Nurses’ views of the decision not to resuscitate a patient

The decision not to resuscitate a patient is a complex issue and there is little guidance for nurses on how such a decision is made. The aim of this study was, therefore, to explore the views and working practices of staff in relation to current guidelines and theories, using a situational analysis. Overall, the staff seemed to meet the criteria outlined in the guidelines, although there was little awareness of the guidelines. Nurses in the clinical area should be both educated in the recommendations for practice and should be consulted and involved in developing such recommendations.

Date of acceptance: October 31 1995.

AIM OF THE STUDY

The aim of the study was, therefore, to explore the views, opinions and working practices of staff, and then to analyse how and to what extent they corresponded to current guidelines and theories. Furthermore, the study aimed to assess whether the guidelines are comprehensive and can be used effectively in practice.

METHODOLOGY

A situational analysis, based on the framework designed by Skilbeck (1976), was carried out. A situational analysis is exactly what it says it is, an analysis of the various factors which influence a situation. A situation is critically reviewed by identifying the factors which may have an effect on it in some way, so that a deeper understanding can be gained.

The model values the intuitive judgement of the professional and sees it as an important part of any rational planning process. This echoes the opinion of Benner (1984), who believed such judgements to be an essential part of professional nursing.

A situational analysis of this type is not intended to be a rigorous, valid and reliable research project. Criteria are identified from the literature and from the practice area to analyse the data, evaluate the situation and propose strategies for action if necessary. The findings and recommendations of such a study are specific to the situation and cannot, therefore, be applied to another practice area (Reid 1991).

Methods used

In situational analysis, the researcher needs to decide what the most appropriate research methods are to collect the data required for the particular situation under scrutiny. (Parlett and Hamilton 1976). Methods should be selected that fit best with the naturalistic design of a situational analysis.

Naturalistic studies seek explanations of situations from those who experience that situation. Thus, it is...
essential that the inquiry be conducted within the natural environment and that the methods are used to reveal the unique meanings of the individuals’ experiences within that context (Depoy and Gitlin 1994).

It was decided that a combination of techniques should be used to reduce the potential bias of the author, who had become, to some extent, part of the ward team as a student nurse. Therefore, participant observation, informal interviews and analysis of documentary evidence from the ward were selected as the methods of choice.

The setting The ward on which this situation was analysed is a 32-bedded unit in a large hospital situated in a multi-ethnic, multicultural, urban, industrialised city which provides extended care for patients coming mainly from acute wards. It acts primarily as a rehabilitation ward, but care is also provided for some patients who are, or become, terminally ill. The ward is split into male and female sides, with six beds in side rooms.

The sample The aim was to obtain a broad collection of views so that the opinions of all grades of staff could be evaluated and the reality of DNR decision making on the ward could be represented as fully as possible (Gilbert 1993).

No exclusion criteria were employed, therefore, and nurses of all grades and with a variety of experience, from within two weeks of qualification as a staff nurse to more than ten years working on the ward, were interviewed. This included the ward sister, the senior staff nurse, six other RGNs of D and E grades and two healthcare assistants. Other relevant healthcare professionals were also approached including the occupational therapist, the physiotherapist, a social worker, and a junior and senior doctor. In this way, the views of most of the permanent staff on the ward were obtained.

Informal interviews Although the interviews were informal, they were usually ‘guided’ or ‘focused’. Guided interviews are particularly useful when, as was the case here, the boundaries of the topic are broadly fixed, but the nature and scope of the answers, and, therefore, the questions to be asked, cannot be anticipated (Field and Morse 1985). The interviewer was free to phrase the questions as required, develop them and even join in the conversation when it seemed appropriate (Gilbert 1993).

Field and Morse (1985) stated that the word ‘process’ is deliberately used when describing an open-ended interview because the interviewer is exploring new territory with the informant. The process of developing the questions that were asked in this study was a dynamic one. Interviewing began early in the placement on the ward with the author letting it be known among all the staff that he was exploring this issue. The staff on the ward were keen to discuss the issue, often approaching the author. The types of questions utilised at this stage were broad and loosely structured, and asked in a conversational manner, for example:

- What are your views on the DNR decision making process?
- How does the DNR decision making process work on this ward?

