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Do Not Resuscitate Guiding Principle: Analysis and Evaluation

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Abstract

The DNR order is complex and interrelated with multidimensional factors. The cancer patients during end stage of disease process need a pure palliative care to be die as peaceful as possible. To achieve such outcome, much medical order must be hold like CPR.

To avoid any dilemma regarding CPR holding, the DNR policy must be stated. In this analysis a one policy was chosen to be evaluated. After comprehensive evaluation to the policy, many missed parts are founded. The major alternatives focused on complete description about CPR; DNR should be planned order; the options for mentally ill patients; and the patients right to request the DNR or/and to hold the DNR order later.

The above alternatives were used, added and supported by research and policies evidences. Each alternative was evaluated; the negatives and positives points were stated clearly as well. The new policy was reported and planned to be implemented in future.

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Introduction

Do Not Resuscitate (DNR) order is an example of end of life care needs for cancer patients during terminal stage of cancer disease. In which the Cardiopulmonary Resuscitation (CPR) order will be hold in case of cardiac or respiratory arrest[1]. In most cases of cardiac arrest, the nurses take a responsibility to call CPR team and make efforts to safe patient's life, unless the DNR order is present. But in cases of absence of such order, legally the nurses aren't empowered to hold CPR even when they know that the case is medically futile[2].

When cancer patients are critically ill, CPR may not function or may work only partially, leaving the patient's brain-damaged or worst medical condition than before the patient's heart stopped. In such cases, certain Patients go to prefer to receive medical care without hostile efforts at resuscitation when they die[3].

The DNR authorities create a field of competition and conflict between two opposite ideas. The first idea believes that the medical team has the only authority to make a decision about DNR, because they are equipped with physiological and medical status of terminally ill patients. On the other hand, the second idea believe that the patient and family have a completely right regarding patients self determination, therefore the decision should be shared with patient and family[4].

In USA, 77% of patients had a DNR order at the time of death, while 13% had an order upon admission. The support study revealed that 39.5% of cancer patients at time of end of life preferred the DNR order, but DNR orders were actually written for only half or less of those patients[3].

In Arab and Muslims countries the DNR become more familiar among patients who are near end of life. The policies regarding DNR are established to regulate the process. Even though a clear policy exists, compliance with the policy is poor, namely addressing DNR status of the patient on admission, completion of DNR documentation, and explanation of the decision to the patient or family[5].

The DNR is an ethical dilemma, and faced by many problems regarding nurse's responsibility, doctor's authority, right of patient to make a decision, time of DNR order, and the slandered of DNR practice. Therefore the policy of DNR is used to manage and regulate all the emerge troubles. Policy can be defined as a "decisions that govern action", and usually it's a result of politics actions[6].

Polices are standardized the action and practice, which mean high quality of care. But policies aren't free from weakness

points, therefore the policy analysis is used to understand the policy, determine negatives by evaluation, and establish a new policy. Policy analysis is a systematic comparison and analysis of a set of policy alternatives to determine which option is most likely to achieve a set of objectives - whether political, economic, social, or otherwise[7].

In this paper, the DNR policy a Jordanian hospital will be analyzed. The current policy is attached in Appendix (A). The objectives this paper are: Emerge the importance of clear and comprehensive policy that standardized the issues and practice regarding DNR; identify the area of weakness in DNR policy; and formulate an alternative DNR policy to be used.

Methods

In order to achieved the purpose of the current policy analysis; the studies were found through an electronic search of the literature using the databases Pub Med, Ovid and EBSCO. The included studies published from 2007 to 2015 and the following search terms were used alone and in combination: "policy", "analysis", "cancer", "nurse and nursing, DNR". Additional articles were found through Google search.

Initial selection took place by assessing title and abstract. When these appeared to meet the study purpose, full-text articles were obtained, read extensively, and assessed in depth.

Establishing evaluation criteria

The purpose of DNR policy was clearly stated, but the values and objectives are missed. The desire outcome of the policy is to maintain the highest level of dignity for cancer patients during end stage of disease process. On the other hand the undesirable conflicts between health care providers, physicians and patients, or among patients and family members may be emerge regarding the best decision of DNR.

Therefore the comprehensive criteria will be used to evaluate the DNR policy, to ensure that the multidimensional characteristics are covering the policy.

