Health Care Delivery

How Do Doctors Discuss Do-Not-Resuscitate Orders?

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Although patient preferences are important in decisions about "do not resuscitate" (DNR) orders, little is known about how physicians discuss these orders with patients. We asked 15 physicians to simulate discussing such orders with a patient. We found a striking variation in whether physicians explicitly asked for patient preferences, how they described cardiopulmonary resuscitation (CPR) and its possible outcomes and whether they made a recommendation to the patient about DNR orders. There was no pattern to the different amounts of information presented about CPR. Physicians gave conflicting reasons for how they individualized discussions with patients. Awareness of such different behaviors may stimulate physicians to examine what they say to patients about this sensitive and important topic and why they say it.

(Miller A, Lo B: How do doctors discuss do-not-resuscitate orders? [Health Care Delivery]. West J Med 1985 Aug; 143:256-258)

Cardiopulmonary resuscitation (CPR) may not be appropriate when cardiopulmonary arrest is the expected result of a worsening clinical course. In such situations, a "do not resuscitate" (DNR) order may be indicated. Shared decision making by physicians and patients about DNR orders has been recommended in the medical literature[1,2] and by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research.[3]* Little is known, however, about how physicians discuss DNR orders with patients. Physicians may find discussion about DNR orders difficult for several reasons. Some physicians may be reluctant to talk with dying patients or to share the decision-making power.[4] Other clinicians may equate talking about death with giving up or failing. Physicians may be unsure about which issues to discuss and how to discuss them. Also, they worry that discussions of limiting treatment will leave a patient with the discouraging message that "nothing more can be done."

To investigate how physicians explain CPR and DNR orders, we asked a group of physicians to simulate how they would discuss "do not resuscitate" orders with a patient who has metastatic breast cancer. The technique of simulated patient encounters has been used to study how physicians make decisions,[5] and case presentations have been used to study how they resolve ethical dilemmas.[6] We were particularly interested in how physicians describe cardiopulmonary resuscitation and its results, whether or not they make a recommendation to the patient and how they describe supportive care.

Subjects and Methods

We studied 15 general internists in the Department of Medicine at the University of California, San Francisco, School of Medicine. They were selected for their reputation for compassionate care of seriously ill patients. Ten physicians were faculty members and five were residents. One other physician was excluded from the study because he had difficulty answering the questions and felt his experience with DNR orders was limited.

One of us, a second-year medical student (A.M.), presented a standardized hypothetical case of a 65-year-old woman with carcinoma of the breast metastatic to liver, lung and bone that has progressed despite hormonal therapy and chemotherapy. Her pain was controlled with a regimen of oral analgesics, but she had progressive weakness and fatigue. She was alert and in reasonable spirits. In the past she had wanted to discuss options for her care.

The physicians were asked to speak to the interviewer and a tape recorder as if they were explaining CPR and DNR

*EDITOR'S NOTE: See also the Health Care Delivery section of the January 1984 issue of *WJM*: M. R. Levy, MD, M. E. Lambe, MD, and C. L. Shear, DrPH: "Do-Not-Resuscitate Orders in a County Hospital," pp 111-113; R. F. Uhlmann, MD, W. J. McDonald, MD, and T. S. Inui, MD: "Epidemiology of No-Code Orders in an Academic Hospital," pp 114-116, and M. A. Lee, MD, and C. K. Cassel, MD: "The Ethical and Legal Framework for the Decision Not to Resuscitate," pp 117-122.

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This work was supported by a summer research fellowship from the Office of the Dean and by the Maureen Church Coburn Trust.

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ABBREVIATIONS USED IN TEXT
CPR = cardiopulmonary resuscitation
DNR = do-not-resuscitate

orders to the patient. The interviewer did not simulate patient questions or responses. After the simulated discussion, the interviewer asked standard questions about what the physician usually said in discussing DNR orders with patients.

Although there was wide variation in individual responses, there was no systematic difference between residents and faculty. Therefore, we have combined our results for faculty and residents, except as noted. Similarly, because there was no systematic difference between simulated discussions and responses to direct questions, we have combined data from these two sources.

Results

All physicians asked the "patient" to participate in the decision about CPR. In all, 11 (73%) asked explicitly what care she wanted if her heart or lungs were to stop. The remaining physicians posed the issue indirectly by asking the patient for her wishes if she became "very ill" or "something catastrophic" happened. All physicians but one summarized the prior clinical course with the patient to put the discussion of DNR orders in context.

Twelve physicians (80%) described CPR, but their descriptions varied. All 12 described intubation, but only 6 mentioned chest compression and only one electroshock. Some of the physicians explained why they do not describe some aspects of CPR. Two said that most patients know what CPR is because it is portrayed on television. Another feared that describing CPR would frighten the patient.

Three physicians (all faculty) did not describe CPR. When asked if he describes it, one responded, "Are you kidding? Patients have enough things to worry about. They've got death to worry about and not our particular version of technocratic death."

Ten physicians (67%) described the possible outcomes of CPR, but again they varied in what they specifically mentioned. Eight physicians described intensive care, five mentioned death explicitly, four said that there would be no change in the underlying illness after successful CPR, three mentioned possible brain damage and two spoke of a prolonged stay in hospital. One physician mentioned intensive care because the patient might be frightened by being in the intensive care unit, but he did not mention brain damage because the patient would not be aware of it. When asked if she mentioned possible brain damage after CPR, another physician said, "That's a good thought. It's so common afterwards, but I don't think I have [mentioned it]." Physicians disagreed whether or not to mention death explicitly: 11 did not; of these, 5 believed it was clear to the patient from the context of the discussion that a person would die without CPR.

