LETTERS

Attending Code Status Discussions at Admission

To the Editors:—The study by Anderson et al.¹ adds to the growing evidence that discussions with seriously ill patients about CPR are often not taking place, and that when they do happen they are mired in jargon and do not include enough consideration of realistic goals of care.

As a corrective the authors suggest that code discussions should be targeted at “patients who are at high risk for requiring CPR or having an outcome that is worse than average.” In effect the authors propose a quality of a subset of patients—most likely to arrest and least likely to benefit from resuscitation—as indications for a code status discussion. Though the authors suggest that targeting this cohort will allow fuller discussions about prognosis and overall goals of care where they are most necessary, these discussions will continue to be hijacked as long as the implicit goal is to steer patients toward signing a DNR order.

We agree that doctors should be talking with their patients about prognosis and therapeutic options, but we consider the notion of presenting this information in the context of choice about code status ill advised. The invitation to patients to discuss goals of care and code status has become a rhetorical cover for convincing patients that there are no longer any curative therapies available to them. The result is to present dying persons the illusion of choice where often none exists, sending the mixed message that death is at once optional and inevitable.

Singling out a particular group of patients as targets of a code discussion consequently only affirms the universal

default status of CPR at the same time that it intensifies the troubling message that some patients have an obligation to choose their own death. It is little wonder, therefore, that physicians remain reluctant to engage these matters with their patients. Even if they are not explicitly able to articulate the troubled logic governing the conversation, their reluctance bespeaks a practical awareness that they are sending mixed messages. Ensuring better communication and care of gravely ill patients consequently requires greater questioning of the default status of CPR and the deformation of the meaning of purposeful choice it entails.

Daniel J. Brauner, MD and Caitjan Gainty, MA.
The University of Chicago Medical Center, 5841 S. Maryland, M/C 6098, Chicago, IL 60637, USA; (e-mail: dbrauner@medicine.bsd.uchicago.edu); Geoffrey Rees, PhD, Rush University, Chicago, IL, USA.

REFERENCES

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