

ORIGINAL ARTICLE

Navigating Do Not Resuscitate Orders: The Involvement of Critical Care Nurses in Malaysia

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ABSTRACT

Introduction: As primary caregivers, critical care nurses play a crucial role in the implementation of do not resuscitate (DNR) orders, ensuring that a patient's rights is respected while providing compassionate and effective care. However, there remains a gap in understanding the experiences and involvement of nurses in DNR orders, particularly in Malaysia. **Objective:** This study aims to explore the involvement of critical care nurses in DNR orders. **Method:** This study employed a qualitative research design and purposive sampling was used to recruit 12 nurses from an intensive care unit in one of the teaching hospitals in Malaysia. Semi-structured interviews were conducted to explore the participants' experiences in caring for patients issued with DNR orders. The data was analysed using thematic analysis. **Result:** Three main themes emerged from the data: 1) providing spiritual care; 2) limited roles in DNR orders decision; and 3) power imbalance. **Conclusion:** This study highlights the significant role played by critical care nurses in the implementation of DNR orders. Support from healthcare institutions is needed to enhance the nurses' roles and skills while fostering a collaborative environment where nurses can effectively participate in DNR decision-making process.

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These orders are important in managing end-of-life care as they guide healthcare providers in providing appropriate and compassionate care while respecting the patient's desires.

INTRODUCTION

Do not resuscitate (DNR) orders are legal written instructions that specify that there will be no initiation of cardiopulmonary resuscitation (CPR) in the event of a patient's cardiac or respiratory arrest (1). The implementation of DNR orders involves complex decision-making processes, requiring healthcare providers to carefully weigh patient autonomy, with other ethical considerations and clinical judgments. Furthermore, DNR orders should not indicate abandoning other types of treatment, rather, they explicitly direct that there must be no CPR action (2).

Critical care nurses are important in the healthcare system including in the implementation of DNR orders, especially in the intensive care unit (ICU) where they provide round-the-clock care to patients in critical conditions. Their expertise and dedication are crucial in managing life-threatening situations, administering advanced medical treatments, and offering emotional support to patients and their families. Among their responsibilities, involvement in the implementation of DNR orders stands out the most due to its profound ethical and emotional implications (3,4). A study found that many nurses were unsatisfied because they were not part of the DNR decision-making process and their opinions were not always heard (5). Such matters must

be considered as physicians organise the treatment procedure, whereas nurses constantly monitor the patients' condition and spend most of the time with them (6).

The exclusion of nurses from these critical decisions can negatively impact patient care, as nurses may feel disempowered or unsure about their role and how to align their care with the medical team's goal (7). Furthermore, this lack of involvement may contribute to moral distress, as nurses could struggle to reconcile their professional, ethical and moral judgement with the decision of those in-charge (8)

Henceforth, the discussion suggests the significance of understanding the experience and involvement of critical care nurses in DNR orders to improve its practice, policy, and support system within the local healthcare setting. Therefore, this study aims to explore the involvement of critical care nurses in the implementation of these orders by exploring their experiences and perspectives in caring for patients with the orders.

MATERIAL AND METHOD

Study Setting, Design, and Sample

This qualitative study was conducted at the ICU of one of the teaching hospitals in Malaysia from May until July 2022. A basic qualitative study design was chosen as it allows for in-depth exploration of participants' interpretation and meaning of their experiences making it highly suitable for understanding the subjective and complex nature of nurses' involvement in DNR orders (9).

A total of 12 participants were recruited using the purposive sampling method. The inclusion criteria were nurses working in the ICU setting for at least six months, able to communicate in English or Bahasa Malaysia, and voluntarily participated in this study. The inclusion criteria of a minimum of six months of clinical experience is consistent with previous research, where a similar threshold was employed to ensure participants have gained sufficient exposure to clinical practice, decision-making processes and patient care responsibilities, thus allowing them to provide informed and reliable insights (10,11). Nurses who did not meet the inclusion criteria such as those with less than six months of ICU experience, those who did not provide informed consent, and those on long leave (e.g., study leave, extended sick leave or maternity leave) were excluded from the study.

