Review

Ethical Dilemma Do Not Resuscitate (DNR) in Nursing Practice

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Introduction: DNR (Do Not Resuscitate) is a condition where the patient experiences cardiac arrest but chooses not to undergo resuscitation. However, the legal consequences of DNR actions, which may either allow or completely prohibit these actions, can vary in different countries. Nurses frequently encounter ethical dilemmas resulting from DNR situations. This literature review explored nurses’ ethical dilemmas regarding DNR and strategies to overcome them.

Methods: This literature review examined previous research findings published in articles. Article searches were conducted using PubMed, ScienceDirect, and Google Scholar, employing keywords such as "DNR," "Nursing Ethics," and "Ethical dilemma," as well as combinations thereof like "DNR in a nursing ethical dilemma." Fifteen articles meeting the inclusion criteria were selected.

Results: Making DNR decisions for patients significantly impacted the continuity of patient care in hospitals. These decisions were influenced by religion/beliefs, life expectancy, limited resources, and past experiences. Nurses stressed the importance of discussing DNR situations openly. Moreover, nurses were crucial in addressing misunderstandings surrounding patient care with DNR orders through practice, education, advocacy, policy implementation, and research.

Conclusion: Nurses require adequate training and education in end-of-life ethics and DNR decision-making to prevent detrimental actions and ensure patients’ peaceful, dignified terminal care.

Keywords: do not resuscitate, ethical dilemma, nursing

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**INTRODUCTION**

Ethical dilemmas can arise when nurses comprehend the steps necessary to save a patient but cannot carry them out due to various considerations, such as sociocultural issues within the patient’s family [1]. Do Not Resuscitate (DNR) entails refraining from rescue measures, including cardiopulmonary resuscitation (CPR), heart-lung compression, defibrillation, and medication, for patients where such measures are deemed unnecessary.

The decision to implement a DNR protocol is deemed reasonable for patients with terminal illnesses, those with a poor quality of life, and those reliant on ventilators where further medical intervention is considered futile. Medical decisions, coupled with the patient’s (or family’s) wishes, often rooted in the patient’s values, serve as the foundation for the DNR decision. However, the legality and consequences of DNR, whether permitted or entirely prohibited, can vary across countries. Various literature and publications have extensively discussed the strong correlation between ethical dilemmas and DNR [2]. Factors associated with receipt of a DNR order include religious and psychosocial conditions [3], spiritual beliefs [4], and ethnicity [5], as well as other characteristics such as chronic illnesses and old age [6].

Nurses frequently encounter ethical dilemmas stemming from DNR situations. Prolonged exposure to ethical dilemmas leads to mental fatigue and disrupts professional practice, ultimately compromising the quality of care [7, 8]. Additionally, problems arising from ethical dilemmas can exacerbate patient suffering and increase treatment costs [9]. This literature review explored nurses’ ethical dilemmas regarding DNR and strategies to overcome them.

**METHODS**

Data collection was conducted through a literature review, which involved gathering library data, reading, note-taking, and processing written materials. The data sources included published journals relevant to the topic [10].

The data collection involved filtering 2,714 literature sources to obtain 15 relevant pieces based on predefined criteria. Inclusion criteria encompassed articles from PubMed, ScienceDirect, and Google Scholar discussing DNR in nursing, nursing ethics related to DNR actions, ethical considerations in managing DNR patients, articles published in English from 2019-2023, research articles with observational designs, and articles available in full text. Exclusion criteria were scooping reviews, literature reviews, meta-analyses, and books.

The search strategy employed in the targeted databases involved entering keywords corresponding to the research title, such as "DNR,” “nursing ethics,” AND "ethical dilemma.” In PubMed, for instance, the keyword "DNR” yielded 3879 articles, and combining keywords resulted in 17 relevant articles within the last five years. However, only two articles were pertinent to the title and full text.

In ScienceDirect, 2832 articles were found using the keyword "DNR,” with 209 articles relevant within the last five years.
Similarly, after applying filters in Google Scholar, 15 relevant articles were selected for review out of thousands of search results. A flow diagram depicting the database's literature search process is presented below.

