O MUNDO DA SAÚDE

DOI: 10.15343/0104-7809.202448e16342024I

Do not resuscitate orders by advanced cancer patients in Brazil: a bioethical analysis

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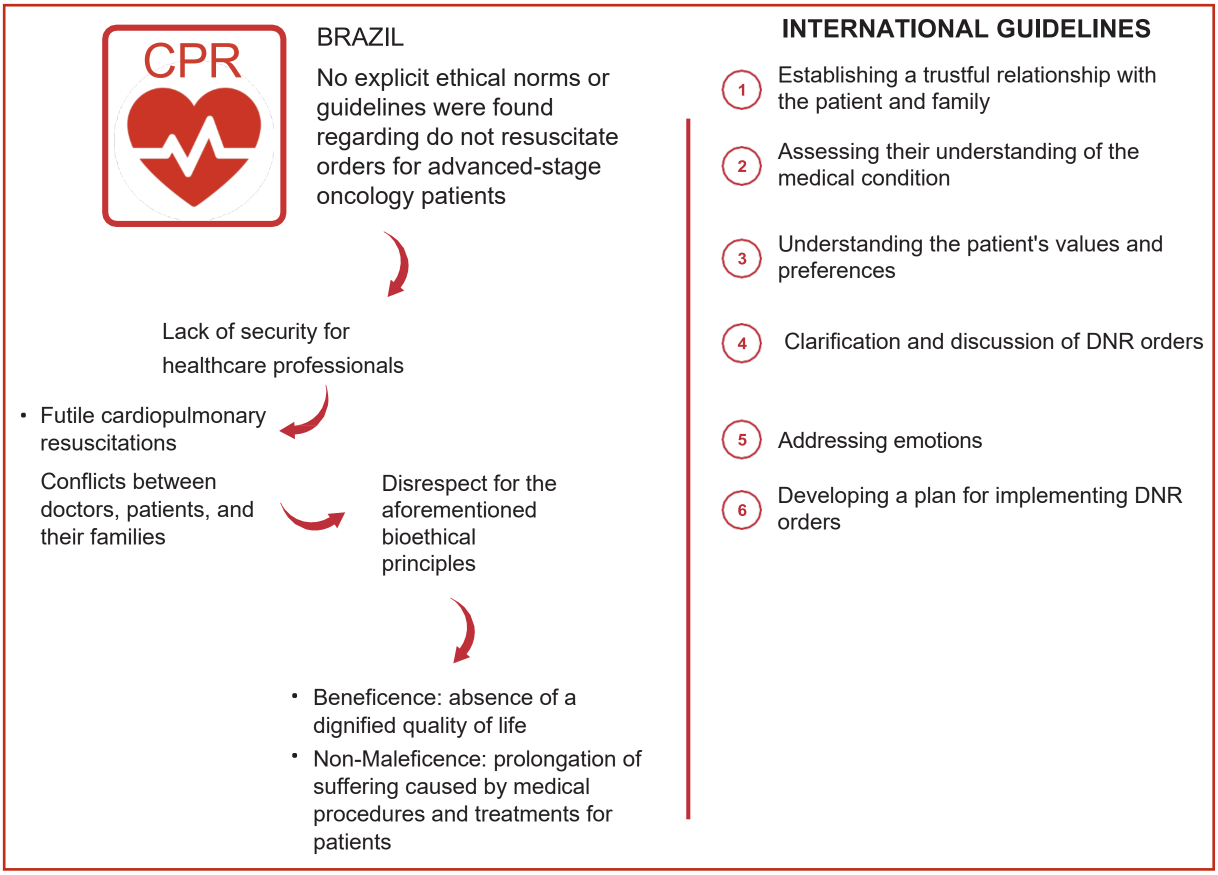
Graphical Abstract



BRAZIL

No explicit ethical norms or guidelines were found regarding do not resuscitate orders for advanced-stage oncology patients

Lack of security for healthcare professionals

- Futile cardiopulmonary resuscitations

Conflicts between doctors, patients, and their families

Disrespect for the aforementioned bioethical principles

- Beneficence: absence of a dignified quality of life
- Non-Maleficence: prolongation of suffering caused by medical procedures and treatments for patients

