

IS LIVING WITH A FATAL DISEASE WORTH LIVING? AN ETHICAL DILEMMA IN DO-NOT-RESUSCITATE (DNR) DECISION-MAKING

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Abstract

Patients with poor prognosis are often considered for do-not-resuscitate (DNR) orders, raising complex ethical, clinical, and communication challenges. This paper explores how DNR decisions are made, implemented, and communicated within healthcare settings, particularly in oncology care. The primary ethical responsibility of healthcare professionals is to maximize patient benefit while minimizing harm. However, conflicts frequently arise between patient autonomy, family wishes, and clinical judgment. This paper presents a case of a young patient with metastatic cancer where disagreement occurred between the healthcare team and family regarding DNR status. Ethical principles, including autonomy, beneficence, and non-maleficence, are critically analyzed alongside religious perspectives, particularly within the Islamic context. The discussion emphasizes that while patient autonomy is central, futile interventions such as cardiopulmonary resuscitation (CPR) may be ethically withheld when deemed non-beneficial by clinicians. The paper highlights the need for structured policies, improved communication, and culturally sensitive approaches to DNR decision-making.

Keywords: DNR, Ethical dilemma, CPR, Futility, Patient autonomy, Decision-making, Communication, Islamic perspective

Case Scenario

A 28-year-old male with metastatic lung cancer presented to the emergency department in an unconscious state with severe respiratory distress, requiring non-invasive ventilation (BiPAP). Due to advanced disease and poor prognosis, the primary consultant recommended a DNR order. However, the patient's family insisted on full resuscitative efforts. The case was referred to the hospital ethics committee, which supported the physician's decision due to medical futility.

Introduction

Despite advancements in the medical field, confusion regarding changing patient status from resuscitation to do not resuscitate (DNR) still exists. Although patients/family are assisted and guided in every aspect of their treatment so that they can make the best choices, this support is lacking in such scenarios. The DNR decision is unique in health care settings as it is taken before the incident has occurred. Without a DNR decision by the physician, health care workers (HCW) are required to do cardiopulmonary resuscitation in case of cardiac arrest, even if it is clear that these efforts are futile. Therefore, it is necessary to take this decision with the full involvement of the patient and family, and such a decision must be communicated to HCWs in order to guide the practice. Nowadays, autonomy of the patients and family has been emphasized, and the stress of "to be informed" have Cardiopulmonary resuscitation being termed mandatory for all patients having a cardiac arrest. Life-sustaining therapy within the medical profession was practiced in the US. It was implied in the UK as well, where it was debated to provide direction to HCWs on which patients should be and which shouldn't be resuscitated in case of cardiac/respiratory arrest. Such as patients above 65 years or those with some type of disease, fall under the category of DNR. The prognosis-after-resuscitation (PAR) and pre-arrest-morbidity (PAM) index score was also considered in deciding DNR.

(From O'Keeffe and Ebell, 1994)

Successful CPR restores breathing and heartbeat and lets the patient return to their previous state of lifestyle. Patient's overall medical condition determines the success rate of CPR, not just the age of the patient, though morbidities linked with the age often play a role in the success of CPR. CPR is not fruitful for patients with an advanced stage of the disease and may leave them in worse condition than before the cardiac arrest. Some patients may choose not to be resuscitated; instead, they prefer to be cared for. DNR does not affect other treatments; it's only the decision about resuscitation.

Patient and family point of view

In determining whether DNR is suitable for a patient or not, the efficacy of CPR, its advantages, and disadvantages should be kept in view. A DNR order must be signed by involving all the stakeholders, i.e. patients, family, and HCWs, prior to anticipated life-threatening conditions, and patient and family end of life wishes which are mutually decided, needs to be communicated clearly to HCWs. The patient's best interest should be the main concern of the HCWs, and the highest priority should be given to the patient's wishes if patients are capable of making their own decisions, irrespective of their conflict with the wishes of the family and HCWs. However, if physicians determine that CPR would not be beneficial for the patient or if the patient's point of view is in conflict with the institution's informed opinion, then the wishes of the patient will not be entertained. Patient and family cannot force the HCWs to perform CPR when it's not in the best interest of the patient (Ditillo, 2002).

Code status of the patient should be decided while deciding treatment goals, i.e., benefits of the treatment, patient's comfort, and an understanding that life support will be removed if the set targets of the therapy are not achieved (Kolarik, Arnold, Fischer, & Hanusa, 2002; Prendergast, 2001).

The rate at which patients are put on DNR status varies as far as comorbidities and age are concerned. For instance, studies indicate that patients who are younger or have cardiovascular diseases have a low rate of DNR status (Holley, Kravet, & Cordts, 2009).

Conflict of ethical principles

In this case, a clash occurs in the decision-making for the patient's future status. When the consultant decides to DNR the patient, but the family disagrees with the consultant due to a lack of trust in the consultant and false hope about the patient's recovery. Patient autonomy should be respected in terms that he/she will be involved in decision making about, plan, and action regarding their future health care procedures. If the consultant follows this principle, then the risk of non-maleficence violated Non-maleficence needs that a procedure does not damage the patient. Consultant applying this principle, but ignorance arises about the autonomy of the patient's family. Many scenarios have difficulty for consultants to apply the DNR principle successfully. Beneficence means that all procedures will be provided to the patient to provide benefits.