![Flow Diagram](image)

**Fig. 1.** PRISMA-based flow diagram

**RESULTS**

This literature review utilized 15 articles meeting the inclusion and exclusion criteria, offering an overview of nurses’ ethical dilemmas regarding DNR and strategies to overcome them. Four sub-dimensions emerged from this review, including the impact of DNR on treatment, factors influencing DNR decisions, nurses' experiences and ethical dilemmas regarding DNR, and perceptions in overcoming ethical dilemmas.
Impact of DNR on Treatment

To clarify the purpose of care provided, the assessment of end-of-life status in critical care areas, particularly the ICU, should be conducted promptly [11]. Implementation of DNR instructions contributed to the moral stress experienced by ICU nurses [12] and led to burnout, which is directly linked to depression and work stress. In another study, ICU nurses caring for DNR patients exhibited higher burnout levels than the median, with burnout, depression, and job stress positively correlated. The highest level of depression was observed among ICU nurses below 25 years old [13].

Signing a DNR order correlates with reduced use of non-maleficence treatments to sustain life. A related study sheds light on decision-making mechanisms and potential benefits of DNR orders in critical care, revealing that many critically ill ICU patients signed DNR orders, which were associated with shorter ICU stays and higher rates of palliative care consultations [13]. Additionally, another study [14] suggested that DNR consent, signed by patients rather than surrogates, may reflect better patient autonomy and decreased use of life-prolonging treatments in the final seven days of patients with advanced kidney disease.

Factors Influencing DNR Decisions

Nurses encounter ethical dilemmas when caring for end-of-life patients in intensive care units. Ethically sound DNR decisions in oncology and hematology care require physicians and nurses to develop appropriate virtues and enhance their knowledge of ethical theories and relevant clinical guidelines [15]. Factors influencing DNR decision-making include religion/belief, limited resources, experience, familiarity with DNR information, and team collaboration [10] [16]. Additionally, various economic, educational, ethnic, and personal factors can influence individuals' attitudes and decision-making regarding DNR orders [16].

Nurses' Experiences and Ethical Dilemmas Regarding DNR

DNR entails a decision made at the end of a patient's life to avoid unwanted cardiopulmonary resuscitation [10]. Nurses are less likely to call rapid response or a physician when a patient undergoes specific clinical status changes if the patient is labeled as DNR/DNI (do not intubate) rather than complete code [17]. Most nurses in CPR teams have limited knowledge of DNR and termination of resuscitation (ToR) and limited competence in making appropriate decisions during CPR. These issues stem primarily from the lack of clear clinical guidelines for CPR and CPR staff's fear of the legal consequences of DNR and ToR [18].

Arianto et al. (2022) emphasized that "in caring for patients at the end of life, nurses and other medical personnel must consider ethics and ethical principles in making decisions and providing the best care for patients" [10]. Pettersson et al. (2020) highlighted that the DNR decision raises ethical considerations, with participants expressing the importance of avoiding harmful actions (non-maleficence) and ensuring a peaceful and "natural" death with
dignity for dying patients. They preferred the phrase "allow natural death" over the traditional "do not resuscitate" [15]. Conversely, research by Chang et al. (2020) indicated that participants with experience in actively initiating DNR discussions with patients or their families were significantly more likely to discuss DNR with patients in future care of terminal patients [19]. Consistent with studies by Lin et al. (2021), more participants (all nurses) reported having initiated discussions about DNR with patients' families than with patients themselves [20].

**Perceptions in Overcoming Ethical Dilemmas**

Addressing misunderstandings in patient care with DNR orders can involve nurse participation, which includes practice, education, advocacy, policy, and research. Kelly et al. [14] explained that while the definition of DNR may seem straightforward, its interpretation in clinical practice can be complicated. They emphasized that DNR should mean "do not resuscitate," not the acronym "Do Not Treat" (do not reduce treatment). Nurses have opportunities to address misconceptions about care for patients with DNR orders through practice, education, advocacy, policy, and research [21].

