

ETHICAL DILEMMA IN A PATIENT WITH A DO-NOT-RESUSCITATE ORDER (DNR): A CASE REPORT

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ABSTRACT

Adhering to professional ethics is fundamental in-patient care. The primary ethical principle is to respect the patient's autonomy in decision-making. However, in many clinical settings, particularly in jurisdictions like Iran, this principle faces significant barriers due to legal and religious interpretations of the "sanctity of life." This article argues that the concept of autonomy, specifically the patient's right to refuse treatment, must be the foundational framework before discussing complex end-of-life decisions like "Do-Not-Resuscitate" (DNR) orders.

We report a case of a 91-year-old patient who returned to Iran with a pre-existing DNR request. The subsequent conflict between his autonomous wishes and local clinical mandates resulted in a traumatic outcome for both the patient and the nursing staff. We analyze how the lack of clear legal guidelines regarding DNR, combined with systemic resource allocation issues, creates profound moral distress for nurses.

This paper advocates for a transition from a reactive clinical approach to a proactive, ethics-based legal framework that honors patient autonomy while safeguarding healthcare providers.

KEYWORDS

Ethical principles, principle of independence, cardiopulmonary resuscitation, ethical challenge, nurse

INTRODUCTION

Nurses are the largest group of healthcare service providers globally. The mission of this profession is to provide necessary healthcare, treatment, and rehabilitation services at the highest standard level to ensure the promotion and maintenance of society's health [1]. In order to achieve these goals, nurses must adhere to ethical principles. Beyond simple technical competence, the moral agency of the nurse is tested in the crucible of end-of-life care, where personal values, religious beliefs, and professional obligations often collide [2]. To navigate these dilemmas, one must first establish a hierarchy of ethical discourse. At the apex is the Principle of Autonomy, which dictates that competent individuals have the absolute right to self-govern, including the right to accept or refuse any medical intervention [3]. A DNR order is not a request for euthanasia, nor is it an abandonment of care; it is the exercise of a patient's right to refuse a specific, highly invasive medical intervention when it contradicts their personal goals of care [4].

Independence comes from the Greek root "Auto-Nomos," where "Auto" means self and "Nomos" means law. In general, it means that a person establishes their own rules and makes decisions about their affairs [5]. Independence is the right that a person has to determine their destiny, rooted in society's respect for recognizing people's informed decisions about their issues [6].

Autonomy in bioethics refers to respecting a patient's decision and choice. Patient autonomy is the patient's right to choose treatment without the intervention of health authorities [7, 8]. Patients with incurable diseases or fear of injuries caused by the CPR process may choose not to receive it when their condition deteriorates [9]. CPR includes all basic and advanced treatment measures in cardiac or respiratory arrest due to various clinical reasons [10].

The Iranian legal and ethical landscape presents a unique challenge. While the ethical principle of autonomy is globally recognized, its implementation in Iran is constrained by a legal system that views the withdrawal of life-sustaining treatment as a potential liability. Currently, under Iranian law, the duty to preserve life is so paramount that a patient's prior refusal of CPR might be interpreted by courts as a form of "intentional homicide" or "abandonment," regardless of the patient's documented wishes [11]. This legal rigidity forces clinicians into a defensive medical practice, where they prioritize legal compliance over the ethical duty to honor patient choices. This creates a double bind for nurses, who are trained to be patient advocates but are legally shackled by a system that refuses to acknowledge the legitimacy of DNR order [12].

Crucially, the moral distress experienced by nurses in these scenarios is not solely due to the violation of patient autonomy. It is deeply rooted in the structural failures of the healthcare environment. For instance, when resources are scarce such as the limited availability of ICU beds or the inequitable allocation of life-support equipment nurses often feel the moral weight of being forced to perform futile CPR on patients who have expressed a desire for a peaceful death [10, 12]. This not only exhausts physical resources but also causes moral injury to the nurse, who feels complicit in a process that they know is medically futile and ethically discordant with the patient's dignity [13].

This presents a moral challenge for nurses; what should be done in opposing the law and religious teachings while respecting the patient's wishes and decisions for their treatment process?

CASE INTRODUCTION

In March 2023, a 91-year-old male with a history of hypertension, osteoporosis, and previous percutaneous coronary interventions was admitted to an intensive care unit (ICU) in Tehran, Iran, due to decreased consciousness and hypoxemia (O₂ sat <80%). The patient had been recently treated for aspiration pneumonia in Los Angeles, where he had signed a formal DNR document.

Upon admission, the family presented these documents. They explained the patient's desire to avoid the trauma of intubation and CPR, preferring a peaceful end-of-life. However, the hospital administration and the treating physicians, guided by a conservative interpretation of Iranian law, clarified that such documents carry no binding legal weight in the ICU. The team felt they had no choice but to follow standard resuscitative protocols to avoid professional and legal repercussions.

Two days post-admission, the patient's condition worsened. Despite the vocal objections of the family, the patient was intubated. When cardiac arrest occurred, the staff initiated full resuscitation measures. The patient died shortly thereafter. In the aftermath, the nursing team reported a profound sense of moral distress. This was exacerbated by several factors:

1. The feeling of powerlessness in failing to protect the patient's bodily integrity;
2. The cognitive dissonance of witnessing a traumatic, futile intervention that ran counter to the patient's stated goals;
3. The systemic frustration of a work environment where defensive medicine is prioritized over compassionate, patient-centered care. The nurses felt that their role had been reduced to mechanical function, stripped of the ethical capacity to advocate for a dignified death.

