

sponsible, as the chaplain noted, for the ethical, moral, and financial debris of a partial code? The state who authorized the use of the advance directive allowing a partial code? The hospital who permitted the partial code? The physicians? The patient? The family? All of the above? It's an issue that merits further discussion, especially with an aging population in which resuscitative success declines,⁵ an ever-increasing use of life-prolonging medical technology that complicates the acceptance of death, and now, Medicare reimbursement for advance care discussions.

So in the end, when a patient survives a partial code, it can often portend a messy and emotional future for the family as well as the physician, not to mention the financial repercussions for the hospital and

family. As with Colorado's advance directive, the Medical Orders for Scope of Treatment (MOST) (<http://coloradoadvancedirectives.com/wp-content/uploads/2014/07/1-MOST-Form-FINAL-2015.pdf>) which offers the choice of full code or no code with no menu of other options—perhaps codes should be an all or nothing event, not “everything but intubation,” or “everything but cardioversion,” or “everything but intravenous medications,” or “everything but chest compressions.” Certainly, some will argue such a policy is paternalistic and devoid of patient autonomy, but if the idea is to save a life and restore the person to the living, why would we not perform a full code, even if brief and time-limited, rather than a resuscitative façade, such as chest compressions without intubation?

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Invited Commentary

LESS IS MORE

Partial Codes—A Symptom of a Larger Problem

Josué A. Zapata, MD; Eric Widera, MD

In this issue of *JAMA Internal Medicine*, Rousseau¹ describes the case of an elderly man with metastatic cancer who underwent a so-called partial code in which clinicians could do “everything but intubation” during an attempt at cardiopulmonary resuscitation. He further describes the efficacy of these partial codes and suggests that code status should never



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involve a litany of options such as “everything but intubation” or “everything but defibrillation.” Instead, he argues that code status decisions should be a simple dichotomy between all efforts at resuscitation or none at all. While a policy change that does not allow for partial codes seems reasonable, it does not address the greater issue of failure in communication between physicians and patients that frequently sets the stage for these adverse outcomes. Partial codes, by their very nature, represent a lack of shared decision-making that is too frequently seen in discussions with patients with severe illness.

An evaluation of whether partial codes are ever appropriate should start off with a review of the efficacy of cardiopulmonary resuscitation both with and without specific limitations. While studies looking at outcomes following resuscitation in patients with a partial code status are few and limited, multiple large-scale studies have found the survival rate to discharge with full resuscitation efforts to be quite low (17%).² In addition, meta-analyses specifically evaluating patients with metastatic cancer who sustain cardiac arrest and receive full efforts at resuscitation have demonstrated that

there is a much lower likelihood of survival to discharge (0%-5%) than patients without cancer.³ When one looks specifically at patients who had some resuscitative measures performed while withholding others, the evidence presents an even grimmer picture of a near-certainty of death within days (0% survival to discharge).⁴

Given the very minimal chance of therapeutic benefit and almost certain harm in performing partial codes, it seems reasonable that they should not be offered outside of the most exceptional cases. Nor should physicians feel compelled to comply with requests for interventions that will not lead to improvement in the patient's prognosis, comfort, or general state of health, particularly those done as an “ineffective symbolic gesture.”⁵ This includes requests for the deceptive and dishonest practice of “slow codes,” in which no true attempt is made to resuscitate a patient under the guise of helping a family or surrogate cope with their grief.

However, an appraisal of whether or not partial codes are appropriate based on efficacy alone does nothing to address the lack of shared decision making that often underlies their existence. In our experience, when a clinician encounters a patient who makes a health care decision that does not seem like a choice that a reasonable and rational individual would make, the next step is always to seek to understand why. Why would this reasonable and rational individual not want to be intubated but still want chest compressions? What do they understand about the extent of their cancer, their life expectancy, and their chances of surviving a cardiac arrest? Most important, what outcomes and goals

do they hope to achieve through this choice? A partial code likely represents a partial understanding by a patient or a partial assessment of their priorities by their provider.

When we equate autonomy with the ability to voice a preference without delving deeper into the motivations and expectations associated with the choice, we neglect our responsibility to the patient. True autonomy is not presenting a patient with a list of items that they can select and check off.⁶ The act of even providing a list of choices may in itself be misleading in that a patient may falsely believe that if a given intervention is offered as an option by a presumably expert and well-intentioned physician, there must be at least some sort of benefit.⁷ Respecting the autonomy of patients can only exist in the context of an informed patient acting in a way that attempts to achieve their goals.

We urge physicians to view any request for a course of treatment that, at first glance, seems to defy reason as an opportunity to come to a full stop and seek to understand the pa-

tient's underlying goals and how they believe such a decision will help them achieve those aims. Trying to preserve the core principle of patient autonomy by simply asking a patient or surrogate whether they want shocks, intubation, or vasopressors (1? 2?) would be akin to bringing a physician to a restaurant and asking them about their preferred proportion of ingredients in their desired entree. Most patrons are not highly trained in culinary arts and rely on the chef to provide a meal that fulfills a few basic guidelines, such as preferred meat or vegetable, or the amount of spice. Similarly, most patients do not know the nuances of various interventions, nor should we expect them to. What matters to them is the outcome. Before jumping to treatments, we as clinicians should strive for true shared decision-making by first inquiring about our patients' hopes and priorities and then leveraging our expertise to guide patients about which procedures and interventions, including resuscitation and requisite components of resuscitation, would help them achieve their goals.⁸

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