Overcoming ethical dilemmas in DNR management requires moral competence, which is acting based on ethical judgment. Ongoing ethics education and discussions to develop a common ethical language and an excellent ethical work climate can improve ethical competence and help nurses and physicians better collaborate with patients regarding DNR decisions, acting in the patient's best interests [15].

The ICU often implements DNR instructions. It is essential to consider promoting discussions of time-limited trials as a solution to help ICU terminal patients withdraw from non-beneficial life-sustaining treatments [13].
### Table 1

Summary of the DNR Studies

<table>
<thead>
<tr>
<th>Author and Year</th>
<th>Analysis: Research Design, Sample, Variables, Instruments, and Analysis</th>
<th>Results of Factor Analysis</th>
</tr>
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<tbody>
<tr>
<td>Ntseke et al. (2023) [12]</td>
<td><strong>Research Design</strong>: The explorative descriptive qualitative</td>
<td>The findings were classified under three main themes: moral distress, communication of DNR orders, and the unavailability of psychological support for nurses.</td>
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<td></td>
<td><strong>Sample</strong>: Twelve critical care nurses using the purposive sampling method.</td>
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<td></td>
<td><strong>Variables</strong>: Independent variable: elements influencing critical care nurses' moral distress while carrying out DNR orders. Dependent variable: DNR order</td>
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<td></td>
<td><strong>Instruments</strong>: semi-structured interviews utilized with exploratory-descriptive qualitative (EDQ) research</td>
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<td><strong>Analysis</strong>: Tesch's eight-step method for data analysis</td>
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<td><strong>The findings were classified under three main themes: moral distress, communication of DNR orders, and the unavailability of psychological support for nurses.</strong></td>
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<tr>
<td>Kelly, P.A. et al. [14]</td>
<td><strong>Research Design</strong>: mixed-methods study</td>
<td>Analysis of interview data revealed this overarching theme: varying interpretations of DNR orders among nurses were common, resulting in unintended consequences. Participants also reported perceived variances among healthcare team members, patients, and family members. Such misinterpretations resulted in shifts in care, varying responses to deteriorating status, tension, and differences in role expectations for healthcare team members.</td>
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<td><strong>Sample</strong>: 35 nurses responded to the case study survey. Thirteen nurses also completed a one-on-one interview. A purposive sampling technique was used.</td>
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<td></td>
<td><strong>Variables</strong>: Independent variable: nurses' perspectives on the meaning and interpretation of DNR orders about caring for hospitalized adults with such orders. Dependent variable: DNR order</td>
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<td></td>
<td><strong>Instruments</strong>: DNR case study survey and semi-structured interview guide</td>
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<td></td>
<td><strong>Analysis</strong>: Thematic analysis methods guided the analysis of qualitative data.</td>
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<tr>
<td>Pettersson et al., 2020 [15]</td>
<td><strong>Research Design</strong>: A Qualitative Study</td>
<td>The physicians and nurses in the study reflected on their ethical competence concerning DNR decisions, what they should be, and how they could be developed. The ethical competence described by the respondents related to the concepts of being, doing, and knowing.</td>
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<td><strong>Sample</strong>: fifteen nurses and sixteen physicians</td>
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<td><strong>Variables</strong>: Independent variable: the concept of ethical competence in DNR decisions Dependent variable: DNR decisions</td>
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<td></td>
<td><strong>Instruments</strong>: semi-structured interview guide</td>
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<td></td>
<td><strong>Analysis</strong>: Thematic content analysis</td>
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<td>Arianto et al., 2022 [11]</td>
<td><strong>Research Design</strong>: The Qualitative Phenomenological Methodology</td>
<td>Four themes were obtained from this study, namely, &quot;the dilemma between the family's decisions and continuing care,&quot; &quot;patient's life expectancy and the family's hope,&quot; &quot;DNR decisions and the nurse's confidence,&quot; and &quot;the family's understanding of the information provided.&quot;</td>
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<td><strong>Sample</strong>: eight participants using purposive sampling</td>
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<td></td>
<td><strong>Variables</strong>: Independent variable: the ethical dilemma experienced by nurses who provide end-of-life care in the ICU Dependent variable: end-of-life care in the ICU</td>
