Physicians’ Understanding of Patient Autonomy and Choice in Discussions Surrounding the Do-Not-Resuscitate Order (FR415-B)

Elizabeth Dzeng, MD, Johns Hopkins School of Medicine, Timonium, MD
Sydney Dy, MD, Johns Hopkins School of Public Health, Baltimore, MD
Thomas Smith, MD FACP FASCO FAAHPM, Johns Hopkins School of Medicine, Baltimore, MD

Objectives
- Define three criteria necessary for a decision to be autonomous and determine whether these criteria have been fulfilled in the quotations in the presentation.
- Describe ideal forms of persuasive communication and contrast that with less desirable communication strategies.

Original Research Background: Physician paternalism has given way to the primacy of patient autonomy. Challenges occur when patients request potentially nonbeneficial interventions, resulting in ethical conflicts between respecting autonomy and acting with beneficence.

Research Objectives: To explore physicians’ conceptualization of patient autonomy and choice and how that affects physician communication strategies in conversations where do-not-resuscitate (DNR) status is discussed.

Methods: Semistructured in-depth interviews were conducted with 29 internal medicine doctors across two sites in the United States who were routinely involved in DNR conversations with patients at the end of life. Participants were purposely sampled by stage of training and medical subspecialty to provide a wide range of perspectives and contribute to understanding emerging patterns and themes. Interviews lasted 60 minutes on average and were audiotaped and transcribed. Transcripts were analyzed and double coded using thematic analysis with an interpretive approach.

Results: Experienced doctors at all sites generally felt comfortable engaging in shared decision making and, when clinically appropriate, making more paternalistic recommendations against resuscitation. However, residents and fellows felt less comfortable restricting choice and felt compelled to offer choice even if the chance of successful resuscitation was negligible, often without explaining the likelihood of survival, its consequences, or in the overall context of goals of care.

Conclusions: Inexperienced doctors often interpreted hospital policies promoting autonomy to mean that they should not provide clinical recommendations, even in situations where they feel it would not be in a patient’s best interest to offer resuscitation. This obscures truly autonomous informed decision making by offering choice without providing the tools and knowledge necessary to make the decision.

Implications for Research, Policy, or Practice: To truly empower patients to participate and make decisions, shared decision making should be encouraged in which doctors impart their medical knowledge to guide informed decisions.