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Review

Physician perspectives on resuscitation status and DNR order in elderly cancer patients

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ABSTRACT

Aim: To evaluate the process of placing DNR order in elderly cancer patients in practice and analysis of physician perspectives on the issue.

Background: Decision not to resuscitate (DNR/DNAR) is part of practice in elderly cancer care. Physicians issue such orders when a patient is suffering from irreversible disease and the patient's life is coming to an end. Modern practice emphasises the need of communication with the patients and their relatives while issuing a DNR. The decision making process of placing DNR can be quite daunting. The moral and ethical dimensions surrounding such a decision make it a contentious topic.

Materials and methods: We searched the literature to find relevant works that would help physicians and especially the junior health care staff in dealing with the complexities. In this article, we discuss the issues that physicians encounter whilst dealing with a DNR order in elderly cancer patients.

Results: There are no objective adjuncts or guidelines directed towards the approach of placing a DNR in elderly cancer patients. Better communication with the patients and relatives when making such decision remains a very important aspect of a DNR decision. Most health care staff find themselves ill equipped to deal with such situation. Active training and briefing of junior staff would help them deal better with the stresses involved in this process.

Conclusion: There are complex psychosocial, medical, ethical and emotive aspects associated with placing a DNR order. Patients and their loved ones and the junior staff involved in the care of patient need early communication and briefing for better acceptance of DNR. Studies that could devise or identify tools or recommendations would be welcome.

1. Background

An article on end of life care says that as we have gotten better at extending life, we have grown more reluctant to talk about death or think critically about whether another intervention is the right answer. For the sake of our patients, our loved ones, and even ourselves, we must do more to promote the conversations on end of life issues.[1] Studies suggest that, within the culture of large hospitals, the focus of care remains on cure and the prolonging of life and the continuation of invasive procedures, and that investigations and treatment are often continued at the expense of the patient's comfort.[2] Do-not-resuscitate decisions are a unique phenomenon, emerging

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within hospitals in the last quarter of the twentieth century.[3,4]

The process and timing of issuing a DNR is variable and depends on multiple factors. Elderly patients are more likely to die with a DNR order in place.[5] A DNR order is usually proposed by senior physicians. While physicians and patients think that they should make the final DNR decision,[6] in practice many patients might not be involved in such decisions. A survey found that given a choice many elderly patients would actually want to be resuscitated.[7] In many cases, physicians might not have a chance, or not want to discuss[8] such issues with patients. When patients' and physicians' understandings of the best decision, or of the preferred role of either party, diverge, conflict may ensue.[9] With an unclear mandate, the patients, their loved ones and the health care workers are subjected to immense stress while contemplating or placing and dealing with a DNR order.

2. Discussion

2.1. *When is a DNR issued?*

A DNR is issued when a patient is known to suffer from an irreversible disease and their life is coming to an end.[10] They are typically made for patients with chronic illnesses approaching death, including patients with metastatic cancer, for whom survival-to-discharge rates following CPR is highly predictable, that is, low to nonexistent.[11,12] It might also be issued when a CPR is considered not to be in the best interest of patients.

However, such criteria might present an oversimplified picture of that intricate issue. For example, the "time to live" or even the prognosis might be subjective and can vary from physician to physician. Also, there is a dearth of evidence on the topic of "the futility of CPR" in elderly cancer patient.

The time of issuing a DNR, too, might largely depend on physician perception. To bring up the topic of DNR earlier might perhaps be useful as patients might have time to think and discuss the issue. However most physicians in a study reported that they would not discuss the end of life options with terminally ill patients who are feeling well and they would instead wait for symptoms or until there is no treatment available.[8]