In what Depoy and Gitlin (1994) describe as a spiralling process, where data collection and analysis occur simultaneously and are integrated, these early discussions informed the more specific questions asked during subsequent interviews, for example:

- Have you ever been in a situation where the DNR status of the patient was unclear?
- What do you feel the nurse’s role should be in the DNR decision making process?
- Have you ever been involved in the process of making a DNR decision and what was your role?
- Whose responsibility do you think it should be to make a DNR decision and why?

The majority of informal interviews were carried out with nursing staff either on a one to one basis, or with two or three members of staff. They usually took place in the staff room during breaks as it was felt that this would afford some degree of privacy and confidentiality. Each member of staff was interviewed informally two or three times, for at least 15 minutes on each occasion. The exception to this was the senior doctor who, because of other commitments was only interviewed once. However, this lasted for 30 minutes and occurred late in the study when the question schedule was quite detailed. Prompts were only necessary when the interviewees digressed from the issue, but were not needed to stimulate the conversation because the staff were so willing to debate the topic.

While full approval was given by all the staff concerned for this work to be carried out, there were limitations in that it was felt to be too sensitive an issue to discuss with either patients, patients’ families, or patients’ friends. This was accepted and, as such, the views of these people were not fully represented.

Participant observation The intention of participant observation is to promote an understanding of the situation through the perspective of the participants themselves (Parlett and Hamilton 1976). The advantages of participant observation for this project were numerous: as a student nurse having had a period of several weeks familiarisation with the ward, the author had gained considerable understanding of the day to day realities of this setting. Additionally, as one of the team, it was hoped that the behaviour of the staff altered minimally during this observation – certainly the participants appeared relaxed and open in discussion with the author, and not, as feared, wary and reluctant to discuss the issues.

There were problems with the author’s role as a
GUIDELINE 1. It is appropriate to consider a DNR decision in the following circumstances:
- Where the patient's condition indicates that effective cardiopulmonary resuscitation (CPR) is unlikely to be successful
- Where CPR is not in accord with the recorded sustained wishes of the patient who is mentally competent
- Where successful CPR is likely to be followed by a length and quality of life which would not be acceptable to the patient.

GUIDELINE 2. Where a DNR order has not been made and the express wishes of the patient are unknown, resuscitation should be initiated if cardiac or pulmonary arrest occurs.

GUIDELINE 3. The overall responsibility for a DNR decision rests with the consultant in charge of the patient's care, after appropriate consultation and consideration.

GUIDELINE 4. Discussion of cardiopulmonary resuscitation with all patients would be inappropriate, however sensitive exploration can be undertaken in some cases.

GUIDELINE 5. The consultant should be prepared always to discuss the decision for an individual patient with other health professionals involved in the patient's care.

GUIDELINE 6. Proper understanding of the DNR order is impossible without knowing the rationale behind it.

GUIDELINE 7. Recording in the nursing notes should be made by the primary nurse or the most senior nurse member of the nursing team.

GUIDELINE 8. The decision should be reviewed by the consultant in charge regularly.

GUIDELINE 9. If the DNR order is made on the basis of absence of any likely medical benefit, discussion with the patient, or others close to the patient, should aim to secure understanding and acceptance.

GUIDELINE 10. Discussions on CPR are highly sensitive and complex and should be undertaken by senior medical and nursing staff.

GUIDELINE 11. Experience with DNR orders is an appropriate subject for clinical audit.

member of the team: it was impossible to identify completely whether staff behaviour had changed as a result of observation. The author, as a student from the university, may have been seen to have a position of some power, and the fact that he had built up a good relationship with the ward staff may have introduced some degree of bias.

Other methods used Documents on the ward which referred to the issue of resuscitation were analysed, for example, the ward philosophy. The author also wrote field notes after every visit to the ward and as soon as possible after each conversation. Detailed notes were taken after the two team meetings during which DNR decisions were made about seven different patients. The author's own impressions and interpretation of what he saw, heard and experienced throughout the place-

ment relating to DNR were also noted.

