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Nursing Legal Implications and Ethical Considerations of "Do Not Resuscitate" DNR: Review

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ABSTRACT

Healthcare providers have significant challenges while making appropriate judgments regarding cardiopulmonary resuscitation (CPR). This review sought to assess nurses' knowledge, attitudes, legal consequences, and ethical considerations regarding do-not-resuscitate (DNR). Nurses' poor DNR knowledge, combined with physicians' inconsistent orders and paperwork, can present ethical issues. Clear standards for DNR orders are required for nurses to avoid any confusion, legal or psychosocial challenges, and worries about CPR, as well as to strengthen their participation in the CPR decision-making process.

KEYWORDS: cardiopulmonary resuscitation, do-not-resuscitate.

1. Introduction

Today, as the quality of medical care and societal welfare improves, the number of

patients in the last stages of chronic diseases grows by the day. As a result, administering care for such individuals presents a number of issues, including whether or not to perform CPR. It should be highlighted that CPR encompasses all primary and advanced therapeutic activities in the event of cardiac arrest for a variety of clinical reasons [1, 2]. Furthermore, while CPR can provide positive outcomes in some circumstances, it might also fail. Even though survival rate is defined as returning to a long and high-quality life free of bothersome problems and disabilities, the percentage of successful CPRs will be low [3]. As a result, around half a century ago, the DNR order was included in medical texts, and the first recommendations for this treatment were produced in response to the ineffectiveness of CPR non most situations, as well as the imposition of high costs in terms of financial expenses and human resource waste [4].

Medical teams may not consider CPR to be a worthwhile activity due to patients' general health, age, functional status during cardiac arrest, distance between cardiac arrest and CPR initiation, underlying disorders, and prognosis. In the majority of situations, patients want a DNR order due to existing problems and consequences [5].

Given the urgency of providing care in this situation, as well as the lack of patient clinical capacity to make informed decisions, the occurrence of emotionally anxious reactions by patients' companions, and the absence of specified clinical guidelines in such cases, physicians may become confused in the decision-making process about whether or not to perform CPR. This uncertainty can lead to improper decisions, and patients who could benefit from CPR may be denied treatment, while those who do receive it may have a short life in the intensive care unit (ICU), accompanied by serious physical difficulties and mental pressures [3, 5].

2. Review:

Life-sustaining treatment is defined as any medical intervention, technology, technique, or drug given to a patient in order to prevent death, regardless of whether the treatment is intended to impact the underlying life-threatening disease or biological process. Decisions to withhold life-sustaining care are made in two situations. In the first, treatment is withheld from an actively dying person whose current condition indicates that effective CPR is unlikely to be successful, or a successful CPR is likely to result in a length and quality of life that is not in the patient's best interests to maintain. The second type of decision is hypothetical, in which treatment is withheld in advance in the event that a life-threatening illness develops [6].

Dealing with this issue varies per society, taking into account differences in religious beliefs, rituals and conventions, cultures, and social level [7]. In this arena, culture is regarded as a critical factor. Despite several research on DNR orders conducted worldwide, physicians and medical teams continue to face obstacles in this area. A DNR order is not seen as an obstacle to providing medical procedures or nursing care services [8]. Patients with DNR orders get all treatment services, including venous therapy, antibiotics, opioids, and pain medications [8].

Despite tremendous developments in care service technologies, nurses continue to care for patients with DNR orders, so there is a chance of nurse engagement or non-involvement in the DNR order procedure [9]. Given the strong relationship between nurses, patients, and their families, nurses' lack of involvement in DNR orders can commonly result in sentiments of anger, fear, and frustration among this group [9].

Once judgments are made in this area, nurses are left to deal with the ramifications of those decisions regarding patient and family care. Lack of precise descriptions for patient care can be impacted by nurses' DNR orders, raising questions about the decision's acceptability and the usefulness of delivering specific treatments to patients with this order [10]. These scenarios can be particularly confusing for nurses who have previously encountered patients who were expected to die but lived after receiving CPR and returned to their usual lives [10].

