Code Status & Advance Directives

A code status is a treatment decision, not a personality question · know which document actually binds you at 3 a.m.

DNR is not *do not treat*

THE DOCUMENTS *they are not interchangeable, and only some are orders*

Document	What it is	How it behaves in practice
Advance directive *living will*	**A statement of wishes**, written by the patient for a future situation	**Not a medical order.** It guides interpretation but usually cannot be acted on directly, and it is often written in general terms ("no heroic measures") that need translating into decisions. **Applies only when the patient lacks capacity**
Healthcare proxy *durable power of attorney*	**Names the decision-maker**	Frequently the most useful document, because it tells you **who** to talk to. **Naming a proxy does not itself say what the patient wanted**
POLST or MOLST	**An actionable medical order**, signed by a clinician	**This one is a physician order and travels with the patient**, including into the community where EMS can act on it. Covers resuscitation plus intubation, hospitalization and artificial nutrition. **Intended for patients who are seriously ill or frail, not for everyone**
Inpatient code status order	The order in your chart	**Only valid for this admission**, and it is what the code team will act on. **Re-confirm it on every admission and after any major change**, rather than copying it forward

When the patient has capacity, the patient decides, and their current wishes override any earlier document. When they do not, the standard is **substituted judgment**, meaning what *this patient* would have chosen, not what the surrogate would choose or what the family can bear. If the patient's wishes were never expressed, the fallback is the **best interests** standard. **Saying this out loud to a family relieves them**: their job is to report, not to decide.

WHAT A CODE STATUS ACTUALLY COVERS *separate the decisions, because patients do*

Decision	Detail
DNR *do not attempt resuscitation*	Applies **only to cardiac arrest**: no chest compressions, no defibrillation, no code drugs. **It says nothing about anything else**
DNI *do not intubate*	A **separate** decision. A patient can reasonably be **DNR but willing to be intubated** for a reversible problem, or **DNI but for attempted resuscitation**, though the latter combination should prompt a careful conversation about what resuscitation without an airway would look like
⚠ DNR does NOT mean do not treat	**The most consequential misunderstanding in this topic.** A DNR patient still receives antibiotics, oxygen, fluids, transfusion, dialysis, ICU care and surgery if those fit their goals. **Documented "less aggressive care" in DNR patients is a recognized quality problem**, so write explicitly what IS being done, not only what is not
Avoid "partial codes"	Compressions without intubation, or drugs without compressions, are **physiologically incoherent** and usually reflect an unfinished conversation rather than a considered plan. If you find one, revisit it
DNR in the operating room	**A DNR is not automatically suspended for surgery.** It must be **explicitly reconsidered and documented** with the patient, surgeon and anesthesiologist, since many "resuscitative" acts are routine parts of anesthesia. The options are suspend, keep, or a goal-directed agreement

HOW TO HAVE THE CONVERSATION *and the phrasing that predictably goes wrong*

Do not say	Say instead, and why
"Do you want us to do everything?"	**Nobody declines "everything".** It implies the alternative is nothing, and it hands a technical decision to a frightened family. Ask about **goals**, then recommend
"If your heart stops, do you want us to restart it?"	It implies restarting is a reliable option. **Give realistic outcome information first**: survival to discharge after in-hospital arrest is modest overall and much worse with advanced illness or multiorgan failure, and survivors may have new impairment
"There is nothing more we can do."	Untrue and abandoning. **There is always symptom control, presence and planning.** Say what you *will* do
Presenting a menu	**Make a recommendation** based on their stated values, the way you would for any other treatment. "Based on what you have told me, I would recommend we do not attempt resuscitation, and continue everything else." **Then check agreement**
Leaving it undocumented	Record **who was present, what was said, what was decided and why**, plus the reasoning. The next team inherits your note, and a bare order with no rationale gets reversed by whoever is on at night

SITUATIONS THAT CATCH PEOPLE OUT *each one has a wrong default*

Situation	What to do
Patient arrives from home or a facility with a POLST	**Honor it, and confirm it.** It is a valid medical order, but check it is current and still matches the patient's wishes now that the situation has changed. **Do not simply default to full code because the document is unfamiliar**, and equally do not apply an old form without asking
Hospice patient presenting to the emergency department	Being on hospice does **not** mean no treatment. They may reasonably want a fracture fixed, an obstruction relieved or an infection treated. **Ask what they came for**, and call the hospice team, who usually know the patient's wishes better than any document
Implanted defibrillator	**Deactivating the shock function is a separate conversation and a separate order.** A DNR does not deactivate an ICD, and a dying patient can be shocked repeatedly. Raise it explicitly whenever comfort becomes the goal, and note pacing function may be left on
Family requests "do everything" against your judgment	**Explore before negotiating.** Usually it means "we are not ready" or "we do not trust that you have tried". Address prognosis understanding and emotion first. **A time-limited trial with defined endpoints** is often the productive compromise, agreed in advance

PEARLS & PITFALLS

- **Confirm capacity before accepting or acting on any decision**, and remember it is **decision-specific and can fluctuate**. A patient may lack capacity to weigh chemotherapy yet retain it for this decision. Delirium is the commonest reversible cause, so treat it before concluding capacity is lost.
- **The surrogate hierarchy is set by state law and varies**, so do not assume the person at the bedside is the legal decision-maker. Ask directly whether anyone was formally appointed.
- **Revisit code status when the clinical situation changes**, not only at admission. A status set in clinic months ago, or before an ICU deterioration, may no longer reflect what the patient would choose.

References: National POLST program guidance · professional society statements on do-not-resuscitate orders in the perioperative period · published literature on in-hospital cardiac arrest outcomes and on care intensity in patients with DNR orders. **Surrogate decision-making law varies by state.**