Background  This Fast Fact is a continuation on Fast Fact #365, which suggests language for routine discussions of code status for patients being admitted to the hospital. The following is meant to be a guide to discussing resuscitation orders when clinicians themselves judge that they should make a recommendation to the patient/surrogate for a ‘do not resuscitate’ (DNR) order. It is important to be aware that patient survival to discharge post-arrest nationally is around 15-20%, and can be reviewed further in Fast Fact #179 and references 2 and 3.

Circumstances when making a recommendation is appropriate  The language below assumes that the clinician has already decided that it is appropriate to recommend a DNR order. This judgement is usually based on a combination of factors including a careful assessment of a patient's hopes, values, fears, and care goals in light of their knowledge of their (usually poor) prognosis, as well the clinician’s medical judgment that attempted resuscitation would not help the patient meet those goals (whether it is to have a dignified death, or to recover fully and return to independent living, or something in between).

Typically, if a patient does not understand or accept the information you share about their likely future course, it is more important to continue working with a grieving patient/family to help them understand or accept their prognosis, before addressing resuscitation orders. Note that there are patients for whom a clinician may judge that recommending a DNR order is not wise, even if they think CPR lacks a medical indication and would not help the patient achieve their goals (e.g., of recovering), due to patient factors such as lack of trust in their care teams, or previous endorsement of wanting unrestricted, invasive medical interventions no matter what. How to approach code status discussions with those patients is complicated, requires interprofessional collaboration, and is beyond the scope of this Fast Fact.

Making the recommendation  We recommend framing the discussion about code status around the clinician making a recommendation for a DNR order, as opposed to asking the patient what they want. Remember, the clinician should have already discussed with the patient/family prognosis, care goals, wishes, and preferences). It is the medical clinician’s role to define and recommend what a reasonable plan of care is, based on a patient’s prognosis and goals, and this is as true of resuscitation orders as it is for recommending antibiotics or aortic surgery. Finally, for patients approaching the end-of-life, we generally recommend lumping a recommendation about foregoing resuscitation efforts along with intubation and mechanical ventilation. I.e., for most patients nearing the end-of-life, recommending a do not attempt resuscitation and a do not intubate order together is most appropriate. Undoubtedly there are exceptions to this, and clinicians need to use their judgment patient-by-patient.

Review prior documentation and clarify the patient’s understanding. There are many possible terms one can use here, and you should only use terms you are confident a patient has a basic understanding of (e.g., ‘code status,’ ‘resuscitation,’ ‘CPR,’ ‘ventilation,’ ‘DNR,’ etc.) and are in common use in your institution. If it’s alright with you, I would like to talk about your code status. I know we discussed this before – can you tell me what you took away from our last discussion.

Acknowledge this may be a change – remember that you should have already established with the patient an understanding of their limited prognosis. Unfortunately, we are in a different place now compared to when we last discussed your code status.

Ask permission to provide a recommendation. Can I make a recommendation about how we should approach your care [if/when] your condition worsens further?

Lead with what you recommend doing before discussing what you would recommend not doing. It is not necessary to describe graphically the physical act of resuscitation. Fundamentally, the reason to not attempt resuscitation is not its invasiveness, but its inadequacy in restoring a patient to good health. If your health worsens, and it looks like you are dying, I think we should do everything we can to make sure you are in a safe environment and to make sure you don’t feel significant pain or breathlessness or anxiousness as you die. I don't think however we should attempt resuscitation or use
the life-support machine when you are dying—those treatments wouldn’t help you recover and would prevent you from having a peaceful death. What are your thoughts about that?

- **Expect emotion, respond with empathy, and continue the discussion based on how the patient responds.** A patient may disagree with your recommendation. It is important to avoid becoming entrenched, and instead try to refocus on the patient's underlying values, goals, and emotions to better understand what underlies their objection.

- A few patients will request **detailed descriptions** of what to expect with CPR efforts, intubation, or the dying process without those interventions. Be prepared to discuss how you keep a dying patient comfortable and free from pain, dyspnea, or anxiety. It is ok to provide detailed descriptions of CPR along with quantitative estimates of survival if that is what is requested. However, it is important to focus the discussion on *outcomes in the context of a patient’s goals* more than technical details. E.g., *While I do think that CPR would be very, very hard on your body, the main reason I’m recommending against it is because I know that what you want most here is that we get you back home, living independently, and us attempting CPR just wouldn’t help get you to that. If you get that sick despite all that we’re doing here, I think it best we focus your care on keeping you comfortable in whatever time you’ve got left.*

- Make sure to inform your patient about **how your institution designates changes to resuscitation orders.** I will update others on your care team, and write what we call here a ‘do not attempt resuscitation’ order. Your nurse will make a change to your armband today too.

**References**


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