CASE REPORT

The value of history and goals of care with code status; even in an emergency setting

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SUMMARY

This is a case report involving an elderly Jehovah's Witness woman with a history of chronic anaemia who suffers cardiac arrest and is resuscitated. This case illustrates, even in an emergency setting, (1) the value of obtaining relevant history, (2) addressing code status within the framework of achievable goals of care and (3) the need to revise both history and goals of care, as more information becomes available. We also propose aspects of this discussion that would benefit from future research.

BACKGROUND

In everyday medical practice, a detailed and complete history and physical examination is performed at the time of admission to hospital. Over the past two decades, a unique part of this history which has been the topic of increasing scrutiny, involves discussion about the patient's preferences in the event of a cardiopulmonary arrest; often referred to as the patient's 'code status'.

Every patient's preferences regarding attempts at resuscitation are addressed at the time of admission, in part, as a response to the Patient Self Determination Act (PSDA), as suggested by the recent study.¹

However, the patient's history, if often limited upon admission, particularly during a medical emergency, and therefore patients' preferences regarding code status often remain unclear. These gaps have potentially serious implications as illustrated in our case of an unconscious, elderly Jehovah's Witness patient with no advance health-care directive.

CASE PRESENTATION

A 75-year-old woman was intubated at an outside hospital following resuscitation from cardiac arrest and transferred to our hospital for further management. Upon arrival at our facility, emergent consent for care was obtained from the patient's daughter, the next of kin surrogate, as the patient was a widow, without an advance healthcare directive or healthcare power of attorney. The patient underwent cardiac catheterisation and was subsequently admitted to the intensive care unit (ICU). As part of standard care for patients who remain in a coma postcardiac arrest, the patient was treated with therapeutic hypothermia which has emerged as the standard of care.

At baseline, the patient appeared to have anaemia of chronic disease which worsened due to significant phlebotomy associated with the therapeutic

hypothermia protocol. Blood transfusion was ordered to maintain oxygen delivery to the injured brain.

When the family (consisting of two daughters and son-in-laws) was approached about the need for transfusion, they declined, citing their religious views as Jehovah's Witnesses. As the patient was unconscious, despite the clear and unanimous family decision, it remained uncertain whether the patient herself subscribed to such staunch religious views.

TREATMENT

After lengthy discussions regarding the risks and benefits of blood transfusion, the family ultimately declined. The medical team, citing the ethical principle of patient autonomy and substituted judgement, deferred to the family's decision as legal surrogates and blood transfusion was not given. Further phlebotomy was minimised and the patient was administered iron and erythropoietin.

OUTCOME AND FOLLOW-UP

The family seemed fully aware of the limitations placed by their request of refusing a transfusion of blood products and remained engaged with the medical team regarding the patient's care. The medical team was able to adjust the plan of care based on the family's concerns and the trust appeared to be maintained.

After a week, haemoglobin began to rise and the patient was ultimately extubated. The patient continued to manifest signs and symptoms of anoxic brain injury particularly in short-term memory loss. The patient was ultimately discharged to an extended care facility. The family continued to appear satisfied with the care of the patient and the outcome. It remained unclear whether blood transfusion would have altered the outcome for the patient.

DISCUSSION

We believe this is the first case report that discusses this common medical conundrum faced by physicians, as they attempt to incorporate patient's/family's beliefs with emerging medical science. Besides Jehovah's Witnesses, other patients may also refuse transfusions based on other religious grounds² or personal conviction.³

Had our patient's/family's preferences been identified earlier, it might have been reasonable not to offer therapeutic hypothermia, given the significant phlebotomy required to monitor serial blood parameters. Earlier attempts at blood conservation and marrow stimulants may also have been implemented.

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However, it remains unclear whether blood transfusion would have altered the patient's outcome; especially in light of the more general concerns about blood transfusions in the critically ill.

The uncertainty of the surrogate decision-maker's ability to accurately represent the wishes of their loved ones is also particularly relevant to this case, given the absence of documentation of the patient's own religious views.

A complete history should give the physician insight into the patient's broader value system. The psychosocial history should include the patient's lifestyle, education, occupation and religious beliefs (especially in relation to the perceptions of health and treatment). It should also include financial status, insurance coverage and habits such as use of cigarettes or alcohol.

Identification of an advanced directive and/or healthcare Power of Attorney should be obtained. In order to protect the rights of its citizens, the US Congress passed the PSDA, which requires all hospitals, nursing homes and healthcare agencies to inform patients about their right to accept or refuse medical treatment, and to execute an advance directives.^{4 5} At present, the concept of advanced directive is not universally shared; furthermore, some form of advance directives is legally recognised in some countries but the public awareness of advance directive is mostly missing.^{6 7} Hospitals vary greatly in their approach to code status orders. In everyday clinical practice, code status is often addressed as binary: 'full code'/everything versus 'do not resuscitate/do not intubate'/nothing. Given the complexity of modern medical care, the terms 'everything' and 'nothing' have limited meaning. A recent study showed that patients in the Medical ICU and their surrogates have inadequate knowledge about inhospital cardiopulmonary resuscitation. Assessments may differ between patients/surrogates and physicians regarding what goals of care are most important.⁸

Kaldjian and Broderick⁹ identified that scant literature exists on goals of care. The problem is exacerbated by lack of a standardised list. Some hospitals utilise a checklist that includes dialysis, vasopressors, blood transfusion etc. It is clear that no checklist will apply to all situations. For this reason, it is essential for the medical team to translate the possible intervention in the context of the patient's/family's beliefs and goals of care.

This case highlights that training programmes need to continue to emphasise obtaining a complete history, including the patient's/family's religious values, before discussing the achievable goals of care, even in emergency situations. Furthermore, future research

needs to be conducted to standardise our approach to these discussions including the risks and benefits of attempting resuscitation.

Learning points

- ▶ Relevant medical history and goals of care should be addressed on admission for all patients, including those in emergency situations.
- ▶ It is important to routinely revise the goals of care according to each patient's/healthcare power of attorney's wishes and patient's changing illness.
- ▶ Physicians should not approach code status as a binary outcome (ie, 'everything' versus 'nothing').
- ▶ Further studies need to be done to provide standard guidelines for the code status orders.

Contributors All authors meet criteria for authorship, had full access to the data, participated in the preparation of the manuscript and accept responsibility for the content of the manuscript and have read and approved the final manuscript.

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