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<td>Author and Year</td>
<td>Analysis Research Design, Sample, Variables, Instruments, and Analysis</td>
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| **Shiu et al., 2022 [16]** | **Research Design:** A retrospective study  
**Sample:** 386 patients’ data from an electronic medical record using including and excluding criteria.  
**Variables:** Independent variable: the impact of signing a DNR order  
Dependent variable: DNR order  
**Instruments:** self-developed recording form  
**Analysis:** the independent t-test and chi-square test to examine whether a DNR was significant | The study found that DNR patients were less likely to receive cardiac resuscitation before death than non-DNR patients. The cardiac resuscitation treatments included chest compressions, electric shock, and cardiotoxic drug injections (p < 0.001). However, the life-sustaining treatments were withdrawn for only a few patients before death. |
| **Chang et al., 2020 [17]** | **Research Design:** cross-sectional survey  
**Sample:** 132 nurses by an odds ratio of 2.0 for the primary outcome and a power of ≥0.9.  
**Variables:** participants' experiences and attitudes regarding discussions of DNR and LST withdrawal for terminal patients  
**Instruments:** semi-structured questionnaire  
**Analysis:** Logistic regression with adjustments for covariates | Regression analysis showed that participants who had past experiences actively initiating DNR discussions with patients or patients’ families, participants aged 40.0 to 60.0 years were significantly less likely to have DNR discussions than those aged 20.0 to 29.9 years. Experience in actively initiating discussions about LST withdrawal with patients’ families, being male, and possessing an education level higher than university were significantly related to LST withdrawal discussions with terminal patients or their families in the future. |
| **Sok et al., 2020 [13]** | **Research Design:** A cross-sectional descriptive design  
**Sample:** 115 nurses caring for DNR patients in ICUs in South Korean hospitals were recruited through convenient sampling.  
**Variables**  
Dependent variable: DNR patients  
Independent variables: burnout, related factors of nurses caring (depression, job stress, and job satisfaction)  
**Instrument:** Questionnaire  
**Analysis:** Pearson’s correlation coefficient, A t-test and ANOVA, and Scheffe’s method | Burnout had a significant, positive relationship with depression ($r = 0.47$, $p < 0.001$) and job stress ($r = 0.57$, $p < 0.001$), but a significant, negative relationship with age ($r = -0.20$, $p = 0.032$). Depression had a significant, positive relationship with job stress ($r = 0.19$, $p = 0.038$) and a significant negative relationship with job satisfaction ($r = -0.22$, $p < 0.018$), age ($r = -0.37$, $p < 0.001$), and total working experience ($r = -0.33$, $p < 0.001$), and current career experience ($r = -0.37$, $p < 0.001$). |
<p>| <strong>Engels et al., 2020 [18]</strong> | <strong>Research Design:</strong> self-administered survey | Nurses are significantly less likely to call rapid response or a physician when a patient |</p>
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| **Yang et al., 2021** | **Research Design:** A Retrospective Observational Study  
**Sample:** patients elected using inclusion criteria between January 2014 and December 2018 in a tertiary teaching hospital in Taiwan: A total of 275 patients  
**Variables**  
Independent variable: the impact of different types of do-not-resuscitate consent on end-of-life treatments  
Dependent variable: patients with advanced kidney disease  
**Instrument:**  
Medical record reviews  
**Analysis:**  
Covariate, chi-square or t-test, and logistic regression for univariate and multivariate analyses | A total of 275 patients were included, of whom 21% signed their do-not-resuscitate consents. A total of 233 patients were followed until death, and 32% of the decedents continued hemodialysis, 75% underwent nasogastric (NG) tube placement, and 70% took antibiotics in their final seven days of life. In comparison to do-not-resuscitate consents signed by surrogates, patients' do-not-resuscitate consents were associated with fewer life-prolonging treatments, such as the placement of feeding tubes and the use of antibiotics in the previous seven days (odd ratio and 95% confidence interval, respectively, were 0.16, 0.07-0.34 and 0.33, 0.16-0.69). |
| **Bordbar, MRF, et al. 2019 [20]** | **Research Design:** cross-sectional  
**Sample:** 343 participants (201 patients, 95 family members, and 47 healthcare providers) from Omid Oncology Hospital, Mashhad, Iran, who were selected through a random, available sampling | 201 patients, 95 of their family members, and 47 healthcare providers (doctors and nurses) were surveyed. The mean age of participants was $48.75 \pm 15.62$ years. The |
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| Goodarzi, A. et al., 2022 [21] | **Research Design:** Descriptive cross-sectional  
**Sample:** 128 eligible nurses from the CPR teams of two hospitals in Kermanshah and Hamedan, Iran, who were recruited through purposive sampling  
**Variables**  
Dependent Variable: Terminating Resuscitation and Do Not Resuscitate Order  
Independent variables: knowledge, attitude, and decision-making of nurses  