Ethical permission As patients were not involved, ethical committee authorisation was not required. Permission was gained to do this project from the university, the senior nurse and ward staff themselves.

It was difficult to ensure complete anonymity, particularly to each other (Reid 1991). The staff were informed of this, so that if they wished to say things which would not be attributed to them, they could. Although this may have affected their responses to some questions, it was felt that, as they were placing themselves in a vulnerable position, this was an essential point to make (Le Roux 1988).

In order to address the main focus of how DNR decisions were made in the practice area, who was involved in making them, and the factors contributing to the decision making process, the wider issues highlighted in the literature were first considered.

RECOMMENDATIONS FROM THE LITERATURE

Legal implications In 1992, the RCN stated: 'Intentionally causing the death of another person, whether that person is already dying or not, constitutes the crime of murder...To have a good motive, such as "mercy killing", is no defence.' On this basis, making a DNR decision could be interpreted as an intent to murder because by not initiating cardiopulmonary resuscitation, the nurse may be viewed as indirectly causing death. However, in order to be found criminally responsible, it is generally necessary to show that the criminal defendant has committed a positive act — failure to act does not usually give rise to criminal responsibility (RCN 1992).

If it is perceived that non-resuscitation is a failure to act positively, the legal issue becomes more complex. The RCN Ethics and Nursing Committee (RCN 1992) attempted to resolve this dilemma by stating that the cause of death is due to the clinical condition and not the failure to act. It also highlights the positive intention of the act to be relief of pain, not to cause death. It concludes: 'The boundaries of the duty to act must be decided individually in the case of each patient.'

Living wills are the topic of much debate but at this time are not recognised in English law.

Moral implications Both doctors and nurses have codes of conduct which could be considered to be guides for making decisions with moral implications. The UKCC's Code of Professional Conduct (1992) states that: 'Each nurse, midwife and health visitor shall act at all times, in such a manner as to safeguard and promote the interests of individual patients and clients.' It also states that nurses, midwives and health visitors must:
- Act always in such a manner as to promote and safeguard the interests and well-being of patients and clients
- Ensure that no action or omission on your part, or
within your sphere of responsibility, is detrimental to
the interest, condition or safety of patients and clients.

The RCN Ethics and Nursing Committee (RCN
1992) put these codes into the context of decisions
about resuscitation. The committee highlighted two situa­
tions which could arise, the first being ‘the unex­
pected collapse of someone for whom there is no
knowledge of any other life-threatening condition’. This
should not cause any moral dilemma as the response
of healthcare professionals should be to initiate resus­
citation immediately as this complies with the code of
conduct and its legal implications.

The second situation arises where ‘the collapse
of a patient whose cardiac or respiratory arrest could
have been anticipated’. This could give rise to moral
uncertainties as to whether the patient should be
resuscitated or not. In this instance, the RCN Ethics
and Nursing Committee (RCN 1992) highlighted three
concerns which should be used as a framework and
enable healthcare professionals to arrive at a morally
correct decision. These are:

■ Bringing about the best consequences and outcomes
■ Respecting the wishes of individuals directly affected
■ Valuing and respecting human life.

Providing all these points have been considered
through the process of ‘individual reflection’, group
discussion has taken place as thoroughly as possi­
ble, and the resulting conclusions acted upon, then
the participants are deemed to have fulfilled their
moral obligation.

Although this addresses what could be considered
to be the professional and moral implications, no
account is made of any possible conflict between pro­
fessional morality and a person’s individual morals.

Ethical considerations Many ethical consider­
ations are included under the banner of moral
implications as in every day usage ‘moral’ and
‘ethical’ can still be used more or less inter­
changeably (Thompson et al 1983).