Materials and Data Collection

The data collection was done using in-depth, semi-structured interviews from May to Jun 2022. The recruitment of participants was done through the head

nurse of the ICU according to the determined inclusion criteria and the suggested participants were approached for consent retrieval and arrangement for interview. All interview sessions were conducted face-to-face in a private room away from other people. Each session was approximately 30 to 40 minutes and all interviews were conducted in Malay language based on the participants' preference. The interview sessions were audio recorded using two devices and field notes were taken for non-verbal communication cues that could not be captured through the devices. Additionally, a semi-structured interview topic guide was used during the interviews, which was designed to explore the participants' experiences and perspectives on caring for patients with DNR orders. The topic guide was reviewed by two field experts to ensure content validity.

The recruitment and interviews continued until data saturation was achieved, which occurred when no new information or themes emerged during the interviews (12). This is to ensure that the data collected is sufficient to cover the depth of the topic and that further interviews would not add significant new insights.

Data Analysis

The data was analysed using thematic analysis, which is commonly used in a qualitative study to systematically organise, identify, analyse, and report the patterns within the data (13). It allows for a flexible yet detailed examination of data that is suitable for exploring participants' experiences on DNR orders in ICU setting. The analysis began with an initial phase of familiarisation, where all interview recordings were listened repeatedly and transcribed into written form. The transcriptions were also carefully reviewed. Initial codes were then generated, where interesting features of the data were coded, and data was collated relevant to new codes. Then, themes were generated when the initial codes were grouped into the emerging themes. These themes were reviewed to ensure their relevancy with the coded excerpts. Then, the themes were further defined and clear definitions and names for all themes were generated. Finally, findings were reported by including compelling excerpts and producing a scholarly report.

To ensure the trustworthiness or rigour of the study, other researchers acted as peer reviewers and examined the research process and the data analysis in peer debriefing. Besides, reflexivity was practiced by the researchers to remain aware of any biases and to ensure the findings.

Ethical Consideration

This research was approved by the Kulliyyah of Nursing Postgraduate Research Committee (KNPGRC) and the International Islamic University Malaysia Research Ethics Committee (IREC) (IREC No. IREC 2022-KON/9).

Approval from the Clinical Research Centre (CRC) of the respective hospital was also obtained. All details regarding the study were briefed to the participants and informed consent was obtained from each participant before the interview session. All information provided by the participants was kept confidential.

RESULTS

A total of 12 ICU nurses were involved in this study and all of them were Muslim. A majority of them had diplomas and only one nurse had a bachelor's degree. Their working experience ranged from one year and six months to 19 years. The participants' demographic profiles are detailed in Table 1.

Table 1: Demographic profile of the participants

Participants	Religion	Educational Level	Total of Working Experience
1	Islam	Diploma	19 Years
2	Islam	Diploma	1 Year 5 Months
3	Islam	Diploma	12 Years
4	Islam	Diploma	2 Years
5	Islam	Diploma	5 Years
6	Islam	Diploma	3 Years
7	Islam	Diploma	3 Years
8	Islam	Diploma	2 Years
9	Islam	Diploma	1 Year 6 Months
10	Islam	Degree	14 Years
11	Islam	Diploma	2 Years
12	Islam	Diploma	3 Years

Theme 1: Providing spiritual care

The participants unanimously recognised that they not only provide basic nursing care needs but also spiritual care to their patients with DNR orders, emphasising the holistic nature of their responsibilities. For instance, a participant highlighted nurses' active role in supporting Muslim patients with their religious practices including reciting the shahadah or Quran to provide solace.

"We as a Muslim will teach the patient to recite the shahadah, recite Yassin if there is time. Yes we do it here. Other than that, we will play any Quranic recitation, surah Yassin or any surah that we usually hear on the computer for them to hear. Then we will ensure that their family is with them but if their family member is far away, we usually do Google Meet". (Participant 1)

Moreover, the participants demonstrated a commitment to facilitating spiritual care for all patients regardless of their race and religion. They acknowledged the importance of respecting and accommodating diverse religious practices. This is evident in the following excerpts which highlight their flexibility and respect for the beliefs of non-Muslim patients.