Consultant/Physician point of view

It is widely recognized by physicians, lawyers, and others that DNR orders are pathologically, physiologically, and ethically appropriate under certain conditions. For many patients, CPR adds more loads than benefits, and may be against the patient's desires. Consultant must tell the patient or family before doing a DNR order if the patient can choose, unless the consultant trusts that discussing CPR with the patient or family would cause severe harm. In a crisis, it is expected that all patients would consent to CPR. However, if a physician decides that CPR will not work, it is not provided.

Opinion of the Ethical Committee

The religion of Islam on the DNR decision is clear. According to the Hadith of Prophet Muhammad (peace be upon him), no one desire for decease since a mishap happens to him, although he should say, *“Allah! Make life easy for me as extended and better for me, and let me go to meet the Creator is better for me”* Although it is tough decision to stop the treatment of life sustaining. Islamic point of view about DNR decision is explained by the KSA Riyadh in a presidency of Islamic administration, Fatwa 12086 number issued in 1989. Fatwa explained and recommend that if more than two consultants are agreed that the recovery is impossible of the patient then life sustaining treatment should withdraw and family opinions will be not entertained and family desire will be not accepted.

Family point of view

One Islamic Fatwa about a DNR the patient order or care removal is a consultant decision which not require family participation. Although a study was conducted in the US and other states, 461 Muslim doctors participated in the study; more than 260 doctors did not recommend, and more than 340 doctors felt that this decision should be discussed with the family according to the family's choice. Mostly, doctors in the study agreed that the decision should be discussed with the patient and family, although that family member may not be present when the patient needs CPR, and the doctor could not do CPR due to the DNR policy.

Justification of My Position

DNR should be considered, particularly with patients who have tried all other kinds of treatment modalities in which there is multi-organ failure, and the expectation for a treatment has faded. The DNR as an idea may appear harsh and intolerable for the patient and their loved ones. It is very important to look for a treatment in critical situations. When the therapy advantage is doubted, looking for therapy

becomes facultative. If the therapy is useless, it should be stopped. CPR has the ability to bring the patient back to their previous life state. Otherwise, CPR will be a burden on the patient and family and will be a waste of resources and time. The DNR orders in fatal disease are allowed in Islam. A conscious and competent patient has the right to decide about life and treatment, and also has the right to refuse therapy and treatment, including treatment that will prolong life artificially. If the patient is not able to make a decision, then consultants have the right to make a decision on the patient's behalf. Islam prohibits assisted suicides and euthanasia, although the desires of the family or patients not to die their loved one and prolonged artificial life with the presence of a hopeless prognosis are forbidden. This type of desire is not accepted, and the patient consultant has the right to a DNR order in such conditions.

Possible Consequences

All over the world a lack of awareness of DNR policies, and also a need for understanding when it comes to treating DNR labeled patients. Patients and families may trust a consultant when receiving treatment. Otherwise, these conflicts will occur in many decisions about their patient's treatment.

Recommendations

Nurses are supposed to be advocates for the patients' rights whenever there is a conflict related to the DNR decision. Nurses should participate in discussions related to the change in the patient's treatment plan and involve the patient and family in the decision related to DNR status. Pros and cons of the CPR and its benefits and drawbacks should be explained thoroughly to them so that they can make informed decisions. The patient/family wishes need to be accommodated to the maximum. However, if there is a difference in the opinion among the patient/family and physicians, the case should be referred to the hospital ethical committee. If a change in code status is decided and the patient is put on DNR status, the nurse needs to take patient and family on board, and it should be clearly documented, reviewed and communicated to other HCWs. It should be clearly documented why patient code status has been changed. Confidentiality of the patient's DNR status should be maintained through effective communication among the HCWs. Nurses have the obligation to provide all palliative care to such patients. Nurses need to be educated that DNR doesn't mean to stop all other treatment modalities so that they continue providing care to the patients. Furthermore, for family satisfaction, the religious scholar may include in the Ethical committee.

Conclusions

DNR decisions are ethically justified in patients with a poor prognosis when interventions are medically futile. However, implementation remains challenging due to unclear policies, ineffective communication, and cultural sensitivities. Improving DNR practices requires enhanced communication, mutual understanding, and trust between patients, families, and healthcare professionals, along with clear clinical criteria and high-quality, patient-centered care. Healthcare providers should prioritize the patient's best interests and engage in timely discussions with patients, families, and colleagues to develop appropriate care plans. In cases of disagreement, referral to the hospital ethics committee is essential. Despite progress in some regions, standardized DNR practices remain limited in many Middle Eastern and Muslim countries, where discussions often occur with families rather than patients, particularly in critical situations.

This gap reflects broader national, educational, and spiritual challenges, largely driven by poor communication. Therefore, continuous evaluation and culturally sensitive approaches are necessary. Interventions should focus on maintaining patient dignity, comfort, and respect. While DNR decisions are primarily the responsibility of physicians, families should be appropriately educated, including a clear explanation of relevant medical and religious (Fatwa) perspectives. There is an urgent need for comprehensive national policies and strategies from Ministries of Health to guide DNR and end-of-life care practices across healthcare systems in Muslim countries.

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