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SHORT COMMUNICATIONS

Do Not Resuscitate (DNR) in Oncology: What Should Be Done and What Should Not Be Done

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Abstract

Do Not Resuscitate (DNR) orders are central to honoring dignity and guiding comfort-focused care in advanced oncology. However, DNRs are often implemented very late frequently within days of death and decisions are sometimes made by family rather than the patient, limiting their benefit. Best practices comprise early, empathetic communication, shared decision-making, explicit documentation, periodic review, and the use of standardized forms to evade ambiguity. Ethical and legal considerations, and the requirement of emotional and spiritual support are paramount to the respectful implementation of care. Together, these measures better align care with patient values and enhance the end-of-life experience.

Keywords: Do Not Resuscitate- Oncology- Shared decision-making- Communication- Documentation

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Introduction

Do Not Resuscitate (DNR) orders play a vital role in honoring the dignity and wishes of patients encountering advanced cancer, directing care toward comfort and respect in their final stages. These orders indicate that no attempts should be made to restart the heart or breathing if they stop. In oncology, DNR orders are often considered for patients with terminal illness to assure a peaceful and dignified end-of-life experience. However, they are frequently done late and involve complex ethical, cultural, and procedural issues. DNR orders are common among advanced cancer patients, with prevalence rates ranging from 59% to over 75% in various settings [1-6]. The impact of DNR orders on the quality of end-of-life care is limited because they are usually issued within days before death, sometimes even as late as 1-7 days prior to death.[1-4, 7]. Patient autonomy is questioned because family members frequently make DNR decisions instead of the patients themselves [2-5]. Early DNR orders allow less aggressive interventions and more comfort-focused care, while late orders may lead to unnecessary treatment and distress [1, 6-8]. This short communication explores what should and should not be done when implementing DNR orders in oncology.

What Should Be Done

1. Early and Open Communication

Initiating DNR discussions early and trying to have clear, compassionate communication are indispensable for patient-centered oncology care. Research highlights several best practices to attain these goals. DNR discussions are often delayed, restraining patients from the opportunity to make informed choices. It is advised to start the process early, while the patient can still make decisions, empowers him and ensures the care corresponds to his beliefs [9, 10]. The patient, their family, and the medical staff need to be a part of the dialogue to guarantee that all perspectives are heard and that the patient's wishes are at the center [9-12].

In discussions about DNR, doctors who have received training in organized communication models, such the SHARE course, show enhanced proficiency. This involves picking a calm setting, verifying the patient's desires, and showing empathy, it improves the quality of conversations around end-of-life care and makes it more likely that DNR orders will be put in place [13].

Effective communication means sharing clear and honest information about health expectations, treatment

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options, and the meaning of a DNR order, so everyone can make informed decisions. Engaging in compassionate and personalized dialogue allows patients and their families to make reasoned choices about their care, diminishing any potential regrets [9-11]. It's important for nurses, social workers, and other healthcare professionals to be ready to talk about DNR orders, as working together as a team leads to better patient and family satisfaction and ensures hospital policies are followed [12, 14].

Clear, timely, and respectful communication is at the heart of these conversations; this will help everyone to understand the patient's wishes, prevent misunderstandings, and work together with empathy, consistency, and strong collaboration to reach the best possible decisions for the patient's care [11, 13]. To make sure that DNR decisions accurately represent the patient's desires and values, it is crucial to have constant, frank discussions with patients and their families. A DNR order should be clearly explained as applying only to the decision to withhold cardiopulmonary resuscitation (CPR) and not as a directive to stop other essential treatments [9, 15, 16]. Clearly stating this distinction provides reassurance to patients, families, and the healthcare team, minimizes the chance of misunderstandings, and supports a care plan that stays true to the patient's goals, values, and best interests.

2. Shared Decision-Making

Engaging patients in shared decision-making and furnishing clear, complete information are crucial for conducting ethical and practical discussions about DNRs in oncology. Shared decision-making (SDM) greatly enhances patient engagement in DNR choices, resulting in increased rates of DNR preferences and better documentation, while also lessening uncertainty in decision-making [17-21].

SDM makes certain that the discussion revolves around the patient's values, goals, and preferences, instead of having decisions made exclusively by healthcare providers or surrogates [17-20]. Involving patients, their families, and healthcare professionals such as doctors, nurses, and other members of the care team can significantly improve the process of making DNR decisions [18, 20, 22].

It is important to have open and honest conversations about the potential outcomes of resuscitation, securing that patients and families undoubtedly understand what it might involve, including the possible benefits, risks, and impact on quality of life [17, 18, 22]. Such transparency builds trust, supports informed decision making, and helps align care with the patient's values and desires [17, 18]. This approach allows everyone to collaboratively make well-informed decisions.

Giving patients the right resources and speaking with openness and honesty helps them clearly understand the possible benefits and risks of resuscitation, enabling them to make choices that truly reflect their own values, priorities, and hopes for their care [21].

Many patients and families want to be more informed and actively involved in these decisions, and when they have the knowledge they need, they are more likely to feel confident in their choices and to accept DNR orders as part of a care plan that truly reflects their wishes [21].

3. Documentation and Review

Clear documentation and regular review of DNR orders are essential to ensure patients' wishes are respected and care remains appropriate as conditions change. DNR orders must be clearly documented in the patient's medical record, including the rationale and details of the discussion with the patient and/or family [20, 23, 24].

