

Are doctors giving enough guidance to patients about end of life decisions?

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Doctors who treat patients as consumers and give them a menu of choices without guidance or recommendations over whether they should be resuscitated or not may prolong their suffering, according to a new research study.

The "Institutional Culture and Policies' Influence on Do Not Resuscitate Decision-Making at the End of Life" study by Gates Cambridge Scholar

and practising doctor Elizabeth Dzung focuses on hospital [doctors](#) in the US and UK.

It looks at the difference between hospitals which have policies or a culture that prioritises patient autonomy with regard to Do Not Resuscitate [DNR] orders and those where doctors' recommendations on what might be in patients' best interests medically hold more sway.

The move towards patient autonomy came as a reaction to the paternalistic approach often adopted by doctors in the past, but Dzung argues that the pendulum may have swung too far, to the detriment of patients themselves.

Dzung says that UK hospitals currently differ from the more consumer-oriented approach of their US counterparts and doctors' recommendations still hold sway over DNR decisions. However, they are moving more towards the US model as the recent case of Janet Tracey at Addenbrookes hospital in Cambridge shows. Tracey's family successfully sued the hospital over a DNR order that was implemented without the family's permission.

Dzung's interview study of 58 doctors and trainees at three academic medical centres in the US and one in the UK shows a difference between experienced doctors and trainees with regard to DNR orders. Experienced doctors at all hospitals were willing to make [recommendations](#) against resuscitation if they believed it would be futile.

However, trainee doctors at hospitals with emphasised [patient autonomy](#) often felt compelled to offer the choice of resuscitation in a neutral way in all situations regardless of whether they believed it would be clinically appropriate. In contrast, trainees at hospitals where policies and culture prioritised best interest-focused approaches felt more comfortable

recommending against resuscitation in situations where survival was unlikely. They felt confident, for instance, to discourage the ineffective use of CPR and found it ethically suspect to offer CPR in futile situations such as for frail elderly patients with incurable metastatic cancer where doing CPR may result in broken ribs and electric shocks as well as depriving them of a dignified death.

Elizabeth Dzung, who is completing a PhD at the University of Cambridge and is also a practising doctor at the Johns Hopkins School of Medicine in the US, says: "A blind focus on autonomy might inadvertently undermine patient care by depriving patients and surrogates of the professional guidance needed to make critical end-of-life decisions. Often [patients](#) are overwhelmed by, do not want to or are not able to choose from a menu of different options and they may end up choosing treatments that are neither in their best interest nor consistent with their goals and values. Perhaps policies more oriented towards best interest decision-making might allow physicians the space to shift their focus from a discourse of choice to that of care."

Provided by University of Cambridge

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