

Late night decisions

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It is now midnight and the second time tonight that I am having a conversation about code status. I am on call for the nephrology ward, and I am admitting a patient to the floor from the emergency department. The woman, in her sixties, has end-stage renal disease. Because of progressively worsening left ventricular function, she has been hypotensive during recent dialysis sessions, and her outpatient team no longer feels comfortable conducting the dialysis. She was seen earlier in clinic by the staff nephrologist, who wants to admit her to the hospital to optimize her cardiac medications and dialysis regimen.

She is sleeping when I walk in her room. I call her name. When she doesn't respond, I tap her shoulder. She rouses and looks startled to see me, one of many strangers she will meet tonight. I apologize for the intrusion and tell her I am here to begin the process of admitting her to the hospital. We talk about her medical history, her social supports, and then I ask, "Have you ever heard of something called a code status?" She does not answer. The silence hangs between us. I try to guess her thoughts. Does she feel uncomfortable with the way I asked the question? Is there a story behind her silence that burdens her answer? Does she understand the term "code status?" Not for the first time, I realize this piece of medical jargon, which is such an easy box to check on the order sheet, will demand a deeply personal exploration.

It is the middle of the night, a monitor outside is beeping, a delirious patient in another room is wailing, this woman in front of me is ill, and we are about to talk about the end of her life. The setting is inauspicious, but my discomfort extends beyond the distractions around us to the weight of asking someone to share their views on their



mortality with a stranger. As I begin to explain myself, I see her brow furrow.

I go on to say my plan is to fix her blood pressure problem and send her home as soon as it is resolved. I tell her I need to be prepared in case something unexpected happens while she is under our care. I pause. "Like your heart stops." The crease in her forehead disappears, and I know that she understands.

Her heart had stopped before. She had a cardiac arrest, was resuscitated and had gone to the cardiac intensive care unit (ICU). "I have talked to my husband about this, and we never want that to happen again."

She tells me a story about that time in the hospital. She had been transferred from ICU into the ward and placed in a

shared room. Her roommate liked to talk, and she was content to listen. The roommate talked about her life, her children and her health. The roommate never wanted to trouble the nursing staff, but my patient would sometimes call the nurse for her when she thought the roommate needed help. One day, my patient overheard a conversation that the roommate was having with her family. She told her children that she never wanted to be resuscitated. Later, it sounded like her roommate was in distress. My patient knew it was serious when the roommate pressed her own call button. The next moments were a blur. Worried voices came from behind the curtain, and overhead my patient heard a code blue being called to her floor, her room, to the bed beside her.

Somehow, that crucial medical jargon — the code status — never made it to the on-call code team. My patient listened to the cacophony of commands, responses, monitors, chest compressions and electrical shocks silence the wishes of her neighbour. “It was awful,” she tells me; this isn’t what her roommate wanted. Days later, the family withdrew life support and her roommate died.

“What are the words we have to say to let them know?” she asks. She wants her husband to know what he should tell the medical team if she cannot. “Do not resuscitate or DNR,” I tell her. There is a sense of relief; this simple phrase can prevent a cascade of intervention. She tells me if it is “her time,” she wants to die peacefully.

I think back to other overnight conversations when I was a medical student. With perfunctory brevity, I would ask, “If your heart stopped, would you want everything done?” Mostly, people said yes. This would become the code status, and I secretly hoped it would not matter for that admission. My naiveté about the consequences of those careless conversations changed slowly during clerkship when I saw person after person with poor prognoses undergo in-hospital cardiopulmonary resuscitation. For these patients, survival to discharge — ignoring quality of life — tended to be an exception. If a patient survived initial resuscitation and was transferred to the ICU, the members of the patient’s family would often face the hardest decision one person can make for another: the decision to withdraw life support.

On this night, I tell my patient it is the right decision. I say this to validate a hard choice, and because I agree with her goals.

I wondered how I would have responded if she had wanted to be a “full code.” How strenuously would I try to convince her to change her mind? Would I tell her that if her heart stops, I would rather pat her hand and call her husband than break her ribs in a frantic, but likely futile, rush to reach into her chest and force her weakened heart to pump blood?

The idea of rightness and wrongness weighs heavily in this conversation. I have

give up hope, even if it is a hope that runs counter to the facts of their case? Of all the invasive questions, examinations or procedures I have performed in my career, this has always been the most challenging. I no longer stop the discussion after asking “would you want everything done?”, because the act of giving a person the opportunity to face and, ultimately, to accept their death is a kindness that I would want for myself and those I hold dear.

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talked with patients about the guilt they carry for giving up too easily or being complicit in their illness. They worry that if they are not willing to fight, the medical team will care less. My motivation is to prevent a patient from needless suffering, but who am I to opine that the kind of suffering on a terminal ventilator is different than the kind of suffering that comes from wanting to stay with your spouse, your children and your friends but knowing you cannot? Each time I have this conversation, particularly when the patient has a poor prognosis, I am conflicted about my role as patients explore their mortality. I want to advocate for what I consider to be a good death, which fundamentally relies on an acceptance of its inevitability. Yet, I wonder: Am I telling them to

Tonight, I am saved from a hard conversation, because my patient and I have a shared understanding. I affirm her choice and let her know I will not forget about her. I smile and shift the focus to getting her better so she can leave the hospital as soon as possible. When this encounter finishes, I start on my next admission and will have this conversation for the third time this night.

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This article has been peer reviewed.

This is a true story. The patient has given her consent for it to be told.