**Instrument:** Instruments were generated using the latest international CPR guidelines and the existing literature on CPR.  
**Analysis:** Chi-square, Fisher's exact, Mann-Whitney U tests, Spearman's correlation analysis, and the logistic and rank regression analyses. | participants' attitudes regarding the DNR order significantly differed in 10 of the 11 items (P ≤ 0.005). Among the three groups of participants, healthcare providers showed the most positive attitude regarding the DNR order. Participants' attitude regarding the DNR orders was significantly associated with age, occupation status, residential place, educational status, and income level (P < 0.05). |
| Çuvalci et al., 2021 [22] | **Research Design:** cross-sectional descriptive study  
**Sample:** 327 health workers, including 77 physicians and 250 nurses, employed in internal and surgical clinics, intensive care units, and emergency services at two different university hospitals in the northeast of Turkey.  
**Variables**  
Dependent variable: Turkish Muslim physicians' and nurses' views about the Do Not Resuscitate order | Only 22.7% and 37.5% of participants had adequate knowledge about ToR and DNR. The significant predictor of DNR and ToR knowledge was educational level, and the significant predictors of decision-making for CPR were academic level, gender, and history of receiving CPR-related education (P<0.05). When facing a cardiac arrest and an indication of DNR or ToR, 12.5% of participants reported that they would not start CPR, 21.5% of them said that they would terminate CPR, and 14.8% of them reported that they would perform slow code. The DNR decision had a significant relationship with educational level, DNR knowledge, and ToR knowledge (P< 0.05). In contrast, the ToR decision had a significant relationship with academic level and ToR knowledge (P< 0.05). |
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<tr>
<td></td>
<td>Independent variable: the factors influencing doctors' and nurses' views on DNR</td>
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<td><strong>Instrument:</strong> The researchers reviewed and created the Structured Information Form to collect the data. relevant literature, the form comprises two sections, including 18 questions in total</td>
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<td><strong>Analysis:</strong> Chi-square test, binary logistic regression analysis.</td>
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<td>Lin et al., 2021 [23]</td>
<td><strong>Research Design:</strong> cross-sectional survey</td>
<td>More participants had experienced initiating discussions about DNR with patients’ families than with patients (72.2% vs. 61.9%, p &lt; 0.001). Unadjusted logistic regression analysis showed that the experiences of actively initiating DNR discussions with patients and patients were a significant factor associated with palliative care discussions (odds ratio [OR] = 2.91, 95% confidence interval [CI]: 1.09–7.79). On the other hand, the experiences of actively initiating DNR discussions with patients and patients’ families were significant factors associated with palliative care discussions with patients’ families (OR = 3.84, 95% CI: 1.22–12.06 and OR = 3.60, 95% CI: 1.19–10.90, respectively).</td>
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<td><strong>Sample:</strong> 128 nurses were randomly recruited from registered staff nurses ≥20 years of age responsible for clinical inpatient care in a tertiary hospital in northern Taiwan.</td>
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<td><strong>Variables</strong> Independent variable: nurses’ experiences of discussing do-not-resuscitate (DNR) decisions and their willingness to discuss palliative care with terminal patients and their family members</td>
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<td>Dependent variable: discussion about DNR and palliative care</td>
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<td><strong>Instrument:</strong> A semi-structured questionnaire</td>
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<td><strong>Analysis:</strong> Chi-square test, logistic regressions</td>
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<td>Mirhosseini. et al.</td>
<td><strong>Research Design:</strong> cross-sectional</td>
<td>The study reported mean scores for attitudes toward DNR order, the procedure of DNR, some aspects of passive euthanasia, and religious and cultural factors. The mean scores were 25.27 ± 2.78, 40.61 ± 5.99, 11.26 ± 2.51, and 6.12 ± 1.27, respectively. Additionally, the study identified associations between various demographic and professional factors and attitudes toward DNR orders. For example, the history of COVID-19-related deaths</td>
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<td><strong>Sample:</strong> 332 healthcare staff (treatment staff and clinical medical science students) from Shahroud University of Medical Sciences using the convenience sample method</td>
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<td><strong>Variables</strong> Independent variable: health care providers attitudes</td>
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<td></td>
<td>Dependent variable: do-not Resuscitate Order in COVID-19 Patients</td>
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<td><strong>Instrument:</strong> Questionnaire to evaluate attitudes toward the DNR order from Dunn (2000)</td>
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### Results of Factor Analysis