Eleven physicians (73%) tailored the description of CPR to fit the patient and her situation. Explanations of how to individualize discussions varied greatly. Three physicians would give *more* details about CPR if the patient indicated that she wanted CPR, to be sure that the patient understood what is involved. Conversely, two other physicians would give *less* description if the patient wanted CPR. One was reluctant to precipitate an overt disagreement with the patient, and the other did not want to appear to dissuade the patient from her preferences. Two doctors would give more details if they believed CPR would not be effective. Another physician would limit the description with patients who deny the situation or have trouble making the decision.

Seven physicians (47%) recognized that their presentation might be biased. One physician said that she usually has decided what is appropriate before she discusses DNR orders with the patient. If she feels that CPR is not indicated, she "stacks the cards" to favor that decision. Another physician described the process as "explaining to the patient what you want and getting the patient to ask for what you want." They worried that patients might insist on CPR against their judgment as physicians. One described the dilemma and his ambivalence:

> I have two biases. One is that the patient needs to be the one to make the decision as long as she's with the program. But interlaced with that is that if there is no hope, then I don't feel that I'm obliged to treat in a hopeless situation. And I'll usually let the patient override that, if the patient is with it. But I'd rather the patient agreed to a "no code." I try not to make my opinion known, so that the patient's decision is informed. But I think I may bias it by making CPR sound as gruesome as it really is. I don't think CPR is pleasant and wouldn't want my wife or parent to have it.

Seven physicians (47%) gave a recommendation to the patient about CPR. One physician explained that the patient depends on the physician's opinion, "just like you'd depend on a car mechanic. . . . But I make it clear that we'll follow the patient's wishes because it's her death." Another physician made clear recommendations, while giving the patient a choice, "My feeling about it is that, given that we can't do much about your breast cancer, we should just make you comfortable if you stop breathing or your heart stops. . . . We wanted to discuss this issue with you and see what your feelings and thoughts about this are." Another physician emphasized supportive care in giving his recommendation: "I think what we should do right now is concentrate on the things we can treat."

Supportive care was mentioned by all physicians during discussions of CPR. One physician emphasized the importance of making the discussion positive rather than sounding as if "I am withholding CPR from you." Specific types of supportive care mentioned were controlling pain, seeing the patient regularly, arranging for visiting nurses and other home care, letting the patient cry and holding the patient's hand. One physician gave the patient her home phone number and said that the patient would probably need to see her more frequently now. Four physicians said explicitly that further care would not be affected by the patient's decision about CPR.

In the simulated discussions, physicians used medical jargon that might not be understood by patients. Such phrases included "big intravenous lines," "oxygen exchange" and "something acutely happened." Other phrases used were general and possibly ambiguous, such as "heroic," "catastrophic," "sophisticated," "cardiac problems" or "respiratory distress."

Discussion

Mutual decisions by physicians and patients have become the ideal for medical decision making. In such shared decision

making, patients must be informed about and understand the nature of their illness, the proposed treatment, the likely outcomes and the alternatives.[3] We found striking variation in discussions with the patient about CPR. Descriptions of CPR and its outcomes varied greatly: almost all physicians mentioned intubation, whereas only two mentioned a long hospital stay. Given such variability, patients may not receive enough information about CPR to enable them to make an informed decision.

There was no consistent pattern regarding different information presented about CPR. For example, some physicians give more details when a patient favors CPR, whereas other physicians give more details when a patient is against CPR. Such discrepancies suggest that it may be helpful for physicians to analyze what they say about CPR and why they say it.

Physicians in this study realized that they can influence patient choices. Some acknowledged that their presentations made it difficult for the patients not to agree with DNR orders. They justified such influence by their belief that CPR was not medically indicated. However, apparently technical judgments that CPR is "futile" or that a case is "hopeless" may be confounded by a physician's implicit assumptions and values, which may differ from those of the patient.[7] One way to minimize the effect of such assumptions is to conduct rigorous studies of patient outcomes after CPR.[8] These studies may identify clinical situations in which CPR is ineffective and therefore need not be offered to a patient as a therapeutic option.

Other physicians in this study hesitated to make recommendations about CPR. They wanted to be sure the patient had a choice and feared they would impose their wishes on her. However, some patients want the physician to make a recommendation, rather than merely describing alternatives.[9] Moreover, a completely objective presentation is impossible, since assumptions and values cannot be avoided. One approach in making recommendations to patients may be for physicians to be aware of their biases and to state them explicitly, like the physician who said that he believed that relief of symptoms was the most appropriate goal of treatment.

Supportive care was considered an important topic in discussions about DNR decisions. Physicians feared that discussions of limiting care could cause patients to feel abandoned or to believe nothing more could be done. Several physicians emphasized that although the explicit purpose of the discussion was to learn the patient's wishes about CPR, a more important implicit purpose was to communicate caring and concern to the patient.

Our study has several limitations. The number of physicians studied is small, and our results may not hold for physicians in other clinical settings, such as nonteaching hospitals and physicians other than internists. The format of a simulated noninteractive discussion is artificial. It is not known how performance in this situation correlates with performance with actual patients. Some physicians may have spoken more technically to a medical student than they would have to a layperson. However, it is unlikely that physicians merely gave responses that they considered to be socially acceptable, since they made candid responses and unsolicited comments.

Several physicians spontaneously remarked that they had found participating in the study to be helpful. One physician commented that his training had given little attention to talking with terminally ill patients. "I had no idea what I was doing when I started. No one talked to me about all this; I just had to wing it. Now I know what sells, and that's what I do." Another physician said that he had never previously thought about what he said to patients concerning CPR and that the simulated case helped him to examine what he says.

We hope that this initial study will stimulate physicians and medical students to examine what they say to dying patients and to consider how their words affect their patients. Simulated discussions between physicians and dying patients may be a useful educational technique to improve the care of such patients.

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