

# Levels of Intervention: Communicating with More Precision About Planned Use of Critical Interventions

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Terms such as “resuscitation,” “CPR,” “DNR,” “full code,” and “no code” mean different things to different people, which challenges communications within and between the general population, healthcare professionals, healthcare institutions and legal jurisdictions. In promoting steps to change clinical practice and the expectations of healthcare users, Kyle Brothers and colleagues (2010) recommend that “DNAR” (or “Do Not Attempt Resuscitation”) be used by healthcare professionals in their discussions with patients, families, and the general population. They hope that doing so will help to undermine false confidence in the public about the potential success of resuscitation procedures. Their recommendation retains a problematic ambiguity that turns on the concept of “resuscitation” itself. I suggest instead that all such terms be made obsolete and the next steps in promoting cultural change include more precise development and communication of the care goals and plan regarding responses to cardio-pulmonary arrest and acute life-threatening events.

My aim here is to urge a shift in how healthcare professionals talk to patients, the general public and each other, and to share one hospital’s experience in striving for more precise communication through practice assessment and policy change.

A significant source of ambiguity and miscommunication surrounds the term “resuscitation.” “Resuscitation” is variously interpreted to imply use of some combination of chest compressions, assisted ventilation, fluids, blood, drugs, shock, dialysis, surgery, and other options available in the vast armamentarium of contemporary healthcare. Some expect that a care plan for “resuscitation” applies only if cardio-pulmonary arrest has occurred; others expect that “resuscitation” includes steps to prevent and reverse acute life-threatening events as well. The same procedures may be interpreted as “resuscitation” in some situations but not others. The same procedures may align with the goals of care in some situations but go against those goals in others. Especially in high-stakes communications about how healthcare professionals will respond to cardio-pulmonary arrest or acute life-threatening events, the use of ambiguous short-hand expressions for complex intervention strategies is highly problematic and should be avoided. Likewise, other factors (e.g., problems in the therapeutic relationship or healthcare team relationships,

ineffective charting, and system issues) that contribute to miscommunication, non-communication or confusion about the care plan in such circumstances, should be addressed.

## ONE HOSPITAL’S EXPERIENCE

When reviewing our hospital’s policy on resuscitation, members of the Clinical Ethics Committee sought input from numerous sources including bedside nurses, attending physicians, nurse-family liaisons (and others who liaise with patients and families on these issues), the Code Blue Committee, leadership, colleagues at other healthcare institutions, the scholarly literature, and legal sources. We wanted to know current practices, their effectiveness, challenges, changes that were needed or desired, and suggestions for how practice could better align with practice ideals.

We found much symmetry in the guiding values and clinical goals of our healthcare professionals regarding respectful, patient-centered, team-approaches to healthcare for advance planning and use of potentially life-sustaining/supporting interventions. Yet, the need to overcome miscommunication brought on by commonly-used ambiguous terms, and specific local practice issues were revealed. No challenge or desire for change was too small for our Committee to assess and attempt to resolve (although not always by policy change).

By being responsive to our local institutional climate, our policy revision process (and the subsequent process to implement the policy, now underway) helps to articulate a shared set of local values and vision for decision-making and to shift local practices to better enable our healthcare professionals to achieve that vision. In discussions with our healthcare professionals and institutional leadership, we share local experiences and case examples that provide rationales for each procedure and point of guidance in the policy.

The most dramatic change from our former policy is how physician orders are communicated in the medical record, and among the healthcare team. New language and a new order sheet were adopted. Previously, following consultation with patients, a physician order assigned a status of “Full Code” or “No Code” to the patient, with the option

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of specifying procedures that would or would not be performed. The current policy (Jewish General Hospital 2007) describes five possible levels of intervention, some of which require that restrictions for specific situations or procedures to be described. A new order sheet was adopted and became the mechanism for ordering and documenting a level of intervention.

Each level of intervention signals to staff the orientation of the goals of care, interventions to be provided (which can be personalized to the situation of each patient), and whether the Code Blue team is to be called to assist in the diagnosis and response to cardio-pulmonary arrest or acute life-threatening events. The Code Blue team is to be called when appropriate for patients designated Level 1, 2A, or 2B, but not for patients designated Level 3 or 4. The order sheet requires additional information linking the order to a timed and dated progress note, a rationale for the order made, and who the order was discussed with.

The levels of intervention that our hospital adopted are:

- Level 1:* Provision of maximal interventions offered by the treating team (including chest compressions and critical care unit transfer.) All patients are assumed to be Level 1, unless medical reasons or patient preference suggest otherwise.
- Level 2A:* Provision of maximal interventions with some restrictions. Chest compressions are to be initiated in the event of cardiopulmonary arrest. Other restrictions must be specified. Restrictions can relate to specific situations or procedures.
- Level 2B:* Provision of maximal interventions with some restrictions, as described in Level 2A. In the event of cardiopulmonary arrest, however, chest compressions are NOT to be initiated.
- Level 3:* Provision of maximal interventions on the ward aimed at treating reversible conditions, maintenance of function and comfort care, but no chest compressions and no transfer to a critical care unit. Any additional restrictions must be identified. Restrictions can relate to specific situations or procedures.
- Level 4:* Provision of interventions adapted to palliation and patient comfort. The primary goal of care is comfort and dignity. This includes relieving lessening symptoms without achieving cure, and can include treating some reversible conditions.

No chest compressions. No transfer to a critical care unit. Instructions regarding treatment of reversible conditions must be specified.

With one exception, the levels of intervention we adopted are consistent with the policy at another local hospital (McGill University Health Centre 2004) where some of our staff also work or trained. Because our Code Blue team can be called to respond to cardio-pulmonary arrest and acute life-threatening events, and some patients' care plans put restrictions on response to the former but not the latter, at our hospital unit staff needs clear direction about whether to initiate chest compressions prior to the arrival of the Code Blue team. Thus to provide that clarity but remain consistent across the two institutions in the numbering of the levels, we divided Level 2 into Level 2A and Level 2B.

## CONCLUSION

The quality and success of a care plan regarding use of potentially life-sustaining interventions depends in part on the quality of developing the plan, communicating the plan, and carrying out the plan. My report of one hospital's experience with assessing and revising hospital policy provides an example of both reviving and changing local conversations about these issues, upon seeing a need to communicate more precisely about planned use of critical interventions. My example forges a greater distinction between how physicians should talk with patients, and how they interpret and transcribe those conversations (and the care plan that arises from them) for communication with others on the healthcare team. By starting from the experience of current practice, and returning to basic goals and values for patient care, this policy review process fostered local conversations that were less about specific interventions available to use than the health situations that arise for patients and how the healthcare team can best respond. ■

## REFERENCES

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