized in Table 1. In spite of these difficulties, participants accepted their responsibility for discussing code status with their hospitalized patients:

... because we’re in it, you know. We’re in it before, we’re going to be in it afterwards and we know the patient, and so I think that is a legitimate role for us, however challenging it is.
— *Practising physician*

For participants, raising the issue of code status meant bringing up the subject of death, which was a challenge:

Starting is the most difficult . . . because I’m never quite sure what their reaction would be. Nobody likes to think of impending death . . . so asking the question is then asking people to confront the fact that they’re perhaps closer to death . . . than maybe they realized. — *Practising physician*

Most physicians found it difficult to discuss death with younger patients, even those with serious illnesses such as AIDS:

These are often young men . . . so it’s particularly difficult to have to tackle the issue. . . . Part of it is perhaps my own feeling that it’s really not fair. . . . You know, somebody in [his] 20s or 30s who’s really not lived a full life [is] going to have it taken away from [him]. . . . — *Practising physician*

When the emphasis had been on cure it was also difficult to introduce the possibility of death:

The problem comes with patients who do not have a chronic, life-threatening illness but become acutely ill. It can be quite difficult to broach the topic because your whole focus with them is to make them better, and it’s difficult to then say, “Well, by the way, should you get worse and suffer cardiac arrest, what would you like us to do?” — *Practising physician*

Table 1: Family physicians’ perceived barriers to discussion of code status

Personal discomfort with acknowledging mortality
Challenge presented by impending discussion about death with patients who are young, acutely ill or in a situation where the focus has been on cure
Fear that raising the topic of death will compromise the doctor-patient relationship or cause harm to the patient
Limited opportunity or ability to establish rapport and trust with the patient within the time constraints imposed by the patient’s condition or the other demands of practice and training
Difficulty in managing conflict between family members
Paucity of role modelling and training in communication skills related to broaching with patients the topics of code status and death

Physicians' own uneasiness with the subject of death was also a barrier:

I know every time I approach a patient I do tense up a little bit and I get a little knot in my stomach because I know . . . it's not pleasant for us to deal with. — *Practising physician*

[I]t brings your own potential mortality closer. — *Practising physician*

A common challenge was related to physicians' concerns about damaging trust:

I think they feel that maybe you're not telling them the truth, that maybe they're sicker than you are telling them — otherwise why would you be asking them about that? — *Practising physician*

The physicians feared that patients might feel abandoned if they raised the issue of resuscitation:

I would always [be] kind of afraid I [might] offend people by talking about this . . . and they would close [up] on me and think I'm just giving up on them. . . . — *Resident*

Physicians felt that their endorsement of a DNR order might be perceived as substandard care:

[E]ven if a person wants to be "no code," a lot of them may feel, including staff, . . . if you say "no code," then the . . . care might be of a lesser quality. . . . — *Resident*

Family physicians spoke about the fundamental importance of continuity of care and the doctor—patient relationship when asking patients about their resuscitation wishes.

Knowledge of the patient makes a great deal of difference. If you know the patient well, you may already know what their wishes are anyway. If not, you know how to approach them. — *Practising physician*

The quality of this relationship affected physicians' ability to broach the topic:

I would do it very comfortably if I know the patient. I would never do it if I don't know the patient. — *Resident*

Physicians described the need to develop relationships with hospitalized patients whom they did not know well, before approaching them about code status:

I don't think you can walk in on somebody, and ask them if they want to be a DNR or not. You need to spend some time, reviewing their whole case and their history, where they live and all the rest of it before you can launch into the subject. If you don't know them . . . it takes a lot of time . . . and get them to know you a little bit, too, which is hard to do . . . especially if they're sick. — *Practising physician*

Physicians spoke of prototypical "difficult" situations, usually related to complex family dynamics, often involving far-flung relatives who have not been able to maintain a good relationship with the patient or have not been in-

involved enough in the patient's life to witness the natural course of the disease:

The difficult ones are the ones that fly in . . . and are involved intensively for a short period of time. They're more difficult to deal with, in every respect, not just code status. — *Practising physician*

Ethical dilemmas were often encountered in the context of family conflict:

[T]he family who've been in denial about the severity of their relative's illness who attempt to intervene with their loved one's wishes to not be resuscitated . . . that can be a problem because, after all, the patient, as long as [he or she is] competent, [has] the right to make the decision. — *Practising physician*

Physicians referred to resources they call on to help in these situations, emphasizing communication skills for understanding and managing conflict:

. . . and that's where I bring in somebody who is a designated ethicist or somebody from the palliative care service who could come in and act as a kind of independent person, . . . somebody who's got that kind of expertise, and certainly expertise as a communicator. . . . — *Practising physician*

Physicians reflected on their medical training and its impact on their attitudes toward death:

I think my training, and perhaps the training for all physicians at the time, was such that all our endeavours were to defeat death, prevent death. So in a way I think we try to avoid it, maybe because of our own sense of mortality. — *Practising physician*

The patient's impending death was sometimes experienced by the physician as a professional shortcoming, a situation that resulted in avoidance:

I remember having difficulty dealing with my patients — this is as a family doctor in the early days, of my patients dying of cancer — the difficulty I had in actually even going in and facing them because I thought I was failing. . . . — *Practising physician*

Scarcity of role models was a significant impediment to code-status discussions for trainees:

I don't think I had many examples of how people do this . . . I would grab any opportunity to go with anybody who is more experienced, a well-spoken person. — *Resident*

Even seasoned practitioners had this experience:

[I]t's difficult for me because I feel like I'm kind of lacking in models. I've never seen anybody else do this. And . . . I've been in practice for a long time. — *Practising physician*

Opportunities to develop skills related to end-of-life discussions were seen as important educational objectives:

[Y]ou can certainly pick up stuff from watching someone do this and in simulated patient interactions. You get to practise . . . and get to know what it feels like. — *Practising physician*

Interpretation

The family physicians saw themselves as important resources for helping patients establish code status during the hospital stay. They articulated the need to understand their own emotional responses toward death and to refine communication strategies for code-status discussions so as to respect the relationships they have developed with patients and their families. The implications of these findings are summarized in Table 2.

Our study echoes a number of themes in the literature. Discomfort with the topic of death, time constraints, discontinuity of physician care between outpatient and hospital settings, and concern about patient and family reactions have been cited as barriers to physician-initiated discussions about advance directives for internists, oncologists and other specialists.^{17,26,27} In a research setting similar to ours, Ventres and colleagues¹⁶ found that attending physicians' and residents' comfort with discussing death, experiences with death and dying, ability to "let go" of the patient and personal knowledge of the patient influenced their approach to code-status decision-making.

Our findings expand on the challenges that family physicians face when discussing resuscitation with their hospitalized patients. Broaching the topic appropriately while building and maintaining trust and managing complex interpersonal and family dynamics in the context of a longitudinal relationship were considered important. Our participants did not emphasize prognostic information, likely benefit from resuscitation, knowledge of patient preferences or patient competency as factors in establishing code status, as postulated elsewhere.¹²

Table 2: Implications of findings for practice and education

Family physicians view the initiation of code-status discussions with their hospitalized patients as a legitimate and beneficial role, despite the inherent challenges

Physicians in training and in practice need to explore their own feelings and attitudes toward death, so that they can approach their patients openly in discussions about resuscitation

Physicians need specific training on how to raise the topics of resuscitation and death without compromising their relationship with the patient or causing harm to the patient

Physicians need to develop and practise effective strategies for establishing trust and determining code status with their patients within the time constraints imposed by practice, training and the patient's condition

Family physicians need to develop an understanding of family dynamics and expertise in communication skills so that they can manage conflicts related to resuscitation decisions; colleagues should be available for consultation in difficult situations

Family physicians in training and in practice welcome a variety of methods to learn these skills, including modelling of code-status discussions by experienced practitioners, practice sessions with coaching and feedback on communication skills, and sessions designed to promote self-awareness

This study had some limitations. Participants were associated with an academic urban tertiary care hospital, so the barriers they identified might differ from those experienced in other settings. However, the model of care on the family practice ward may be comparable to that in community hospitals, where family physicians care for their own patients, so our results may be applicable in a range of Canadian hospital settings.

Several researchers have outlined approaches to overcoming some of the barriers we identified. Tulskey and associates^{28,29} suggested that communication about resuscitation decisions should be taught with the same stringency as other essential medical skills. Teaching goals and methods are outlined in a recent consensus statement,³⁰ and ways to enhance self-awareness have been described by McWhinney³¹ and Longhurst.³² The effectiveness of educational interventions designed to enhance physician self-awareness, patient-centred communication strategies and conflict-resolution skills for code-status decision-making in hospitals should be evaluated. Family physicians who develop these interpersonal skills could become ideal role models and teachers of end-of-life issues for medical students and residents.