A DNR decision when viewed in an ethical con­
text may be considered to be a form of passive
euthanasia, this being the term used when someone
is deliberately allowed to die. Euthanasia in itself is
the subject of ethical debate, much of which is beyond
the scope of this project. However, it is useful to consider
the view of Melia (1989), who asserted that to consid­
er cases of passive euthanasia where the patient is
‘allowed to die without undue medical intervention’
under the euthanasia banner (albeit qualified by the
label ‘passive’) is of no particular value as it leads to
more concern than is really necessary.

In an attempt to provide a framework in which
guidelines can be drawn up, the BMA and the RCN
jointly produced a paper (RCN/BMA 1993) which out­
lined a defined set of circumstances in which the the­
ory pertaining to DNR decisions can be applied to
working practice. The paper also made it clear that
overall responsibility for a DNR decision lies with the
consultant in charge of care after discussion with nurs­
es, other doctors, the patient and, in certain circum­
cstances, the patient’s relatives or close friends. This
paper is the closest to a defined theory which can be
applied to working practice at the present. It is by no
means conclusive and, as such, remains open to crit­
icism and review. It is also relatively recent and, there­
fore, it remains to be seen how it is received by nursing
and medical staff.

After reviewing the current theoretical thinking
around the DNR decision, the next step was to com­
pare this with what was happening in this particular
practice area under study.

DOCUMENTARY ANALYSIS

First, an analysis of the ward philosophy was carried
out. The ward followed the Roper et al (1981) model of
nursing and also had its own set of aims and goals,
neither of which addressed the issue of resuscitation
directly. The ward philosophy, the care plans and the
model used on the ward could be seen to agree with
the process of making a DNR decision in that they all
advocated trying to: ‘Ensure a peaceful, dignified and
pain-free death according to the patients’ and carers’
wishes in terminal illness.’ As the process of CPR is
rarely dignified or peaceful, and if successful may
merely prolong the suffering of a terminally ill patient,
there was potential conflict between the nursing mod­
el, the ward aims and goals, and the reality of the
experience of CPR for the patient.

OBSERVATION AND INTERVIEWS

To analyse this data, a broad framework with the fol­
lowing categories was used:

■ The key areas identified in the guidelines
(RCN/BMA 1993) (Fig. 1)
■ The issues which concerned individuals most and
were raised most often (not the most controversial)
■ Statements which related to DNR decision making
only and not other related concerns.

Issues such as euthanasia, the rights of babies
born with learning difficulties and many others were
frequently raised, but although these were interesting,
a decision was made to focus specifically on DNR
decisions.

Overall, the main concerns raised did relate to
those identified in the guidelines, but with varying pri­
ority. In addition, a number of other issues were also
seen as very important.

Guidelines 1 and 8 Both in discussion and in
observation, DNR decisions did seem to fit the cri­
criteria outlined by the RCN and BMA (1993). In the
team meetings, the DNR decision appeared to be
based upon the likelihood of CPR being unsuccess­
ful. Length and quality of life should CPR be
successful was also taken into consideration, and
the decision did appear to be reviewed. This was
in accordance with the guidelines outlined previ­
Implications for practice.

1. Many nurses appear to be unaware of the existence of guidelines on DNR orders.

2. Nurses should be educated in the recommendations for practice in this area.

3. Nurses should be involved and consulted in developing recommendations for making DNR decisions.

4. Nurses should be given greater opportunity to discuss their fears and anxieties surrounding DNR decisions.

5. Nurses appear to be reluctant to discuss DNR decisions with patients and their relatives.

Throughout the placement, staff were observed raising any concerns they had with the ward sister who would in turn discuss this with the consultant at the relevant meeting. When talking with various nurses and nursing assistants, it appeared that they were all happy for their views to be represented by the ward sister. Many suggested that she was vastly experienced in this field and, as such, made an excellent advocate for them. 'I prefer to leave the decision to someone more experienced', was a comment a number of nurses made.

Guidelines 4 and 9 An area in which there appeared to be discrepancies between recommendations and practice was the apparent lack of consultation and discussion with the patient or the patient's friends/relatives. This lack of communication has been highlighted in many documents; a study of student nurses' views on DNR decisions found that rarely were either patients or relatives involved in the decision about whether or not to resuscitate (Candy 1991). Pottle (1992) reported a survey in which only 5 per cent of doctors and nurses felt that a patient should be involved in making a DNR decision and 71 per cent of consultants had never discussed this issue with a patient.