INTERNATIONAL GUIDELINES

1. Establishing a trustful relationship with the patient and family
2. Assessing their understanding of the medical condition
3. Understanding the patient's values and preferences
4. Clarification and discussion of DNR orders
5. Addressing emotions
6. Developing a plan for implementing DNR orders

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Abstract

Do Not Resuscitate (DNR) Orders consist of the explicit determination not to perform Cardiopulmonary Resuscitation (CPR) in patients with irreversible loss of consciousness or untreatable cardiac arrest. Although complex and multifactorial, the decision-making process regarding DNR is part of the routine in oncology departments and should be based on ethical regulations on the subject. Therefore, the aim of this study was to map guidelines on DNR for advanced cancer patients and analyze these technical recommendations in light of bioethics. An integrative review was conducted in national and international scientific databases, as well as a documentary search on the websites of the Federal Council of Medicine (CFM) and the Brazilian Society of Clinical Oncology (SBOC). From the selected references, it was found that: i) national ethical and oncological documents do not directly mention DNR; ii) international guidelines suggest steps in discussing DNR with advanced cancer patients, from building a trusting relationship with the patient/family to discussing DNR and developing a shared care plan. It is concluded that cancer is one of the main factors leading a patient to request DNR, and the lack of specific technical guidelines on DNR for advanced cancer patients in Brazil may result in futile cardiopulmonary resuscitations and/or create conflicts between doctors, patients, and their families, thus highlighting the disrespect for the bioethical principles of autonomy, beneficence, and non-maleficence.

Keywords: Do Not Resuscitate Order. Medical Ethics. Treatment Withdrawal. Adherence to Advance Directives.

INTRODUCTION

According to the National Cancer Institute (INCA), Brazil will have approximately 4,000 cancer cases per year by 2025[1]. The estimates calculated by INCA since 1995 indicate a proportional increase in the number of cases due to the aging of the Brazilian population.

This growing number of people living with cancer will progressively require technically and ethically qualified support from oncologists, as has been highlighted in the literature[2,3], especially regarding measures that ensure humane, dignified care that respects end-of-life wishes.

Among the measures that prevent the prolongation of suffering for these patients, Do Not Resuscitate (DNR) Orders stand out. These consist of the explicit determination not to perform Cardiopulmonary Resuscitation (CPR) in patients with irreversible loss of consciousness or untreatable cardiac arrest[4].

Although complex and multifactorial[5], the decision-making process regarding DNR will become part of the routine in oncology departments, which should be based on specific ethical and legal guidelines on the subject. Despite this scenario, Nogueira *et al.*[6] point out that there are still no clear ethical-legal regulations regarding the use of DNR by advanced-stage cancer patients in Brazil, leaving healthcare professionals, such as nursing staff, legally unprotected and insecure.

It is worth clarifying that, currently, neither the resolutions of the Federal Council of Medicine (CFM)[7,8], nor the National Palliative Care Policy by the Ministry of Health (MS)[9] expressly mention the respect that healthcare professionals should have regarding DNR, although they ethically authorize the limitation or suspension of diagnostic or therapeutic procedures that artificially prolong the dying process.

This gap prompted the development of this research, which aimed to map the guidelines on DNR for advanced-stage cancer patients in Brazil and analyze these technical guidelines in light of Beauchamp and Childress's Principlist Theory of Bioethics[10].

Thus, given the need to disseminate guidelines on the use of this type of treatment refusal in Brazil, it becomes urgent and necessary, considering the aging population and the consequent increase in cancer incidence, which will require healthcare specialists to be better prepared to address the emblematic issue of human terminality.

METHODOLOGY

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An integrative literature review was conducted based on a search for articles on the following research platforms: VHL, PubMed, and SciELO, on 01/19/2024, to answer the following research question: "What are the national guidelines on DNR for advanced-stage cancer patients, and how are these guidelines analyzed from a bioethical perspective?"

The MeSH (Medical Subject Headings) descriptors used in this research were: do not resuscitate orders, medical oncology, bioethics. The corresponding entry terms for each MeSH descriptor were also used in the same search. The combination of descriptors and entry terms was performed using the Boolean operators AND and OR. Only date limits were imposed for the searches in the PubMed (5 years) and VHL (20 years) databases. No time limits were applied to other databases.