In a recent qualitative study exploring psychological and spiritual issues at the end of life, Kuhl³³ found that for some patients the way in which physicians interacted with them *increased* their distress. We might thus learn from patients how they think their family physicians should initiate dialogue about resuscitation in hospital.

Competing interests: None declared.

Contributors: Dr. Calam was responsible for research design, data analysis and writing of the manuscript. Ms. Far was responsible for research design, data collection, data analysis and writing. Dr. Andrew contributed to the data analysis and to manuscript editing.

Acknowledgements: We thank the members of the University of British Columbia Department of Family Practice Writers Group for their support and suggestions about this paper.

References

1. Ebell M. Practical guidelines for do-not-resuscitate orders. *Am Fam Physician* 1994;50(6):1293-9.
2. Morgan R, King D, Prajapati C, Rowe J. Views of elderly patients and their relatives on cardiopulmonary resuscitation. *BMJ* 1994;308:1677-8.
3. Morris BA, Van Niman SE, Perlin T, Lucic KS, Vieth J, Agricola K, et al. Health care professionals' accuracy in predicting patients' preferred code status. *J Fam Pract* 1995;40(1):41-4.
4. Bedell SE, Pelle D, Maher PL, Cleary PD. Do-not-resuscitate orders for critically ill patients in the hospital. How are they used and what is their impact? *JAMA* 1986;256(2):233-7.
5. Van Delden JJM, van der Maas PJ, Pijnenborg L, Looman CWN. Deciding not to resuscitate in Dutch hospitals. *J Med Ethics* 1993;19(4):200-5.
6. Lipton HL. Physicians' do-not-resuscitate decisions and documentation in a community hospital. *QRB Qual Rev Bull* 1989;15(4):108-13.
7. Skerritt U, Pitt B. 'Do not resuscitate': How? why? and when? *Int J Geriatr Psychiatry* 1997;12:667-70.
8. Rodney P. Moral distress in critical care nursing. *Can Crit Care Nurs J* 1988;5(2):9-11.
9. Stolman CJ, Gregory JJ, Dunn D, Levine JL. Evaluation of patient, physician, nurse, and family attitudes toward do not resuscitate orders. *Arch Intern Med* 1990;150:653-8.
10. Tulskey JA, Chesney MA, Lo B. How do medical residents discuss resuscitation with patients? *J Gen Intern Med* 1995;10:436-42.
11. Sulmasy DP, Terry PB, Faden RR, Levine DM. Long-term effects of ethics