Analysis: Descriptive and inferential statistics (multivariate) linear regression analysis

Results of Factor Analysis

Among the relatives of healthcare staff was associated with a more positive attitude towards the DNR order in patients with COVID-19. Furthermore, the study revealed a significant and direct relationship between work experience and attitudes about the DNR order. It was also found that higher working hours increased the likelihood of a positive attitude toward the DNR order. Moreover, a history of COVID-19 in healthcare staff was a contributing factor to a more positive attitude toward passive euthanasia.

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**Clemente J. et al., 2023 [25]**

**Research Design:** cross-sectional with a descriptive survey

**Sample:** 120 registered nurses (RNs)

**Variables**

- Independent variable: DNR Status
- Dependent variable: the perceptions and actions of ICU and medical/surgical nurses in response to a patient's DNR status

**Instrument:**

A descriptive survey will be conducted with both quantitative and open-ended questions. The survey was modified from the original "Nurses Perceptions Surrounding DNR Status in the Critical Care Setting Survey," a 68-item survey of nurses registered with the Alberta Association of Registered Nurses. The modified survey was placed on an online platform, SurveyMonkey.

**Analysis:**

Answers in SurveyMonkey were analyzed, put into concepts, and coded. Codes were then categorized and synthesized into specific themes using thematic analysis

This resulted in a total end-to-end convenience sample of 120 RNs and a 26.4% response rate. The demographics of the sample reflect an average of 14.05 (SD 9.18) years of experience, 70% with a Bachelor of Science degree, 57.5% working in critical care, and 36.7% working as MST nurses. Many participants also claimed they would implement strategies to ensure the patient does not die alone (62.4%) while believing that patients may sometimes improve (76.3%). Another variation was found where participants responded they 'never' experienced emotional withdrawal from the patients with DNR orders (55.6%), whereas others responded they experienced emotional withdrawal sometimes.
DISCUSSIONS

DNR instructions impact the treatment provided to patients and care providers, particularly nurses. Studies indicate that patients who sign a DNR are less likely than non-DNR patients to receive cardiac resuscitation before death, and life-sustaining treatments were discontinued for only a few patients before death [19]. The decision to sign a DNR consent may reflect better patient autonomy and reduced life-prolonging therapies [21]. However, executing DNR orders is known to contribute to moral distress in critical care nurses [11], with studies showing higher levels of burnout, depression, and job stress among ICU nurses caring for DNR patients [20].

According to research, the decision to implement DNR instructions is influenced by several factors, including economic, educational, ethnic, and personal factors, as well as the knowledge of ethical theories and relevant clinical guidelines among physicians and nurses [13, 17].

When a patient is labeled as DNR, nurses are significantly less likely to call rapid response or a physician [18], and they often experience ethical dilemmas regarding DNR instructions. These dilemmas include concerns about the family’s decisions conflicting with continued care, the patient’s life expectancy versus the family’s hope, the nurse’s confidence in DNR decisions, and the family’s understanding of the provided information [16]. To address these dilemmas, nurses initiate discussions about DNR with the patient and the patient’s family, with past experiences significantly influencing future talks [15]. However, there are also dilemmas related to termination of resuscitation (ToR) knowledge and competence in making appropriate CPR decisions for patients who have signed DNR consent [23].

