

## **Do-not-resuscitate (DNR) orders in palliative cancer patients: medico-legal aspects** by Dr. Sharon Watanabe

A 58 year-old man with advanced cancer was admitted to the Palliative Care Unit for pain control. Prior to admission, the referring consultant discussed the rationale for a DNR status with him. The patient was cognitively intact, and he consented to a DNR status. A family member was present during the discussion. The patient's pain control was stabilised on the Unit, and he was eventually discharged home. Two and a half weeks later, he was re-admitted to the Unit at the request of his family physician with a one-day history of shortness of breath and confusion. Ongoing consent for a DNR status was assumed. The patient was diagnosed with pneumonia and started on intravenous antibiotics. Despite treatment, his cognitive and respiratory status declined over the ensuing hours. At this point, his family requested that the DNR status be rescinded, and that the patient be referred to the intensive care unit. Their stated rationale was that the patient had been very functional (e.g. renovating his kitchen) and enjoying a good quality of life, up until the day of onset of the acute illness. They surmised that if he had been competent, he probably would not have agreed to a DNR status on this occasion. The patient did not have a personal directive. Despite extensive discussions by the attending physician about the lack of benefit of aggressive measures, the family remained insistent. After consultation with the hospital administration and legal counsel, the decision was made by the attending physician and administration of the Unit to accede to the family's wishes. A referral was made to the Intensive Care Unit, which agreed to accept the patient in transfer. However, after further discussion and reflection, the family decided that a transfer of care to a completely new team would not be in the patient's best interest. They agreed to maintain the patient's DNR status, and continue antibiotic treatment and symptomatic measures on the Palliative Care Unit. The patient eventually recovered from the pneumonia. At the time of discharge home, he expressed uncertainty about his wishes regarding DNR status, should a similar event occur in future.

### **Why are patients with advanced cancer advised to accept a DNR status?**

- Studies have shown that although some patients with metastatic cancer may initially respond to cardiopulmonary resuscitation (CPR), the chances of survival to discharge are minimal to nil. The procedure may be physically traumatic, and may lead to the patient spending his or her final hours or days in an intensive care setting.

### **With whom should DNR status be discussed?**

- DNR status should be discussed with the patient, if he or she is competent to do so. Otherwise the discussion should be undertaken with the patient's agent, if one has been appointed, or with the patient's significant others.

### **Who should discuss DNR status, and when?**

- Ideally, the patient's primary physician should have the initial discussion. However, prior to admission to a Palliative Care setting, it is recommended that a Palliative Care consultant review the discussion.

### **What should be discussed?**

- DNR should be addressed in the context of a broader discussion about the patient's understanding of his or her illness and prognosis, and goals of care.

- In order to be able to make an informed decision, the patient should be made aware of the benefits and burdens of CPR.
- It should be clarified that agreement to DNR status does not preclude other supportive measures.

**How should the discussion be documented?**

- It is not necessary for the patient to sign consent to DNR status. Rather, documentation should be made of the names and relationships of those who participated in the discussion, the content of the discussion, and the decision.

**What if the patient refuses a DNR status?**

- The reasons for refusal should be explored. Reasons may include misperceptions about the success of CPR, hopes, fears, guilt, and distrust of the medical system.
- Some hospital and professional policies are supportive of physicians unilaterally assigning a DNR status, whether or not the patient consents. This is based on the argument that there is no obligation to provide a treatment that is medically futile. However, whether or not a treatment is futile depends on one's perspective and values. Some may argue that if CPR has any chance of prolonging life, then it is not futile. In fact, precedents in Canadian law suggest that a unilateral DNR order can only be justified if the patient is in a persistent vegetative state. Therefore, it is recommended that every attempt be made to resolve disagreements regarding DNR status through open and ongoing discussion. If the patient is already admitted to a palliative setting and requests that DNR be rescinded, then transfer of care may need to be considered.

**Can the patient's surrogate decision-maker override a previously expressed desire for DNR status?**

- Yes. However, the surrogate decision-maker must present a convincing case that the patient would have changed his or her mind under the present circumstances.

Recommended reading:

Von Gunten CF. Discussing do-not-resuscitate status. *J Clin Oncol* 2001;19:1576-1581

Kite S, Wilkinson S. Beyond futility: to what extent is the concept of futility useful in clinical decision-making about CPR. *Lancet Oncol* 2002;3:638-42