- education on the quality of care for patients who have do-not-resuscitate orders. *J Gen Intern Med* 1994;9(11):622-6.
12. SUPPORT Principal Investigators. A controlled trial to improve care for seriously ill hospitalized patients. The study to understand prognoses and preferences for outcomes and risks of treatments (SUPPORT). *JAMA* 1995;274(20):1591-8.
 13. Lowe J, Kerridge I. Implementation of guidelines for no-CPR orders by a general medicine unit in a teaching hospital. *Aust N Z J Med* 1997;27(4):379-83.
 14. Mittelberger JA, Lo B, Martin D, Uhlmann RF. Impact of a procedure-specific do not resuscitate order form on documentation of do not resuscitate orders. *Arch Intern Med* 1993;153(2):228-32.
 15. Markson LJ, Fanale J, Steel K, Kern D, Annas G. Implementing advance directives in the primary care setting. *Arch Intern Med* 1994;154:2321-7.
 16. Ventres W, Nichter M, Reed R, Frankel R. Do-not-resuscitate discussions: a qualitative analysis. *Fam Pract Res J* 1992;12(2):157-69.
 17. Markson L, Clark J, Glantz L, Lamberton V, Kern D, Stollerman G. The doctor's role in discussing advance preferences for end-of-life care: perceptions of physicians practicing in the VA. *J Am Geriatr Soc* 1997;45(4):399-406.
 18. Calam B, Andrew RF. CPR or DNR? End-of-life decision-making on a family practice teaching ward. *Can Fam Physician* 2000;46:340-6.
 19. St. Paul's Hospital. *Resuscitative intervention*. Doc no. AE 4700. Vancouver: The Hospital; 13 Sept 1994.
 20. Crabtree BF, Miller L. Primary care research: a multimethod typology and qualitative road map. In: *Doing qualitative research. Research methods for primary care*. Vol 3. Newbury Park (CA): Sage Publications; 1992. p. 3-28.
 21. Crabtree BF, Miller L. Key informant interviews. In: *Doing qualitative research. Research methods for primary care*. Vol 3. Newbury Park (CA): Sage Publications; 1992. p. 70-89.
 22. Straus, A, Corbin J. *Basics of qualitative research: grounded theory procedures and techniques*. London: Sage Publications; 1990.
 23. Grams GD, Herbert C, Heffernan C, Calam B, Wilson MA, Grzybowski S, et al. Haida perspectives on living with non-insulin-dependent diabetes. *CMAJ* 1996;155(11):1563-8. Abstract available: www.cma.ca/cmaj/vol-155/issue-11/1563.htm
 24. Lincoln YS, Guba EG. Processing naturalistically obtained data. In: *Naturalistic inquiry*. London: Sage Publications; 1985. p. 332-56.
 25. Guba EG. Criteria for assessing the trustworthiness of naturalistic inquiries. *Educ Commun Technol J* 1981;29:75-91.
 26. Morrison RS, Morrison EW, Glickman DF. Physician reluctance to discuss advance directives: an empiric investigation of potential barriers. *Arch Intern Med* 1994;154:2311-8.
 27. Smith TJ, Desch CE, Hackney MH, Shaw J. How long does it take to get a do not resuscitate order? *J Palliat Care* 1997;13(1):5-8.
 28. Tulskey JA, Cesney MA, Lo B. See one, do one, teach one: house staff experience discussing do-not-resuscitate orders. *Arch Intern Med* 1996;156:1285-9.
 29. Tulskey JA, Fischer GS, Rose MR, Arnold RM. Opening the black box: How do physicians communicate about advance directives? *Ann Intern Med* 1998;129(6):441-9.
 30. Danis M, Federman D, Fins JJ, Fox E, Kastenbaum B, Lanken PN, et al. Incorporating palliative care into critical care education: principles, challenges, and opportunities. *Crit Care Med* 1999;27(9):2005-13.
 31. McWhinney IR. Illness, suffering and healing. In: *A textbook of family medicine*. 2nd ed. Oxford: Oxford University Press; 1997. p. 83-103.
 32. Longhurst M. Physician self-awareness: the neglected insight. *CMAJ* 1988;139:121-4.
 33. Kuhl D. Spiritual and psychological issues at the end of life [dissertation]. Vancouver: University of British Columbia; 1999.

Reprint requests to: Dr. Betty Calam, Rm. 9005, Ward 9A, Providence Building, St. Paul's Hospital, Providence Health Care, 1081 Burrard St., Vancouver BC V6Z 1Y6; fax 604 806-8556; bcalam@providencehealth.bc.ca



Canadian Medical Association

2001 Special Awards

The Canadian Medical Association invites nominations for the CMA 2001 Special Awards. Submissions will be reviewed by the Committee on Archives in January 2001 and award recipients will be notified in March. The awards will be presented at the CMA Annual Meeting in Québec, Québec, Aug. 12-15, 2001.

Medal of Honour

The CMA Medal of Honour represents the highest award that lies within the power of the Association to bestow upon a person who is not a member of the medical profession.

The award is granted in recognition of personal contributions to the advancement of medical research, medical education, health care organization and health education of the public; service to the people of Canada in raising the standards of health care delivery in Canada; and service to the profession in the field of medical organization.

F.N.G. Starr Award

The Frederic Newton Gisborne Starr Award represents the highest award that lies within the power of the Association to bestow upon one of its members.

Achievement is the prime requisite in determining the recipient of this award.

Medallists may have achieved distinction in one of the following ways: by making an outstanding contribution to science, the fine arts or literature (nonmedical); by serving humanity under conditions calling for courage or the endurance of hardship in the promotion of health or the saving of life; by advancing the humanitarian or cultural life of his or her community; or by improving medical service in Canada.

Such achievement should be so outstanding as to serve as an inspiration and a challenge to the medical profession in Canada.

Medal of Service

The CMA Medal of Service is awarded to a CMA member who has made an exceptional and outstanding contribution to

the advancement of health care in Canada. This may be a service to the profession in two of the following areas: to the field of medical organization, to the people of this country to help raise the standards of medical practice in Canada, or a personal contribution to the advancement of the art and science of medicine.

Nominations, including supporting documents, should be submitted in writing with an attached curriculum vitae to:

Kathy Hannam
Corporate Affairs
Canadian Medical Association
1867 Alta Vista Dr.
Ottawa ON
K1G 3Y6

Closing date for receipt of nominations is Nov. 30, 2000.