To overcome the ethical dilemmas of DNR, nurses have opportunities to address misconceptions about care for patients with DNR orders through practice, education, advocacy policy, and research [12]. Continuous education on moral and cultural issues can help reconcile attitudes between caregivers and patients [17]. Studies in Islamic countries like Iran and Turkey indicate a desire among physicians and nurses for the legal implementation of DNR orders [14]. However, there is a need for educational interventions and collaborative efforts to address conflicts between healthcare staff attitudes and religious teachings, fatwas, and laws regarding DNR orders [24]. Developing clear, culturally appropriate guidelines regarding DNR and ToR is also crucial to prevent potential harm and increase the involvement of CPR nurses in decision-making processes [23].

Nurses must enhance nursing care for patients with DNR orders. To safeguard patients’ autonomy and their rights to make decisions about their DNR and LST (life-sustaining treatment), there should be more discussions about DNR and LST withdrawal with patients. Measures are required to facilitate discussions of DNR and LST with patients to ensure better end-of-life care [15]. However, in the ICU, it is essential to consider that promoting discussions of time-limited trials might be a solution to assist ICU
terminal patients in withdrawing from non-beneficial life-sustaining treatments [19].

Our study compiles various literature discussing the ethical dilemmas nurses face regarding DNR. The novelty lies in summarizing problems from medical, biopsychosocial aspects, and treatment effects resulting from DNR instructions, as well as nurses' experiences and strategies for overcoming ethical dilemmas.

Several countries categorize DNR as an act "Against Medical Advice," where patients refuse recommendations from healthcare workers regarding their treatment plan. In Indonesia, the implementation of DNR is legally based on Ministry of Health Regulation Number 37 of 2014 concerning Determination of Death and Organ Utilization, indicating conditions not indicated for CPR, such as terminal conditions, irreversible diseases, and diseases with a prognosis of death [26]. From the literature presented regarding ethical dilemmas in DNR, it can be concluded that discussions on DNR should be further carried out to achieve end-of-life care goals. However, there is limited knowledge among the public and health service providers, including doctors and nurses, regarding the legality of these regulations, resulting in rare discussions with patients and their families regarding DNR.

LIMITATION OF STUDY

A limitation of our study is that we did not include Indonesian language literature from our own country due to the focus on English language articles. Only one English language article was found in Indonesia; thus, the phenomenon of DNR in Indonesia was not adequately reflected in this study.

IMPLICATION OF STUDY

The findings of this study can serve as a reference for readers when considering DNR practices in the field. Nurses have various responsibilities beyond obtaining signatures for legal protection when implementing a DNR. Firstly, when the family and patient make a DNR decision, nurses should engage in further discussions about stopping LST and ToR. Secondly, it is essential to ensure that DNR is legally recognized in the respective country to prevent careless implementation by healthcare providers. Additionally, there is a need to enhance knowledge and competence regarding the implementation of DNR to ensure that the intended aim of providing peaceful patient deaths is achieved.

CONCLUSION

Communicating DNR decisions with patient families can be challenging. Methods for facilitating discussions about DNR and LST with patients are necessary to protect patient autonomy and rights in decision-making regarding DNR and LST and to ensure better end-of-life care. Nurses require adequate training and education on end-of-life ethics, DNR decision-making, and effective team collaboration in DNR decision-making processes. Clear, culturally appropriate guidelines regarding DNR and ToR are essential to prevent confusion, legal or psychosocial issues, and concerns among CPR nurses and enhance their involvement in the CPR decision-making process. The
implementation of DNR can cause considerable stress to ICU healthcare providers. Strategies or interventions are needed to reduce burnout among ICU nurses caring for DNR patients. Additionally, national guidelines and legal frameworks for implementing DNR orders are necessary. Strategies or interventions are also required to alleviate fatigue in nurses caring for DNR patients.

REFERENCES