For the selection process, the Rayyan® platform (https://www.rayyan.ai/) was used. The articles resulting from the search strategies were added, and three collaborators were invited for a blind selection based on the reading of titles and abstracts. Conflict resolution was made available to all collaborators, which were resolved by consensus. Once the conflicts were resolved, the full articles included in the blind selection were read. The final inclusion of articles was then completed.

Initially, 50 articles were found through the aforementioned platforms. Of the 50 studies, 11 were selected after reading the titles and abstracts. Among the 11, 2 articles were excluded due to the unavailability of full-text versions, and 2 were excluded for being off-topic. An additional 8 references were selected through manual search for alignment with the theme, as graphically presented in Figure 1, which shows the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) diagram[11].

The inclusion criteria adopted were: a) articles addressing do not resuscitate orders in oncology patients; b) articles available in full and free of charge. As an exclusion criterion, articles that did not meet the inclusion criteria outlined in items a and b were excluded.

In the final review, 15 bibliographic references were included.

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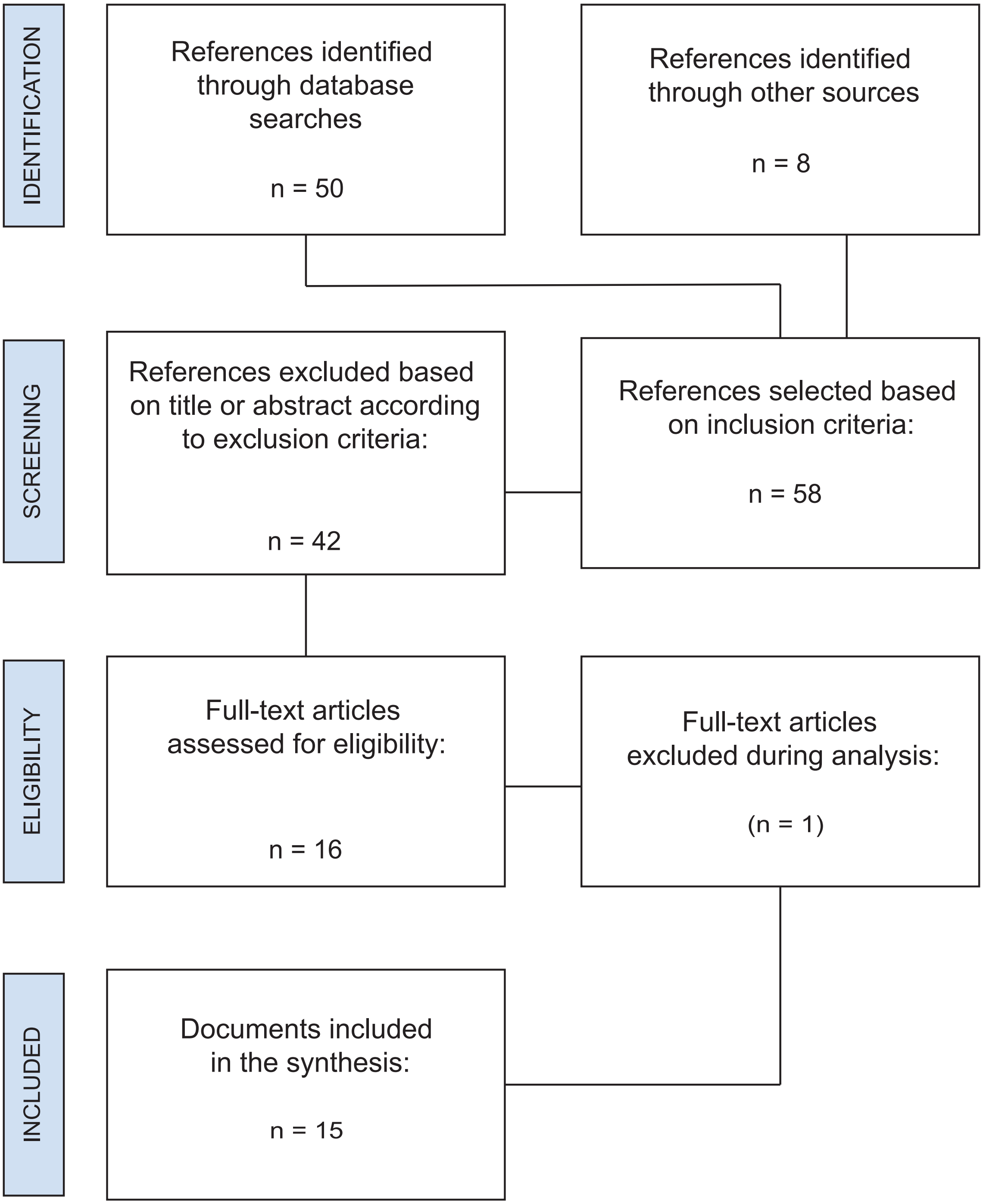

