BRIEF REPORT

«DO NOT RESUSCITATE» IN TERMINAL ILL PATIENTS

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Nowadays, the number of patients in end stage of chronic diseases is steadily increasing mainly due to the quality of medical care and the improvement of the welfare of society. Nurses encounter with several challenges when providing care to this group of patients, doing or not doing cardiopulmonary resuscitation (CPR). [1]

The term "Do Not Resuscitate" (DNR) describes a procedure in which the patient or the loved ones have signed a special form after being full informed that they do not wish to undergo CPR in an event of cardiac arrest.[1]

Under this condition, emerge various issues such as: a. is the decision a product of elaborate information? and b. are caregivers fully aware of patient' wishes, at a time he/she is not capable to make such a decision?.[2] The decision-maker has to evaluate patient's past and present feelings, beliefs and values.[3]

Indeed, physicians have to evaluate prognosis along with patients' wishes when considering this order. However, several adverse prognostic factors influence physicians' willingness to implement DNR order, such as advanced age, low body mass index and disease stage. Among 55,865 heart failure patients from 290 hospitals, only percentage of 12.1% had an early DNR order.[4] The DNR order which is applied only to cardiac arrest, does not affect the implementation of other therapeutic interventions. Even if a DNR order is given for advanced-stage patients, medication should be continued for symptom management, as long as no adverse effects occur.[5]

The DNR order is difficult for both patients and health care professionals.

It is not rare that patients may change their DNR preferences over time. Hypothetical scenarios estimate that approximately 10-25% of patients reverse prior decisions to withhold life-sustaining treatments.[2] End-of-life discussion is often deferred until more emergent occasions, thus limiting patients' awareness of their prognosis and make them have unrealistically optimistic expectations.[6] On the other side, patients in the terminal stage of incurable diseases may consider that DNR allows them a peaceful death.[7]

Clinical decision by medical teams is based on patient' state of physical and mental health and capacity. The justification for DNR is not whether the patients will be cured or recovered but whether CPR would offer what they acknowledged as a worthwhile quality of life.[3]

In terms of nurses, a recent study in Turkey (2022) among 1250 nurses with mean age 34.5±7.7 years demonstrated that the majority (94.3%) agreed that healthcare professionals involved in DNR decision-making process should have ethical competence. Furthermore, participants' opinions on DNR decisions differed according to the number of years of employment and unit of duty.[8] Similarly, a recent metanalysis (2021) showed that nurses were willing to get involved in DNR order and recommended that each hospital should develop a written DNR policy directing staff and avoiding confusion toward this respect.[1] In Taiwan nurses, who had prior experiences in initiating such discussions with patients or patients' families, were more likely to have future DNR discussions with terminally ill patients. The same research showed that regarding age, nurses aged 40 to 60 years were less likely to have DNR discussions compared to those aged 20 to 29.9 years.[7]

In terminally ill patients, should be developed a plan that includes: a) discussion of discontinuing medications that

do not directly affect symptom management or quality of life, b) documentation of patients' decision regarding resuscitation efforts, c) deactivation of implantable devices (according to law of state), d) description of preferred place of death, and e) referral for psychological or spiritual support.[2]

Discussions at the end of life or care planning in advance with family is a challenge for health professionals. According to estimates, less than 30% of survey participants have an advance care planning. Most individuals with advance directives share the following characteristics: chronic illness, regular access to healthcare, higher income, higher education and older age.[9] In general terms, it is important to provide information tailored to meet patients' needs.[10] Familiarity to procedures gained by provided information may play a critical role in reduction of anxiety.[11]

Future studies are needed to better understand decision makers' perceptions of DNR orders for patients. Considering religious values and beliefs, this issue needs to be delineated globally, in order to reduce confusion in medical teams at bedside.[1] To protect patients' autonomy and their right to make decisions about their DNR, measures are needed to facilitate discussions with patients to ensure better end-of-life care.[7]

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