Incomplete or unclear DNR records can cause confusion, lead to therapies the patient chose to forgo, or result in their wishes being overlooked [23, 25]. To avoid this, the DNR should clearly state what care is included or excluded, who took part in the discussion, and the medical reasons for the decision [20, 23]. Using electronic health records and standard forms makes the information easier to find and understand [24, 26, 27]. Because a patient's condition and preferences can change. DNR orders should be checked and updated regularly, [28-30] especially at important times like when a patient is admitted to the hospital, before surgery, or after a sudden change in their situation [28-30]. Studies show that advanced directives, including DNR orders, often change as a person's situation or wishes evolve, so reviewing them often helps keep the record accurate and respectful of what the patient wants now [28, 30]. To make this happen, hospitals and clinics need clear rules and simple processes that ensure these reviews and conversations take place at the right moments [28-30].

4. Ethical and Legal Considerations

Making sure DNR decisions obey both ethical principles and the law is key to handing care that is respectful, legal, and compassionate. At the heart of this is patient autonomy; the right of every patient to choose whether or not they want resuscitation, with their wishes guiding the decision [19, 31-34].

"Do no harm" means not giving treatments that might cause more pain or have no real benefit, especially for people with serious or terminal illness [19, 31-33]. At times, a patient's wishes may differ from what their family wants, what their culture expects, or what hospital rules suggest [19, 31, 33, 34]. When this happens, the best approach is to carefully think through each situation on its own, weighing the patient's rights and well being alongside the concerns of others, to reach a decision that is both respectful and compassionate [19, 33, 34].

Legal frameworks for DNR orders vary by country and region: Some countries (e.g., the US, UK, many in Europe) have clear legal protocols supporting DNR orders, while others lack specific legislation or even prohibit DNR [33, 35, 36]. In most jurisdictions, DNR orders must be documented, discussed with the patient (or legal surrogate), and adhering with institutional and national laws [32, 33, 35-37]. In the perioperative and surgical setting, professional societies emphasize that DNR orders should not be automatically suspended; instead, patient autonomy and informed consent must guide perioperative DNR management [32, 37, 38]. DNR orders in the context

of mental illness or suicide attempts require careful legal and ethical review, including screening for capacity and intent [39, 40].

What Should Not Be Done

1. Avoid Delaying Discussions

Delaying DNR discussions until a patient is critically ill or unable to speak for themselves takes away their right to make informed choices and often results in decisions that do not match their true wishes [9]. It is equally important not to assume what a patient might want; instead, each case should involve a careful, personal conversation that gives the patient the chance to understand their options, share their values, and take part in the decision making process while they are still able [9].

Most doctors agree that DNR conversations should happen early in the course of an illness, while the patient can still fully understand the situation and share their wishes [9, 41-45]. Talking about it sooner gives patients and families the time they need to absorb information, think about what matters most to them, and make choices that match their values, rather than having to make rushed, stressful decisions during a medical crisis [9, 44, 45].

When healthcare professionals develop the skills to communicate with clarity, warmth, and empathy, they can timely engage in meaningful conversations with patients and families that lead to well informed, respectful decisions, that are aligned with the patient's values, priorities, and overall goals of care [9, 43, 45, 46].

2. Avoid Ambiguity

Mistakes in patient care can emerge from unclear or ambiguous DNR orders. This insufficiency of clarity can lead to confusion and misconceptions, particularly in emergencies. Ambiguity may result in either unwanted resuscitation or the inappropriate withholding of other treatments not intended by the DNR order [15, 47, 48].

Using clear, procedure based DNR forms and structured documentation removes uncertainty about which treatments should be given or withheld, making communication between healthcare providers smoother and reducing the chance of mistakes [15, 48, 49]. When DNR orders use vague language such as not clearly stating the difference between resuscitation, intubation, or other levels of care patients may receive treatment that does not match their wishes [15, 47].

Standardized forms and clear guidelines make it easy for the whole care team to understand exactly what a DNR order allows and what it does not, helping ensure that every decision is consistent, accurate, and truly reflects what the patient wants [48, 49].

3. Do Not Ignore Emotional and Psychological Support

DNR discussions can be deeply emotional for patients and their families, often bringing feelings of anxiety, uncertainty, hope, fear, and even acceptance, especially when facing a terminal illness or an emergency [43, 50]. For families making decisions on a patient's behalf, the process can carry a heavy emotional burden, with moments of hesitation, conflict, and distress [50].

These challenges are even greater when DNR conversations happen suddenly or during a crisis, making it vital to approach them with sensitivity and at the right time [43]. In these moments, patients and families value having clear, honest information, open and compassionate dialogue, and the reassurance that their healthcare team is there to support them through every step of the decision making process [33, 43, 50].

Providing counseling, emotional support, and involving palliative care teams can guide patients and families through the decision making process, help reduce emotional strain, and bring a greater sense of comfort and peace with the care being provided [33, 43, 50].

When appropriate, including religious or spiritual support can address deeper emotional and existential needs, creating a truly holistic approach that cares for the patient as a whole person mind, body, and spirit [33].

In conclusion, early, clear, and compassionate DNR discussions in oncology preserve patient autonomy, reduce unwanted interventions, and improve end-of-life care. Shared decision-making with patients, families, and multidisciplinary teams increases informed, value-concordant choices and enhances documentation and review. DNR orders should be unambiguous, clearly recorded, periodically reviewed, and accompanied by palliative and psychosocial support to uphold dignity and reduce distress

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Statement of Transparency and Principles

• The authors declare no conflict of interest.

• The study was approved by the Research Ethics Committee of the authors' affiliated institution.

• The study data are available upon reasonable request.

• All authors contributed to the implementation of this research.

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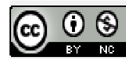

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