Figure 1 - PRISMA-ScR® Flowchart with the application of the research methodology (2024).

A documentary research on the subject was also conducted on the websites of the Federal Council of Medicine (CFM), National Academy of Palliative Care (ANCP), Spanish Society of Palliative Care (SECPAL), European Association for Palliative Care (EAPC), International Association for Hospice & Palliative Care (IAHPC), National Cancer Institute (INCA), Ministry of Health

(MS), Brazilian Society of Bioethics (SBB), and the Brazilian Society of Clinical Oncology (SBOC), using the previously mentioned descriptors. Finally, 5 national documents were selected.

RESULTS

Based on the bibliographic references found, the results were compiled into three categories of analysis: national documents on the subject, international guidelines on DNR for oncology patients, and the (dis)advantages of DNR, which are presented below.

(In)Existence of national documents on DNR

The documentary research conducted on the websites of CFM, ANCP, INCA, MS, SBB, and SBOC did not find any document directly addressing the topic of Do Not Resuscitate (DNR) Orders for oncology and non-oncology patients. Therefore, it is inferred that, in the Brazilian context, there are currently no specific ethical or legal guidelines to direct healthcare professionals regarding DNR.

In the Federal Council of Medicine (CFM) database, only two resolutions were found that indirectly address the topic: one concerning the possibility of suspending invasive procedures in terminal patients, Resolution No. 1.805[7]; and another regarding the possibility for patients to express their end-of-life wishes before losing lucidity, Resolution No. 1.995[8].

CFM Resolution No. 1.805/2006[7] allows physicians, when a patient is in the terminal phase of life with severe and incurable illnesses, to limit or suspend procedures and treatments that prolong the patient's life, ensuring the necessary care to alleviate symptoms that cause suffering, with the aim of providing comprehensive care. The consent of the patient or their legal representative is required. Furthermore, the physician has the obligation to inform the patient or their legal representative about the appropriate therapeutic options for each situation, ensuring the right to a second medical opinion.

Thus, since DNR orders are understood as a form of limiting medical procedures, this resolution ethically authorizes physicians to respect the wishes of patients who do not want cardiopulmonary resuscitation, even though it does not explicitly mention DNR.

CFM Resolution No. 1.995/2012[8] defines the patient's advance directives (AD) as the prior expression of their wishes regarding procedures and treatments they plan to receive - or not - when they are unable to express their will freely and autonomously. Within the context of these directives, the patient may simply designate a representative to express their interests and preferences regarding which therapies should be accepted or avoided. In either case (directives expressed by the patient or the representative), the physician will consider the instructions that align with the Medical Ethics Code, recording them in the patient's medical records. The physician may even oppose family members' wishes if they contradict the expressed directives[8].

Similarly to the previous resolution[7], it is observed that since DNR orders can be included in the patient's advance directives, this 2012 Resolution ethically authorizes physicians to respect the patient's expressed wish not to undergo cardiopulmonary resuscitation.

Regarding the national oncological documents found on the website of the Brazilian Society of Clinical Oncology (SBOC), it was noted that there is a clear stance on the importance of incorporating palliative care into the treatment of advanced cancer patients[12], the free expression of preferences regarding medical treatments through advance directives (AD) and the collective effort to ensure that the patient's wishes are honored are considered guiding principles of palliative care[13] at CFM Resolution No. 1.995/2012[8]. This guide emphasizes the importance of patient autonomy: decision-making at this final stage of life must be closely aligned with the patient's preferences, in accordance with the implementation of informed consent.

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Thus, the SBOC documents[12,13] reaffirm the importance of palliative care for advanced-stage cancer patients, without explicitly mentioning respect for DNR orders given by the patient or their representative.