"For non-Muslim patients, we usually allow the relatives to be there and they have their own prayers right... We allow them to perform their prayers as long as it doesn't disturb other patients". (Participant 10)

"For Muslim patients, I will teach them to recite the shahadah. For Chinese patients for example, I'm not sure what it is but sometimes they put something besides patients. I will always ensure that it is there and respect their beliefs". (Participant 8)

Theme 2: Limited roles in DNR orders decision

A majority of the participants described their role in DNR discussions as primarily being witnesses, with limited opportunities to actively contribute. Despite this, they expressed a strong desire to be more involved in the decision-making process, particularly in providing relevant information about patients' conditions. This desire reflects their recognition of the unique and valuable insights they hold as a nurse in caring for patients.

"We mostly act as witnesses, but we have the right to explain about our patients during family conferences because we take care of the patient 24/7 hours. We have the right to discuss with the family so that they know the patient's current condition, before and after because most of the doctors do not include all... (Participant 3)

"It needs to be in line. It cannot be only treatments and ignoring nursing care. No. Both need to be in line. When we settle discussing on the medical part we can discuss the nursing part and then we can get a good view of our patients... " (Participant 10)

On rare occasions, some nurses reported proactively informing physicians about their patients' deteriorating condition prior to family conferences. This proactive role, although limited, demonstrates a potential pathway for enhancing nurses' contribution to DNR decision-making processes. However, the hesitancy to fully engage in the discussion may relate to the traditional hierarchical nature of ICU settings.

"It's like this...usually any decision the doctor will decide...but I will discuss with the doctor before meeting with the family. "Doctor...I think this patient has no hope...no presence of cough and gag during suctioning and the patient's pupil is fixed...You need to explain this to the family."" (Participant 3)

"I will voice out before family conference, during the family conference, only when being asked." (Participant 7)

Theme 3: Power imbalance

The analysis revealed that one of the major challenges for the nurses' involvement, especially in the discussion about DNR orders is power imbalance. Nurses are perceived to have less power compared to physicians, which undermines their ability to contribute effectively to discussions and decisions regarding these orders.

Some of the participants expressed concerns that their contributions might not be taken seriously by others or that they could make mistakes. These fears may indicate a lack of confidence or a perceived lack of authority in their role.

"It's not that I'm shy but I'm afraid that people won't believe what I said." (Participant 11)

"Yes I do feel like I wanted to (be involved) but the doctor won't ask for it...because afraid that we wrongly say something." (Participant 2)

They also felt obligated to accept the decision for DNR orders made by physicians and families and perceived that the families trust physicians more than nurses.

"That kind of opportunity is actually good, so that we can discuss. Every person has their own opinion, right, but when the doctor already explained and the family has given their decision, we have to accept it too." (Participant 9)

"Sometimes I feel like the doctor...their opinions...the family trust them more compared to staff nurses." (Participant 4)

The participants reflected that such conditions happened due to their lack of medical and nursing knowledge. They acknowledged the need to improve their knowledge before having the confidence to contribute to DNR orders in addition to having adequate experience. These reflections indicate that the power imbalance felt by nurses in decisions related to DNR orders is influenced by their perceived lack of knowledge, leading to a diminished role in critical discussions.

"I agree but in terms of nursing knowledge...must improve. In terms of medical knowledge also need to improve. I would take that opportunity but must improve in that terms...For now, I am not yet ready for it." (Participant 8)

Thus, some of the participants highlighted the necessity of enhancing their knowledge base to build the confidence required for effective participation in DNR decision-making process.