Administrative ease

Administrative ease reflects the ability of the policy to be manageable and usable by system hierarchy. The administrative ease criteria of the policy come from two dimensions. First, it's available for all health care providers on a computerized system of a hospital. Second, the most concepts are defined clearly which reflect the usability of policy even by new physicians or nurses.

Effectiveness

Effectiveness reflect the degree of accuracy and successful to achieve the desire objectives. The current policy is stated clearly to achieve the outcomes. But we need to be more effective by using new options.

Costs and benefits

The DNR procedure is costly effective over terminally ill cancer patients, because many related equipments and procedures are hold, for examples; mechanical ventilator and endotracheal intubation.

Equity

The set of principles that maintain the fairness toward all concerns is equity. The DNR policy met the safety approach for health care providers and for patients. It's formally supported and gives the rights for all relevant parties to make a decision.

Legality

The policy is legally reviewed and approved by medical board. The medical ethics committee was reviewed and updates the policy regularly.

Political acceptability

The DNR order become widely used in hospitals, it's now more accepted and supported by legal (low), social and religious authority. Therefore the policy isn't against political issues.

Cultural factors

Patients and their relatives need to be well prepared before discussing the DNR issue. Culturally, such order is not easily accepted. Therefore, more emphases need to be put on family education about DNR order and all other end of life issues.

Identifying alternatives

The current policy is solid in general, applicable and the basic criteria requirements are covered. But some questionable values and additives are vital to be included in the policy. The policy need the following components: 1) that is important to define the CPR and clarify it in term of oncology; 2) the DNR should be planned (as a policy) upon admission for specific patients according to the medical condition of patients; 3) that is not clear what are the options of decision making for mentally ill patients; 4) we need an alternative in case if patient request DNR (based on patients wishes); and 5) it's crucial to understand the policy if the patients change the mind about the DNR after the order take effect.

Assessing alternatives

The alternatives will be assessing according to the criteria of policy administrative ease, effectiveness, equality, legality, and political acceptability. For the first alternative, CPR and DNR are opposite procedures. Patients and families have the right to understand what are usually done and what are usually hold. Therefore the complete description of CPR procedure is needed in DNR policy[8]. The CPR must be at the beginning part of policy (before detailing the DNR).

For the second alternative, the physicians' experiences, multidisciplinary consultation and patients' hemodynamic status are factors that should be used to estimate if the patient near end stage of cancer disease or not. That mean the general statues of patients can lead the health care providers to plan the DNR order.

For the third alternative, the DNR order depend on decision making that shared between health care providers and patients. But in cases of mentally deterioration of end stage patients; the alternative person must be present to make a decision[9].

For the fourth alternative, the wishes for dying patients are important part of palliative care. The responding to patients requests is vital to end the patient's life as peaceful as possible. But what the oncology nurse should do when the patients request the DNR? Is it conflicting with health care providers' decisions? In term of equity the request must be take effect or at least it should not to be neglect (Deciding about CPR. Retrieved from http://wings.buffalo.edu/bioethics).

For the last alternative, when the DNR take action and the patient change the mind about the order later on what the solving. From my point of view; since the order begins with patients decisions it must be end with their own decisions. (Table 1-3)

Table 1: Comparison between Alternatives.

Alternatives	Administrative Ease	Equality	Effectiveness	Legality	Political Acceptability
CPR description	Easy	Equal and safe	Effective	Legal	Accepted
Planning the DNR	Easy	Equal and safe	Effective	Legal	Accepted
Decision making for mentally ill patients	Easy	Equal and safe	Effective	Legal	Accepted
Patients request DNR	Not easy	Equal and safe	Less effective	Legal	Accepted
Patients change the mind about DNR	Not easy	Equal and safe	Less effective	Legal	Accepted

Table 2: Strengths and Weakness of Alternatives.

Alternatives	Strengths	Weakness
CPR description	CPR is a common procedure in health setting, the cancer patients have a suspected to be arrested and in daily conditions the order takes effect. Therefore the patients and family must know that the important live saving order will be hold.	The patients stress level may increase when they know that a many medications, devices and intubation process will be stopped.
Planning the DNR	All next procedures will be expected, the patients and families are prepared well, and saving the health care providers time.	Clinically, the vast majority of people requiring resuscitation Suddenly, planning for things occur in unexpected time is problematic.
Decision making for mentally ill patients	The delegation to make a decision to someone relevant or to a close friend is a good option for mentally ill cancer patients. Usually the delegated person is equipped and aware about patients' preferable things.	Such decisions are totally personal. Even the close relevant or friend can't take a correct decision 100%.
Patients request DNR	Save the patients and families right to choose the best regarding end of life. Allow natural death is one of patient's rights.	Not all wishes or requests are medically applicable; it is create a dilemma.
Patients change the mind about DNR	Maintain patients' equity.	The unexpected change is difficult. The health team needs to change the plan of care.