Finally, on May 7, 2024, the Ministerial Order No. 3.681 of the Ministry of Health (GM/MS) was published, which, by establishing the National Palliative Care Policy, listed as a guiding principle of palliative practice the refusal of treatments and diagnostic procedures that may cause suffering or measures that artificially prolong the dying process (Article 2, Section VIII)[9].

Thus, it was found that none of the five national (ethical or oncological) documents directly addressed DNR orders, limiting themselves to allowing physicians to suspend procedures and treatments that prolong the patient's life, as well as to the formulation of advance directives by the patient or their representative, which implicitly include the observance of DNR orders by healthcare professionals.

International guidelines on DNR for oncology patients

The mapped international guidelines suggest the following steps in discussing DNR with advanced cancer patients: i) establishing a trustful relationship with the patient and family; ii) assessing their understanding of the medical condition; iii) understanding the patient's values and preferences; iv) clarifying and discussing the DNR orders; v) addressing emotions; and, finally, vi) developing a plan for implementing the DNR orders.

Beauchamp and Childress (2013)[10] emphasize that trust is the foundation for an effective and ethical therapeutic relationship. A strong bond allows patients and their families to feel secure in sharing sensitive information and trusting the guidance of healthcare professionals. For this, it is essential that healthcare professionals demonstrate empathy, transparency, and clear communication.

Furthermore, assessing the patient's and family's understanding of the medical condition is crucial to ensure that they make informed decisions. Chen *et al.*[14] highlight that physicians should regularly check patients' understanding of their conditions and treatments, correcting any misunderstandings and providing additional information as needed. Similarly, the studies by Lee *et al.*[15] , Mani *et al.*[16] and Mathur *et al.*[17] emphasize the importance of active communication between physicians, patients, and families in the decision to implement Do Not Resuscitate (DNR) orders. This can promote a better quality of life during this emotionally challenging period, while steering away from invasive and non-beneficial procedures.

Knowing the patient's values and preferences is also essential for providing patient-centered care. As Beauchamp and Childress clarify[10], considering the patient's personal and cultural values is a crucial aspect of ethical decision-making in healthcare. This includes understanding the patient's religious beliefs, expectations, and wishes regarding treatments and end-of-life care. From the perspective of Garrido *et al.*[18], it is necessary to reinforce respectful and open discussions about the individual preferences of advanced-stage cancer patients, who tend to opt for less aggressive measures in their final moments of life.

Furthermore, studies such as those by Cocks *et al.*[19] and Mathur *et al.*[17] emphasize the importance of honest and detailed conversations about DNR, addressing both the medical aspects and the patient's desired values. Thus, discussing DNR requires sensitivity and clarity to ensure that the patient and family fully understand the implications of such orders.

According to Beauchamp and Childress[10], healthcare professionals must be prepared to handle the emotions of patients and their families, offering emotional support and validating their feelings. Wright *et al.*[20] found a positive association between well-conducted end-of-life discussions and better emotional outcomes for patients and their caregivers.

Finally, developing a care plan involves integrating all the collected information—such as values, understandings, preferences, and emotional aspects to formulate a treatment plan that respects the patient's autonomy and wishes. Lee *et al.*[15] show that a well-defined plan can improve the quality of end-of-life care and reduce the incidence of unwanted interventions. Curtis and Barnato[21] also highlight the importance of consistency among healthcare professionals in implementing these plans to ensure that the patient's wishes are respected throughout all stages of care.