"When you have the experience then you will know what is right and wrong and then you need knowledge too. What's the point of having experience without knowledge?" (Participant 10)

"So if I want to voice out...I'll be needing more knowledge." (Participant 11)

DISCUSSION

This study revealed that the majority of participants are actively involved whenever a patient has been issued with DNR orders. One significant aspect of their involvement is providing spiritual care to patients, which is essential for the patients' well-being and supports individual progression toward acceptance (14). In contrast to other studies where nurses perceived DNR orders as one of the barriers to delivering optimal care (5,15), the participants in this study highlighted that nurses are committed not only to providing basic nursing care needs but also to offering spiritual care to their patients with DNR orders, regardless of their race and religion. The holistic care that they provide is aligned with patient centred care framework where they respect and facilitate individual beliefs and values even in situations where curative care is no longer possible (16).

Additionally, the study revealed nurses' recognition of their limited involvement in DNR decision-making, as they predominantly serve as witnesses to these discussions. They expressed a desire to engage more meaningfully in these decisions. They emphasised the importance of shared decision-making between physicians, nurses, and family members to ensure the best patient outcomes. One of the participants highlighted that nurses spend a considerable amount of time with patients and feel they have the right to discuss the patients' conditions with their families. This aligns with the American Nurses Association's recommendation, which advocates for nurses to collaborate with other healthcare practitioners to ensure satisfactory management and support for patients and their families during end-of-life care (17). However, some participants felt powerless and frustrated because they believed certain information needed to be communicated but were not allowed to speak about their patients during discussions. Similar finding was found in another study where ICU nurses struggled with physician communication and expressed concerns that physicians failed to provide a clear picture of the patients' conditions, leading families to have false hopes (18). On rare occasions, some nurses had active discussions with physicians before the DNR decision-making process to ensure their opinions were considered. Some physicians even sought nurses' input before discussing DNR decisions with families. However, this is not commonly found in the literature where ICU nurses felt their opinions were often disregarded by physicians (18). The limited involvement of nurses in DNR decisions may lead to moral distress that develops as they cannot carry out the care that they believe to be the most appropriate for the patients (19,20).

Despite their strong desire to be actively involved in

DNR decision-making, the participants acknowledged several potential barriers to such goal. A primary barrier is power imbalance, which they associate with a lack of knowledge. Similar to the findings of previous literature, this study found that nurses' confidence in discussing end-of-life care options with physicians, patients, and their families is influenced by their perceived power imbalance and their level of knowledge (6, 21). The participants perceived that family members believe that physicians have more authority and power during the DNR decision-making process. They also felt that families trust physicians more than nurses, which is consistent with a study where the participants agreed that physicians are more suited to make DNR decisions due to their specialised role and medical expertise (6). As noted by participants, gaining experience and improving their knowledge base were seen as essential steps toward overcoming this power imbalance. This indicates a need for greater focus on nursing education and professional development especially in areas related to end-of-life care, ethical decision-making and DNR orders. The nurses also may benefit from having clearer guidelines for DNR orders which is important in avoiding potential confusion, and legal or psychosocial issues surrounding the orders, which ultimately facilitating their involvement in DNR decision-making discussion (22).

CONCLUSION

This study highlights the commitment of ICU nurses to providing holistic care, including spiritual support, for patients with DNR orders. They are also committed and wish to contribute more significantly, rather than merely acting as witnesses. However, many of them perceived power imbalances had limited their involvement in the process. These imbalances are mainly attributed to nurses' lack of confidence in their level of knowledge. Therefore, to empower them, targeted education and training are essential. Knowledge improvement should focus on enhancing their understanding of medical decision-making, ethical considerations and DNR protocols, while also fostering a culture of collaboration and shared decision-making in deciding on DNR orders. Addressing these issues can improve patient outcomes and nurse satisfaction, ultimately promoting a more integrated approach to end-of-life care. The limitation of this study is that it was conducted within a specific cultural and institutional context, which may limit its applicability to other settings. The experiences of nurses in different settings might vary significantly. Therefore, future research should explore strategies to enhance nurses' roles in DNR orders across diverse healthcare settings and cultures.

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