Case Study – A Multidisciplinary Healthcare Team Disagrees with Keeping the Patient Full Code

By Ryan Pferdehirt, DBe and Tarris (Terry) Rosell, PhD, DMin, HEC-C

January 2024

Bioethics case study on healthcare team disagrees.

George is an 84-year-old male admitted to the medical ICU for respiratory failure and multiple life-threatening comorbidities after having had a severe case of COVID. The patient is currently supported by life-sustaining interventions including dialysis and ventilation. As an ICU patient, his situation is complicated, requiring the attention of all members of a multidisciplinary healthcare team who are not all of one mind as to whether George might yet recover sufficiently to return to a long-term care facility.

Despite intensive care, after several weeks of treatment and aggressive measures, George's health continues to decline. Most members of the ICU team, and the palliative care consultant, believe that prognosis is poor and death is imminent. Their patient is still Full Code, however, and his wife and daughter are adamant that providers "continue to do everything that will work." George himself has lacked decisional capacity from the time of admission and had not completed any advance directives. His daughter says, "Dad's a Vietnam veteran. He's always been a fighter!"

During a long "goals of care" meeting that Palliative Care conducts with George's family, they state that if ventilator support is not working for George, at that point they would be okay with extubation and allowing him to pass away naturally. But until then, even if his heart were to stop, they want to "give Dad a chance to win this battle" and attempt resuscitation—"paddles, shocks, compressions, and whatever it takes to give him a fighting chance!" For now, the code status remains "Full Code." But there is moral distress amongst team

members who feel that CPR on this frail, dying 84-year-old would be “torture”. During a team “huddle” later that afternoon, most everyone expresses disagreement with keeping the patient Full Code. The palliative care physician says, “We need to help this family do the right thing and agree to transition this poor man to comfort measures only, CMO. Continued ventilation, dialysis, the whole nine yards—and CPR especially—is all futile. What we’re doing is nonbeneficial and harmful to this guy.”

Heads nod around the conference table. Pulmonologist Dr. Jacobi, however, says she understands the prognosis is poor. “But I cannot in good faith say to this family that the vent is ‘not working’ or ‘nonbeneficial’, at least in the sense that it surely is keeping George alive longer. And that seems to matter to his family.”

The rest of the team continues to express their distress that George is dying and “we keep doing things to him.” Someone states with emotion that Dr. Jacobi’s approach is going to make the patient unnecessarily suffer. Dr. Jacobi responds that she doesn’t appreciate being pressured to go against her best medical judgement and conscience.

Meanwhile, a text message from George’s daughter to the palliative care physician is received and read aloud: “Mom and I are getting confused because we keep hearing different messages from doctors here. We want to do what’s right for Dad, but it’s just so hard to know what’s really going on.”

The ICU attending decides to place a request for ethics consultation.