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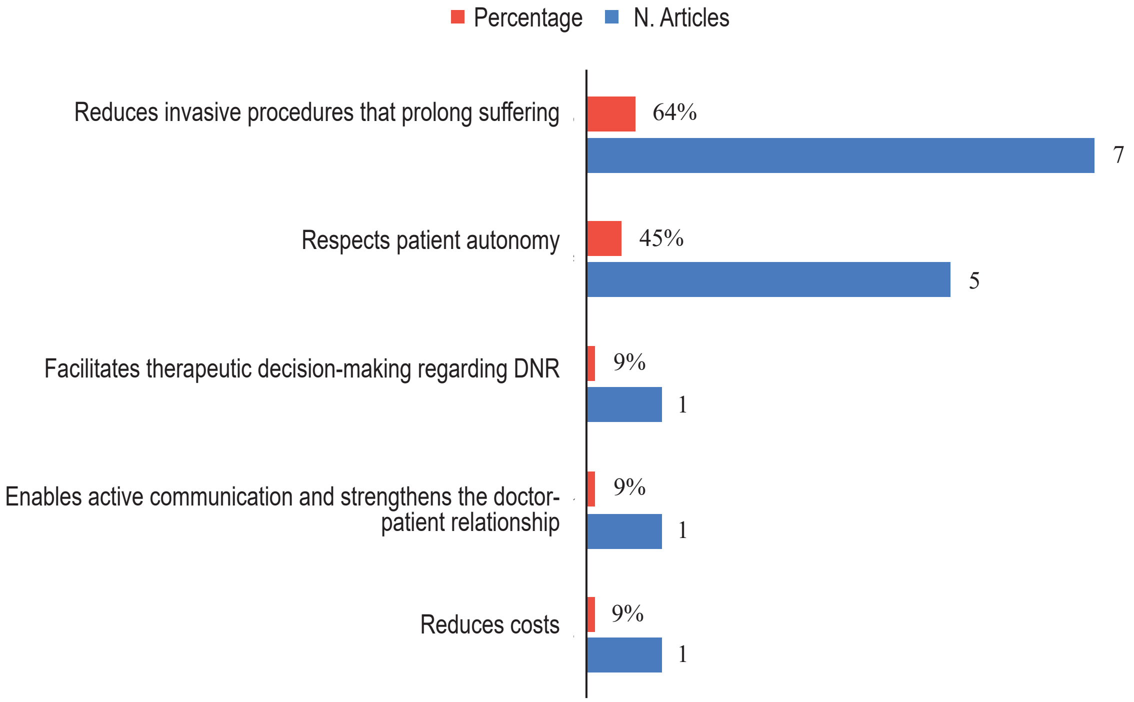
Advantages and disadvantages of DNR orders

The results regarding the advantages of using DNR orders by oncology patients, as most frequently cited in the articles found, are compiled in Graph 1.

Graph 1 - Most commonly cited advantages of the use of DNR orders by oncology patients in the literature.



Based on the presented graph and the cross-sectional study by Waller *et al.*[22], it is emphasized that the physician's communication skills and active listening are crucial in alleviating the psychological distress of patients. This practice fosters a sense of support and involves the patient as the main agent in directing their treatment. In this patient-centered medical practice, where the

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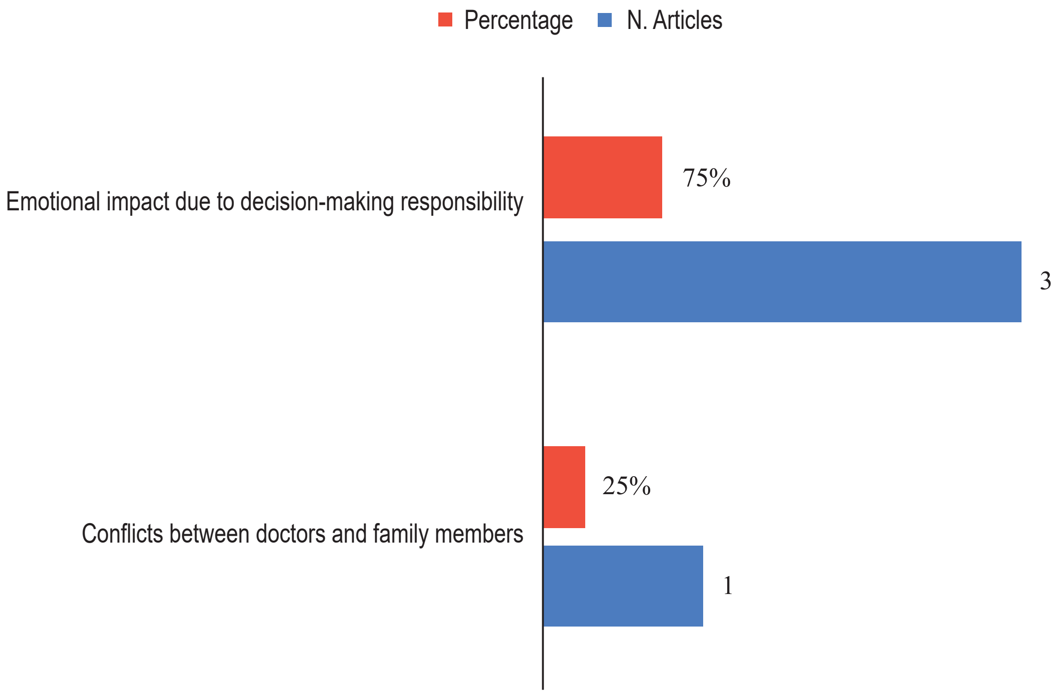
goal is the active participation of the patient in their care process, the documents by Wright *et al.*[20], Garrido *et al.*[18], Putzel *et al.*[4], Zegers[23], Lee *et al.*[15] and Allen[24] indicate that the decision to limit invasive treatments for terminally ill patients, who do not benefit from prolonged therapeutic measures, helps reduce suffering and facilitates therapeutic decision-making in the adoption of DNR orders, as also noted by Chen *et al.*[14]. Furthermore, Garrido *et al.*[18] point out that the presence of a DNR order may be associated with lower end-of-life care costs, as interventional practices are avoided.