Table 3: Research and Policies Evidences of Alternatives.

Alternatives Policies	Research Evidence	Policy Evidence
CPR description	The option is useful to simplify the meaning of end of life care. It's a necessary conversation between providers, patients, and families to achieve the goal[7].	The policy is applicable in Peninsula Community Health, 2011.
Planning the DNR	Can benefit patients who have elected specific limits on life-support and treatments. Improve patient comfort[9].	The policy is applicable in New Jersey hospital, 2010.
Decision making for mentally ill patients	That promotes more effective communication and end-of-life discussions for patients, families, surrogates, and health care practitioners[8].	The policy is applicable in New York State Department Of Health, 2012.
Patients request DNR	Flexible policy promotes the comfortable measures of patients near end of life[8].	The policy is applicable in NYS Department of Health, 2010
Patients change the mind about DNR	Its unusual event, but if emerge, the patient right take must take place[8].	The policy is applicable in NYS Department of Health, 2010

Discussion

In late stage of cancer disease the aim of medical treatments, nursing interventions and doctor orders is to maintain the highest level of quality of life as possible. Which mean that all sequences of different treatment modalities use to care the patients rather than to cure the disease. CPR order one of the medical choices that applicable in cases of cardiac arrest, pulmonary arrest or both. But CPR, even when it successful, consider as a one of the factors that interrupt the major purpose of treatment of cancer patients when they are near end of life, which is maintain the high quality of life.

Therefore the opposite order was established and become widely usable among cancer patients, it's a DNR order. The aim of such order is hold the cardiac resuscitation, medications that sustain the life and intubation. Allow the patients to be naturally died, not mean that the other treatment modalities will be hold. Under DNR order the chemotherapy, palliative medications and all other procedures will continue. The nature of DNR emerge a state of confusion among patients, families or even health care providers themselves. Ethical, religious, social and political issues are take effect according to multi factorial background for each member. Therefore the policy should be stated.

Based on above, the DNR policy must be clearly stated, strongly enough and take in mind every single things regarding order process. In this paper analysis the policy was missed some parts or values and the alternatives was established to close the gap. One of the alternatives was the well definition of CPR, that will be facilitating the understanding of DNR and the picture will be clear. Note that the description of CPR will put the patient in temporary stress situation, the other stakeholders will know exactly what they are going to do[7].

The oncology nurses are the primary care givers for terminally ill patients in most cases. They are equipped with patient situation and overall medical picture. But they haven't the authority to apply the DNR order in case of sudden arrest. For that the policy should state the DNR procedure as a planning for all terminally ill patients upon admission[10]. The alternative about decision making for mentally ill cancer patients must be clearly reported. The communication with patients in DNR order is crucial. But if the patients can't due to mental factors the other significant one should be acquainted. This step will not be applicable if the above alternative was missed (early planning of DNR). Upon admission the patients must be signed to delegate the decision making to at least two relevant or close friends. They will be decision makers when the patients are mentally deteriorated[8].

The last two alternatives were about patient right to request the DNR and to change the mind after the DNR order. In both cases the equity takes the patients right for such requests. But the medical condition of patients will be neglect because the only patients' whishes take effect. That mean more equipments and procedures will be used, it's not costly effective and increase the load over nurses.

Evaluating alternatives

To move the policy concepts to reality and take effect, the policy will be presented to the organization to be approved and take a legal structure. The policy components (purpose, guidelines, procedures… etc) will define clearly for health care providers and patients.

To ensure the policy effectiveness, the policy will be tested within a time frame. Then the final decision will take place. Policy can be evaluated at different time. Therefore the new policy will be evaluated by administrator as an operation process of patients planning. Also, a health care provider will evaluate the policy by using specific criteria. Finally, the patients and families have a chance to evaluate the policy implementation process depending on their own feedback.

The policy failure is expected, the failure might relate to misunderstanding of policy, or due to implementation of policy. Other unexpected factors may play role in the failure. However all efforts will done to avoid any error or failure as possible.

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