When approaching staff about patient consultation, it was found that the main reason for not involving the patient was that it is a very sensitive issue and that asking an already sick patient difficult questions could 'worsen their condition and worry them unduly'. Patients' relatives who were already concerned could be further distressed. It was also mentioned that individual cases varied enormously and that blanket procedures could not, therefore, be applied.

It appeared that when patients or their relatives were consulted about the decision, it was because they had initiated conversation around the subject. Once they voiced their opinion, it was valued and respected. In some cases, the relatives could be instrumental in helping staff come to a decision.

Another possible explanation may be that communication between patients, patients' families and clinicians has traditionally been seen as difficult. It may be that staff are more reticent to discuss subjects such as resuscitation than the patient themselves (Speck 1992).

Guidelines 6 and 7 Although the decision was usually recorded in the medical records, rarely was a full explanation given and often it was not stated in the nursing notes at all. This was an area where the staff appeared unaware of their responsibilities.

Guideline 10 The care that was given to patients was equitable and appeared unaffected by the patient's DNR status.

Three other issues were raised by the staff interviewed which were not highlighted in the guidelines.
First, a number of them mentioned that it was difficult not to be influenced in the DNR decision making process by what they themselves would want in that situation. On further discussion, it became apparent that none of them felt that their personal views necessarily conflicted with the current professional process of making a DNR decision, but that they would welcome support as they were concerned that this sometimes affected their professional judgement. The other two issues both related to communication. A number of them thought that they were unaware of all the patients' DNR status. Observations showed that, usually, staff were informed. However, this did indicate that communication on the ward could have been improved.

In addition, both nurses and doctors believed that the other group would have differing views about who should be resuscitated. The reality was that their opinions during this period of time were rarely different. Such misunderstandings of each others' views may have been because the sister conducted virtually all discussion with the doctors.

CONCLUSION
Following analysis of the data collected, it was concluded that, in the main, this ward adhered to the guidelines as laid down by the RCN and BMA (1993) throughout the process of making a DNR decision. However, it was also apparent that this was, to some degree, the result of the combination of luck and good professional judgement, as many of the staff were unaware of the details and/or existence of guidelines for making a DNR decision.

Furthermore, the study did highlight other issues of concern – notably, the ever expanding role of the ward sister as representative of the views of all nursing and auxiliary staff, and how feasible this is; second, why, in this 'consumer conscious' age (DoH 1989), healthcare professionals seem to be so reluctant to discuss such important issues with patients and relatives.

It remains to be seen whether patients will be consulted more fully about a decision which is, after all, a life or death situation for them. In the US, legislation has already been introduced under which hospitals must explain to the patient his or her right to refuse treatment and which also legalises living wills. This would appear to give the patient increased choice about decisions such as resuscitation. If legislation was changed in this country, it would be interesting to observe the effect it had on doctors' and nurses' views about consulting with patients.

The study was also a good example of the dilemmas facing all nurses who are attempting to deal with the many conflicting demands of their role while developing the skills to make judgements and decisions which have profound moral, ethical and legal implications. To do so, they are often expected to adhere to guidelines and theories which have rarely been fully tested or analysed in practice.

The eagerness shown by the staff to discuss their anxieties may be an indication that they, like many healthcare professionals, are rarely given the opportunity to explore such emotive issues with their peers. Knowing that they were adhering to most of the BMA/RCN guidelines may have been of considerable comfort to them, as would realising that others share their dilemmas. That many of them were unaware of the guidelines' existence is, therefore, of additional concern.

It is essential, as nursing becomes an increasingly autonomous and accountable profession, that nurses in the clinical area are both educated in the recommendations for practice and are consulted and involved in developing such recommendations. Nurses owe this to themselves, the profession and their patients, as technology will almost certainly make these decisions more, not less, of an issue in the future.

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