Thus, according to Garrido *et al.*[18], Cocks *et al.*[19], Putzel *et al.*[4], Zegers[23] and Mathur *et al.*[17], patient autonomy is the main pillar in the organization and implementation of DNR orders. Through their participation in care planning, their wishes are respected, ensuring a more comfortable end-of-life experience.

Regarding the disadvantages of the use of DNR orders by oncology patients, as most frequently cited in the selected articles, the results are presented in Graph 2.

Graph 2 - Most commonly cited disadvantages of the use of DNR orders by oncology patients in the literature.



Based on the argumentation of Putzel *et al.*[4], Garrido *et al.*[18] and Wright *et al.*[20], it is highlighted that the implementation of DNR orders in oncology patients can be a challenging moment for healthcare professionals. This process requires skills and discernment to navigate ethical, moral, and emotional issues, demanding that the care team have proper psychological and emotional management.

Furthermore, from the perspective of Mathur *et al.*[17], family conflicts may arise due to disagreements regarding the therapeutic approach and medical conduct, even when the goal is to respect human dignity, promote quality of life, and prevent prolonged suffering in terminally ill patients.

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Beauchamp and Childress, in the book Principles of Biomedical Ethics[10], detail the four fundamental principles of bioethics, which are explained below.

The principle of autonomy refers to the right of individuals to make their own informed and voluntary decisions regarding their body and medical care. The principle of non-maleficence requires healthcare professionals to avoid intentionally causing harm; this principle simply explains that physicians must weigh the benefits and burdens of all interventions and treatments, avoiding those that are excessively burdensome and choosing the best course of action for the patient. The principle of beneficence implies the obligation to act in the patient's best interest, promoting their well-being and ensuring that treatments offer more benefits than harms. Finally, the principle of justice is interpreted as the fair, equitable, and appropriate treatment of individuals[10].

As the absence of specific technical guidelines on DNR for advanced oncology patients in Brazil may lead to futile cardiopulmonary resuscitations and/or generate conflicts between physicians, patients, and their families, as previously explained, this national regulatory gap implies a violation of the bioethical principles of autonomy, beneficence, and non-maleficence.

Thus, to uphold the principle of autonomy, open and transparent communication with patients and their families becomes crucial, respecting their autonomy and wishes. Often, it is necessary to encourage early and ongoing discussions about the patient's treatment preferences, including the possibility of implementing DNR orders, as highlighted by Mani *et al.*[16], Mathur *et al.*[17] e Putzel *et al.*[4]. In this regard, international guidelines recommend considering DNR orders for advanced cancer patients based on factors such as prognosis, quality of life, and the patient's wishes. These elements must be taken into account when making decisions.

Similarly, regarding the principles of non-maleficence and beneficence, it becomes imperative to weigh the risks and benefits of medical procedures, including cardiopulmonary resuscitation (CPR), in advanced cancer patients. CPR may not be beneficial and could result in prolonged suffering without significant improvement in quality of life.

