

The Resuscitation of “Slow Codes”: Fraud, Lies, and Deception

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“Oh what a tangled web we weave, when first we practice to deceive.” (Sir Walter Scott)

“Sex, Lies, and Videotape” is a wonderfully catchy title for a groundbreaking film. “Fraud, Lies, and Deception” is not a felicitous title for an article on ethical aspects of cardiopulmonary resuscitation (CPR). Yet it is precisely that route Lantos and Meadow (2011) propose in their essay “Should the ‘Slow Code’ Be Resuscitated?” Though they adamantly insist that their proposed approach is not deceptive, their “tailored” resuscitation effort of “3 minutes, or even 30 seconds” is designed precisely to deceive families who want “everything possible” done to save their loved one. Furthermore, the shift in nomenclature from the derogatory “slow code” to the more artfully phrased and pleasant-sounding “tailored code” fooled no one. Changing the term does not change the ontological reality. As Gertrude Stein (1922) put it in her metaphysical musings, “A rose is a rose is a rose.” Nor does the new nomenclature alter the characteristics of the entity. “What is in a name?” Shakespeare asks. Call it what you will, “A rose by any other name would smell as sweet” (Shakespeare 2000, Act II, Scene ii, 12).

When the revision of the “slow code” was first proposed last year in *Pediatrics*, two well-known bioethicists, Joel Frader of Northwestern Medical School and Eric Kordish of the Cleveland Clinic, were quick to comment that though such a tactic might be tempting, “it is not right” (Frader, Kordish, and Lantos 2010). Frader described the authors’ maneuver as “deception,” “lying,” and “a serious violation of the prima facie duty to tell the truth.” Kordish characterized the proposal as “untenable,” one that would “lead to an erosion of trust and cascade of problematic consequences.” As he put it, “If you are going to do something, do it right. Charades are not acceptable when it comes to life-and-death matters.”

The issue raised by Lantos and Meadow of family demands for treatments judged inappropriate by physicians is not new. The uniquely American phenomenon of complying with a family request no matter how far it deviates from the standard of care—or even from the best interests of the

patient—is chronicled in Edmund Pellegrino’s (1993) historical survey of bioethics. The shift from physician paternalism to patient involvement in decision making to the now near-absolute claims of the patient’s or proxy’s choices is the result of a combination of forces that have occurred over the past three decades. Among the factors leading to this outcome are the development of sophisticated life-prolonging technologies, the rise of third-party coverage, and the elevation of individual over communal values.

The shift of focus to autonomy, with its concomitant requirement of informed consent, soon translated into the belief that respect for autonomy not only mandates patient or family involvement in decision making, but also requires the physician to do whatever the patient or family desires. Such a reaction has led to the situation Lantos and Meadow describe where physicians believe that they have only three options with regard to the irretrievably dying patient:

1. Persuade the family to accept a DRN order.
2. Accede to the family’s wishes for CPR.
3. Refuse to perform CPR and seek legal remedies to override family choices.

They find the second option repugnant and the third confrontational, burdensome, and generally ineffective. At the same time, they recognize the reality that many families are psychologically unable to “give up” on a dying patient. Lantos, in fact, has co-authored a very sensitive essay on Dostoevsky’s insight into the reality of that phenomenon (Montello and Landos 2002). In it he sets the tone for part of his new approach on DRN orders. Since many families cannot bring themselves to signing a “death warrant,” do not confront them with that option. So far, so good. But then Lantos and Meadow propose deceiving the family into thinking that a full “resuscitation” will be performed, when, in fact, rather than the standard CPR something substantially less will be performed. And “performed” is the operative word. Their “slow code” does not conform to the American Heart Association standards on CPR. Rather, it is an artfully staged “performance” of something

substantially less than a full effort at resuscitation. As such, it opens the physician to potential liability for negligence as well as the tort of "loss of chance" for a longer life.

What can the physician do in the face of parental or family opposition "to giving up"? How do physicians respond to the family members who, in Dylan Thomas's phrasing, do not want a loved one to "go gently into that good night"? The authors' approach is an echo of the classic perfume ad: "Promise her anything but give her Arpege." Telling the family you are going to do resuscitation, and calling it off after three seconds, is a textbook illustration of fraud. Webster's dictionary shows how apt the use of the word "fraud" is for the Lantos/Meadow proposal. It defines the term as "The intentional perversion of truth in order to induce another to part with something of value" (Merriam-Webster 2011). One cannot with candor or professional integrity tell the family members who want "everything possible done," "If his heart stops we will continue to do everything we can that we think will help"—and then perform only three seconds of cardiac massage. As Kordish tellingly notes, "Three chest compressions do not a resuscitation make." Partial orders, which Goldenring caricatures as "Light Blue, Sky Blue, Navy Blue and Dark Blue Codes," not only place unwanted burdens on the hospital staff, waste their time and energy, and lead to frustration; they are also, in his explicit phrasing, "an ethical fraud" (Goldenring 1979).

If a code is called, it should be undertaken like any other medical intervention: as a well-considered affirmative act to benefit the patient. As such, when a code is initiated the staff members can respond knowing they will not be deliberately imposing a final useless indignity at the end of life. Nor will they be engaging in a charade intended to deceive the family, such as one we have witnessed in which a physician during teaching rounds told the assembled residents and medical students, "In a slow code simply shoot the epinephrine into the mattress."

The nadir of "slow codes" were the infamous "purple dots" in which adhesive stick-ons were attached to the nurses' "Kardex" at New York's La Guardia Hospital, the "red circles" drawn around patients' names at New York Presbyterian Hospital, and "blackboards of doom" in which patients' code status was written in chalk on a blackboard at Memorial Sloan-Kettering Hospital (Paris 1985). The outrage over those incidents led to the New York Hospital Association's plea to Governor Mario Cuomo, "We want some guidelines and we will take them in whatever form we can get them." The result of that request was a recommendation by the New York State Task Force on Life and the Law, which was subsequently enacted into law and required specific consent of a patient or the explicit written authorization of the next of kin before a DNR order may be written (New York Public

Health Law Section 2965,(1)(a), Article 29-B). It took the New York legislature more than 20 years to correct that enormously abusive response to "slow code" orders (Miller 2010).

Rather than passively yielding to demands for inappropriate CPR for a dying patient on whom the procedure would be unavailing, or seeking to override family objections to a DNR with the blunt cudgel of a court order, the physician might with compassion and sensitivity address the real issue: The patient is dying and is now beyond anything that medical interventions can do to reverse that process.

In wisdom as ancient as that of Hippocrates, inform the family that despite the use of all the techniques known to medicine, the patient has been overmastered by his or her disease and is now slipping from our grasp. The most we can do now is to keep the patient comfortable and support the family members as they accompany the patient on the last stages of life's journey. Comfort and company are the most that medicine can offer the patient. Honesty, truth, and compassion are the best that can be provided to the family. The caring physician owes the patient and the family nothing less. ■

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