DISCUSSION

The implementation of a DNR order is a fundamental expression of human autonomy. The failure to honor it in this case underscores a systemic void in Iranian healthcare [14]. To bridge this gap, we must reconsider how we integrate ethical principles into clinical practice:

1. **Prioritizing Autonomy:** Clinical decision-making must move away from the assumption that saving life at all costs is the only ethical imperative. Respect for patient autonomy includes the right to a dignified death, which necessitates the formal recognition of DNR requests [3].
2. **Addressing Legal-Ethical Friction:** It is time for Iranian lawmakers and clinical ethics committees to move beyond the traditional binary of Resuscitate vs. Murder and develop a legal framework that recognizes the validity of Advanced Directives (Ads). This would provide the necessary safe harbor for clinicians to act in accordance with patient wishes without fear of litigation [2,3].
3. **Broadening the Scope of Moral Distress:** Moral distress is not merely a philosophical byproduct; it is a clinical hazard. As demonstrated by the scarcity of resources, when nurses are forced to perform futile procedures, it compromises the overall efficiency and humanitarian quality of the ICU. Healthcare institutions must implement structural support mechanisms, such as ethics consults and debriefing sessions, to address these issues before they lead to nurse burnout and moral injury [15,16].

In conclusion, the case of this patient is not an isolated event but a call to action. By aligning our legal mandates with global ethical standards, educating staff on the nuances of autonomy, and acknowledging the environmental triggers of moral distress, we can ensure that patients like the one described in this report receive care that respects their dignity rather than merely prolonging their suffering [17,18].

ETHICAL CONSIDERATION

The ethical considerations and scientific value of the report were discussed with the late H.SH.'s wife and children, who have given their consent for the publication of the results. Additionally, this study was conducted in compliance with the standards of the Organizational Ethics Committee of Tehran University of Medical Sciences and the 1964 Declaration of Helsinki.

References:

1. Hawthorne DM, Gordon SC. The invisibility of spiritual nursing care in clinical practice. *Journal of Holistic Nursing*. 2020;38(1):147-55.
2. De Brasi EL, Giannetta N, Ercolani S, Gandini ELM, Moranda D, Villa G, et al. Nurses' moral distress in end-of-life care: a qualitative study. *Nursing Ethics*. 2021;28(5):614-27.
3. Laakasuo M, Palomäki J, Kunnari A, Rauhala S, Drosinou M, Halonen J, et al. Moral psychology of nursing robots: Exploring the role of robots in dilemmas of patient autonomy. *European Journal of Social Psychology*. 2023;53(1):108-28.
4. Both-Nwabuwe JM, Lips-Wiersma M, Dijkstra MT, Beersma B. Understanding the autonomy-meaningful work relationship in nursing: A theoretical framework. *Nursing outlook*. 2020;68(1):104-13.
5. Molina-Mula J, Gallo-Estrada J. Impact of nurse-patient relationship on quality of care and patient autonomy in decision-making. *International journal of environmental research and public health*. 2020;17(3):835.
6. Hughes J, de Gray L. Ethical challenges faced when there is a mismatch between guidelines, patient autonomy and clinical practice. MA Healthcare London; 2021. p. 1-4.
7. Schneider-Kamp A, Askegaard S. Putting patients into the centre: Patient empowerment in everyday health practices. *Health*. 2020;24(6):625-45.
8. Rusnac IM, editor The principle of autonomy and its particularities in the local community. *MedEspera*; 2020.
9. Chen R-Y, Li Y-C, Hsueh K-C, Wang F-W, Chen H-J, Huang T-Y. Factors influencing terminal cancer patients' autonomous DNR decision: A longitudinal statutory document and clinical database study. *BMC Palliative Care*. 2022;21(1):149.

10. Safari Malak-Kolaei F, Sanagoo A, Pahlavanzadeh B, Akrami F, Jouybari L, Jahanshahi R. The relationship between death and do not resuscitation attitudes among intensive care nurses. *OMEGA-Journal of Death and Dying*. 2022;85(4):904-14.
11. Mohammadpour S, Behzadipour S, Ghazbani A, Khaleghi MM, Mehdizadeh G, Hosseinpour F, et al. A legal right or violation of sanctity? A narrative review of surveys on euthanasia in Iran. *Canon Journal of Medicine*. 2022;3(2):14-21.
12. MEMİS HK. Do Not Resuscitate (DNR) Orders from an Islamic Perspective. *darulfunun ilahiyat*. 2022;33(2):411-37.
13. AbuYahya O, Abuhammad S, Hamoudi B, Reuben R, Yaqub M. The do not resuscitate order (DNR) from the perspective of oncology nurses: a study in Saudi Arabia. *International Journal of Clinical Practice*. 2021;75(8):e14331.
14. Crosbie H. Handing Autonomy Back to the Patient: Reducing Restrictive Practice.
15. Entwistle VA, Carter SM, Cribb A, McCaffery K. Supporting patient autonomy: the importance of clinician-patient relationships. *Journal of general internal medicine*. 2010;25:741-5.
16. Saltbæk L, Michelsen HM, Nelausen KM, Theile S, Dehlendorff C, Dalton SO, et al. Cancer patients, physicians, and nurses differ in their attitudes toward the decisional role in do-not-resuscitate decision-making. *Supportive Care in Cancer*. 2020;28:6057-66.
17. Gül Ş, Bağcivan G, Aksu M. Nurses' opinions on do-not-resuscitate orders. *OMEGA-Journal of Death and Dying*. 2022;86(1):271-83.
18. Goodarzi A, Sadeghian E, Babaei K, Khodaveisi M. Knowledge, Attitude and Decision-making of Nurses in the Resuscitation Team towards Terminating Resuscitation and Do not-Resuscitate Order. *Ethiopian Journal of Health Sciences*. 2022;32(2).