DISCUSSION

The decision-making process in oncology is complex and involves multiple factors, including both analytical and rational models for the best evidence-based therapeutic proposal, as well as the biopsychosocial aspects surrounding oncology patients. The variability in practices and decision-making criteria regarding DNR orders highlights the need to acknowledge and address the complexity of these decisions to improve clinical practice and ensure that the patient's wishes are honored.

In the international context, the United States implemented the national Portable Medical Orders (POLST) program, a document designed to guide physicians regarding prior decisions made by patients who, at the time of an emergency, are unable to express their wishes about treatments and medical prescriptions. This planning was established in response to the conditions surrounding the doctor-patient relationship in cases of advanced illness, focusing on accessible communication, access to information, knowledge of prognosis, and treatment options. According to the CaringInfo program , this guide is intended to communicate the patient's decisions regarding medical care to the healthcare team, including DNR orders that limit life-support actions, recognizing that the underlying pathology is responsible for organ impairment and diminished quality of life.

In Brazil, the outlook for respecting DNR orders is concerning. Comin *et al.*[25] highlight the lack of awareness among respondents regarding end-of-life processes, including palliative care. According to their research, which interviewed Brazilian oncology patients, 89% of patients stated that healthcare professionals were careful when providing the diagnosis and explaining the disease. However, 95% reported not being informed about life expectancy, which consequently affects the patient's planning and perspective on their illness and future due to a poorly communicated prognosis[26].

This lack of an empathetic and diligent approach by physicians during consultations leaves the patient unaware of their right to refuse diagnostic and therapeutic procedures, limiting their autonomy and leading to dissatisfaction and misunderstandings among family members, doctors, and patients. The advance care planning outlined by Dias *et al.*[27] aligns with the sharing of knowledge and the encouragement of patient autonomy, emphasizing their role as the main agent in discussions about treatments, expectations, and future perspectives. For this to happen, physicians must move away from a disease-centered care model and apply their medical knowledge to facilitate shared decision-making that aligns with the patient's wishes.

CONCLUSION

In conclusion, although advanced-stage cancer is a significant factor for a patient to request DNR orders, no explicit ethical norms or guidelines were found in Brazil to guide healthcare professionals in discussing and implementing such orders.

Certainly, the ethical regulation of documents that express the final wishes of advanced-stage oncology patients in a planned and early manner already ensures respect for the principle of autonomy, by allowing the patient to express their values and preferences regarding when CPR should be avoided.

However, the existence of explicit guidelines on DNR would provide healthcare professionals with greater confidence in pursuing a dignified quality of life for patients (respecting beneficence), thus avoiding the prolongation of suffering caused by medical procedures and treatments (which would violate non-maleficence).

In this way, the absence of specific technical guidelines on DNR for advanced oncology patients in Brazil may result in futile cardiopulmonary resuscitations, as well as generate conflicts between physicians, patients, and their families, demonstrating a disregard for the aforementioned bioethical principles.

The formulation and adherence to DNR orders should follow a standard determined by guidelines and regulations that specify when and how to assist healthcare professionals and family members during the decision-making process at the end of a patient's life.

The compilation of selected international guidelines recommends the following steps: i) establishing a trusting relationship with the patient and family; ii) assessing their understanding of the medical condition; iii) understanding the patient’s values and preferences; iv) clarifying and discussing DNR orders; v) addressing emotions; and finally, vi) developing a plan for implementing the DNR orders.

Following this recommendation will ensure that the patient's advance directives, agreed upon with the physician regarding appropriate therapeutic modalities for each situation, are essential for providing humanized care up until the moment of death.

CRediT author statement

Conceptualization: Santos, MBGC. Data Curation: Ferreira, AS. Formal Analysis: Teixeira, GS. Investigation: Santos, MBGC. Methodology: Ferreira, AS. Project Administration: Teixeira, GS. Supervision: Borba, MN. Validation: Ferreira, AS. Visualization: Teixeira, GS. Writing-original draft preparation: Santos, MBGC; Ferreira, AS; Teixeira, GS. Writing-review and editing:: Santos, MBGC; Borba, MN.

All authors have read and agreed to the published version of the manuscript.

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DOI: 10.15343/0104-7809.202448e16342024I

Received: 31 may 2024.
Accepted: 06 september 2024.
Published: 27 september 2024.