Problems that arise in the face of a DNR order can be classified as either intrapersonal or interpersonal. In this regard, intrapersonal difference is generated by a conflict between individual values in interactions with DNR orders and the immediate discontinuation of care services in light of patients' long-term suffering. Interpersonal difficulties occur when nurses' perspectives differ from those involved in the DNR procedure [11,12]. In intensive care units (ICUs), where the primary goal is to maintain vital physiological functioning, a DNR order is viewed as a complex and multifaceted event that might provide challenges for nurses. So, nursing staff in ICUs recognize that DNR orders can frequently cause ethical issues when providing care services. As a result, nurses are more likely to focus on patients' families, allowing for greater flexibility in terms of patient visits and family presence at the bedside [13].

In the Western world, more than 90% of patients reported learning about CPR from media. Patients frequently underestimated their chances of life after CPR, and this misinformation frequently led to the decision to perform resuscitation in instances where good results were quite unlikely.[A study of popular medical dramas projected an extremely high survival rate following CPR, which contradicted actual numbers. Patients and their relatives frequently engage in decisions about resuscitation and end-of-life care during times of significant emotional hardship. In a short period of time, people are expected to process and assess sophisticated medical information before making decisions regarding themselves or their loved ones. As a result, prior knowledge, information, and media depiction have a considerable influence on decision-making [14]. A research found that 50% of elderly individuals who initially wanted to be resuscitated altered their minds after receiving more extensive information about the CPR method and chances of survival [15]. Handouts and a movie about advance directives were used as an educational intervention to improve understanding and influence attitudes and behaviors toward resuscitation. Physicians must explain the procedure, clinical accompaniments, and outcomes, which include intubation, mechanical ventilation, artificial feeding, hydration, supplemental oxygen, and pharmaceutical medications. As a result, the decision to institute CPR is not a single ethical decision, but rather a series of choices that are either packaged together or spaced across time [16].

In the Jordan study, Al Khalaileh looked at nurses' attitudes and experiences with DNR orders. In this study, 111 nurses from three state-run hospitals were evaluated. According to the statistics, 21% of nurses have participated in decision-making for this surgery. Ultimately, it was determined that such nurses were willing to participate in DNR orders [17].

In Belgium, De Gendt et al. investigated nurses' views regarding making judgments about DNR orders in geriatrics departments and discovered that 74% had been involved in the DNR order process. As a result, these individuals recognized that they had the option of a DNR order and had developed favorable opinions concerning this process [18]. Another study by Moghadesian et al., done at two institutions in the cities of Tabriz and Kurdistan, Iran, found that 186 nursing students had negative sentiments concerning DNR orders. However, these pupils claimed that they needed to understand a lot more about the method. It appeared that informing students about the DNR order could influence their sentiments in this regard [19].

A study conducted by Manias in Australia found that nurses had good opinions concerning DNR orders. Furthermore, they emphasized the engagement of patients' families, patients, and nurses in decision-making about DNR orders, as physicians were primarily responsible for such decisions. Finally, they emphasized the need of having uniform rules for determining DNA order [20].

Furthermore, in Islamic culture, where life and human life have specific values and life moments are held in high regard, the development of guidelines that have transparently elaborated the procedure for making decisions about DNR orders and reducing the interference of personal, impractical, and non-professional factors is critical. According to the relevant literature, while DNR orders are in place in several Muslim nations, they are not yet lawful. There are currently questions in Iran about the constitutionality of this decision, and there is no clear answer; nonetheless, evidence suggests that Iran's legal system has the potential to regulate the DNR order and associated concerns [21].

Furthermore, practically all research concluded that DNR orders must be implemented. Instructions, permits, and legal requirements for DNR orders were also very important. Furthermore, given their involvement in such cases, the nurses who participated in the examined studies said that they required to have the authority to write DNR orders. Pettersson et al. (2014) found that developing standards and documenting DNR orders was also important in Sweden [22].

Another study conducted in Rwanda by Nankundwa et al. found that only physicians made choices for DNR cases, after interviewing a total of 6 ICU nurses. Nurses in this survey also agreed that they should be permitted to make decisions on DNR orders. Additionally, the presence of rules for such a technique for the nursing group was required [23].

3. Conclusion:

It should be emphasized that deciding on DNR orders is a complex task that can be

influenced by a variety of factors. The findings of these research suggested that choices about the fulfillment of DNR orders should not be based only on the wishes of a single individual. In the aforementioned research, the majority of nurses felt that nurses, patients, and patients' families were required to play roles in deciding on DNR orders, and thus their willingness and preferences had to be considered. Previous research found that nurses believed they needed to play a role in DNR orders and have the authority to make decisions, as they had no defined position in this sector.

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