2.2. *How is DNR issued?*

In normal circumstances, physicians observe the clinical status of the patient and monitor their progress. A clinical evaluation includes a fair assessment of response to treatment, disease progression and further therapeutic option. An important part of this assessment is making a prognosis and involving symptom control and palliative team if the need be. Normally the palliative team is involved for symptom control or if it is thought that the patient has less than one year to live. If a patient has an irreversible disease and is in a state of imminent deterioration, a DNR order is contemplated. Ideally, the physician broaches the issue with the patient and proposes a DNR. There are different ways of doing it but most medical models of end-of-life decision making by patients assume a rational autonomous adult obtaining and deliberating over information to arrive at some conclusion.[13]

From the physician's point of view a correct prognosis is of utmost importance. It also involves estimating approximately how long the patient is expected to live. In spite of a sea of experience, making a correct estimate of "time to live" can be a challenge. The clinical status of the patient changes depending on new and background problems and response to treatment. The General Medicine Council in the United Kingdom recently published guidelines stating that terminally ill patients should have their preferences, for cardiopulmonary resuscitation (CPR) routinely ascertained.[14] It is not unusual to have differences in this estimation for the same patient by different teams. It is said that, as compared to the palliative team, physicians are more optimistic when prognosticating patients.[5] There have been attempts to devise tools to assist in prognostication. Palliative research has suggested various tools for the purpose of prognosis. PaP score[15] and PiPS predictor model[16] are two such tools that can be utilised. The BCI index is a similar tool that is based on laboratory investigations.[17] However, such tools remain in the realms of specialist palliative teams. A wider acceptance with possible simplification by all the members involved in patient care seems to be a promising approach.

2.3. *Who decides on DNR? And the need of communication in decision to place DNR*

It is advocated that the patient and their family should be involved in the decision process. Discussing the CPR policy and preparing the patient and their representatives and communicating more extensively during interviews are recommended.[18] They should be explained what a DNR means. A study noted that physicians and patient disagree on the indication of CPR in one third of cases and hence they assumed that many patients are resuscitated against their wish.[6] Physicians should be educated in the communication skills necessary to undertake these discussions as they have been shown to lead to an increase in the use of patient preferences.[19]

In many cases the patient might not be able to understand or comprehend such issues because of their mental status, confusion or poor GCS as a result of their disease and clinical worsening. Patients' actual or preferred involvement in decision making can vary according to factors such as patient age, the disease in question and the nature of the decision itself.[9] A study suggested that if patient preferences are truly to be respected, for some, this may require that they are not so engaged.[9]

Different places have different approach towards issuing a DNR. The three main parties involved are patients, patients' loved ones or next of kin and health care providers. There are three identifiable models of decision making: paternalist, consumerist and shared decision making (SDM). Within the Paternalist model, the physician makes healthcare decisions, drawing upon their medical knowledge of the patient; the patient's role is to acquiesce with the physician's decisions.[20,21] The consumerist approach, also termed as the informed decision making or informed choice, has been identified as a dominant model within current medical practice[22] The shared decision making (SDM) model, is often positioned and advocated as the ideal middle ground between the two

extremes of the paternalist and consumerist models.[22,23] SDM has strong advocates and trust has previously been identified as vital within clinical interactions and SDM.[24]

It is difficult to advocate one model over other. It is recommended that clinicians should adopt a flexible approach to decision making, aiming to determine and negotiate with patient preferences, as any one model of decision-making will not capture the current realities of clinical practice.[9]

With regard to timing of broaching the issue of DNR, it has been advised that more complete and earlier discussion on wider range of options of care for patients at the end of life should be undertaken. An earlier involvement of palliative team might be related to better understanding and acceptance of DNR. The study by HM Jung et al. found that patients in a palliative care unit were more likely to permit a DNR.[25] Advance directives have become a part of clinical practice for over two decades[5] and it might be utilised early on for elderly patients in anticipation of foreseeable deterioration. Some patients might be reluctant to discuss issues in advance. The use of two questions, "(a) If you cannot, or choose not to participate in health care decisions, with whom should we speak? and (b) If you cannot or choose not to participate in decision-making, what should we consider when making decision about your care?" may accomplish major goals of an advance directive.[5]

2.3.1. *Co-morbidities*

Elderly patient suffering from malignancy are more likely to have other co-morbidities that might be an impediment in clinical improvement of the patients. These co-morbidities might worsen the quality of life and can contribute to eventual deterioration and death. A consideration of such co-existing medical issues is a must while contemplating a DNR in elderly cancer patients. A logical approach would lead us to conclude that the presence of other significant medical conditions would influence the decision to place DNR order. However, a comprehensive study to quantify such issues and their use in DNR decisions and end of life care would be useful.

2.4. *What DNR is not?*

When death is foreseeable, therapeutic tenacity must be avoided.[10] One of the most niggling aspects of DNR for the patients and their relatives might be the notion that this decision equates to non-treatment. A DNR order does not reflect preference of other forms of life sustaining treatment. Patients wish may differ on the issue of DNR order but it is the duty of health care worker to educate the patient and their next of kin. A better understanding of CPR, including a picture of possible outcomes might be useful. It is quintessential that all parties involved understand that DNR does not mean that other treatment should be discontinued and by no means should the patient be abandoned.[10] This fact should be clearly explained and emphasised by the health care workers to the patients and their loved ones. The routine care should not be hindered by a DNR.

2.4.1. *What happens after DNR?*

The palliative team and the oncologists can work closely at this point to evaluate issues that can be alleviated or symptoms that can be remedied. Most patients in a study saw the preference of DNR as a positive outcome of not interfering with a natural death with the decision being a personal and legal right of a competent autonomous person.[26] Some studies suggest that DNR should be assessed on daily basis.[10] The process is still evolving.

2.4.2. *Issues of the health care providers*

Almost all health care professionals will at some point care for dying patients, and they should have the skills to do it well.[27] Most people at the end of life are cared for by generalists and die in generalist settings.[28,29] Lack of access to education and training was recognised as a key barrier for generalists who were required to provide end of life care.[29]

Currently, a multidisciplinary team review the problems and decisions are made. The most crucial decisions are conveyed to the junior staff and the nurses. These staff work in a close proximity with the patient. Junior doctors might infrequently be subjected to immense stress which might be the consequence of the lack of understanding and training of the issues. Newly qualified doctors perceive that they receive little formal teaching about palliative or end-of-life care in their new role and the culture within the hospital setting does not encourage learning about this subject.[28] Undergraduate medical education is currently failing to prepare junior doctors for their role in caring for dying patients by omitting to provide meaningful contact with these patients during medical school.[28]

The concepts of therapeutic proportionality, treatment futility and therapeutic tenacity can help physicians in their decision making about when CPR is technically and morally mandatory.[18] The decision of DNR highly depends on the assessment of the primary physician. Studies have highlighted the decision makers' "modernist" repertoire of reasoning or "romanticist" repertoire of emotions can influence the decision they make.[13]

A clearly defined objective guideline on basics of end of life issues and DNR is missed. There have been some good attempts like the Smith et al. study. They have recommended a protocol to negotiate the goal of care with patients. It comprises of creating a proper setting, clarifying what the patient and family already know, exploring the hopes and expectations of the patients and suggesting realistic goals, using emphatic responses, making a plan and follow through.[30] There might be other useful advice but the knowledge is scattered. Further research and compilation of evidence for a meaningful approach is mandated.

3. Conclusion

Placing a timely and appropriate DNR order is an important aspect in managing elderly cancer patient. While senior physicians might be experienced and well equipped to handle the complexities of placing a DNR, junior staff do find this a difficult task. Physicians, especially junior members of the team, might be faced with medical, ethical and moral questions while contemplating a DNR on patients. They might also be subjected to psychological stress if there is a lack of training and knowledge or experience of handling such situation. There is a scope of research and training to standardise and streamline the process of placing a DNR. Patients and their

relatives need to be communicated and educated about the DNR and what it entails. An early discussion about end of life issues has been advocated. An objective guideline or adjunctive tool which can weigh the appropriateness of DNR would be welcome.

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Conflict of interest

None declared.

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