



Iranian Nurses' Perspective on Non-Resuscitation: Content Analysis

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ABSTRACT

This study was conducted to evaluate the Iranian nurses' perspective about non cardiopulmonary resuscitation. This study is Directed qualitative content analysis and analyzed the perspectives of 8 nurses on different aspects of the formulation of non-Resuscitation guidelines through semi-structured in-depth interviews (40 to 60 minutes). An interview guide was set based on the categories, and tips were provided for conducting interviews and performing the related codification in each class after analyzing the interviews. In the "professional" category, 4 codes of "futile care", "stereotyped care", "fear of distrust" and "moral distress"; in the "patient and family" category, 2 codes of "selfishness vs. sacrifice" and "protection of human dignity"; in the "moral" category, one code of "lack of understanding of the meaning of morality"; in the "legal" category, 2 codes of "fear of the law" and "fear of accusation of the nurse"; in the "religious" category, 3 codes of "fate", "forgiveness of sins", and "miracle"; and in the "economic" category, one code of "money as a facilitating or hindering factor" were extracted. In the formulation of non-Resuscitation guidelines, it is necessary to pay special attention to the Iranian context and the extracted codes such as respect for human dignity, fate, miracle, lack of understanding of the meaning of morality, fear of accusation of nurses, and economic costs.

Key words: Non-resuscitation, Not for resuscitation, Nurse, Iran, Qualitative research, Content analysis

INTRODUCTION

Cardiopulmonary resuscitation (CPR) has been used to return the heartbeat and breathing of the patients with cardiopulmonary arrest back to normal in all hospitals to save the lives of patients since 1960. However, the CPR order has been associated with concerns and challenges such as prolongation of the dying process[1], transfer of the patient to the hospital, admission to the intensive care unit, the use of equipment and facilities, occupation of beds in the intensive care unit despite the urgent need of other patients to beds, severe emotional harm to the patient and their family, value, legal, moral, and religious conflicts, and occupational burnout of the care providers[2,3]. In 1976, the "Do Not Resuscitate (DNR)" policy in dying patients met with serious oppositions. However, after that, the proportion of patients who tend to receive limited end of life supports and services increased from 51 to 90 percent in the United States over a period of 5 years from 1988 to 1992[4].

The decision about the patient's death is not made only by a member of the treatment team and all members of the treatment team that have a direct role in the care of these people should be involved in decision-making. Nurses take

care of the patients for long hours[5,6]. They are not the main decision makers but are in the first line of care provision to patients; therefore, they are one of the most influential members of the decision committees for these patients[7].

Although the DNR decision and its report to patients and their families is the duty of physicians, other members of the care team including nurses have a logical and legal role in the process of decision making about end of life care. Nurses are at the bedside of the patients during the dying process and build a trust-based relationship with patients and their families. Spending long hours with the patients has empowered nurses to achieve a particular vision and systematic understanding, and has made them aware of the time when patients do not respond to treatment[5]. Removing the nurses from the decision-making cycle of these patients can result in a sense of guilt in them, and leads to the formation of burnout. In addition, the presence of nurses in the formulation and decision-making process for these patients can protect them against many legal, moral, and normal challenges [3]. The Canadian Nurses Association believes that the nurses' role is essential in providing care to dying patients, preserving their human dignity, independence, and respect for the patient. Nurses are directly responsible for asking patients about end of life care. Therefore, their role is important in the execution of the guidelines of CPR, DNR, and the use of mechanical ventilation[7]. Nurses are also a key member of the leadership and coordination of the treatment team. They can identify the feelings, desires, and ideas of the patients and their families due to spending long hours at the patients' bedside, and therefore make decision-making easier for the treatment team[8,9].

Accordingly, a guideline is being prepared as a draft for clinical CPR of the dying patients. The first phase of this study (literature review) is completed and based on this phase, the second phase of the study (interviews with experts and competent authorities) is being conducted. This article describes the perspective of Iranian nurses on the formulation of the DNR guideline.

MATERIALS AND METHODS

Design

This study was part of a dissertation for a PhD degree in nursing and midwifery approved in Tehran University of Medical Sciences. The dissertation was developed in two sections, and a review of the literature comprised the first phase of the development of a clinical "Do Not Resuscitate" (DNR) guideline in dying patients. What is expressed in this paper is part of the second phase of the study (interviews with competent authorities regarding the guideline) using directed content analysis.

Participants

This paper analyzed the perspectives of 8 nurses on different aspects of the formulation of DNR guidelines through individual semi-structured in-depth interviews. At first, based on content analysis of the review of the literature on 6 main categories including professional, patient and family, moral, legal, religious and economic, and guiding questions were prepared for each point of view. It should be noted that after each question, the categories were deeply studied using exploratory questions.

Data Collection

In this study, data was collected through guided or theory-based content analysis described by Hsieh and Shannon (2005). In the first phase, studies and guidelines on DNR and particularly the Islamic and legal principles related to decisions on DNR were reviewed without time limitation. To search for these studies, electronic bibliographic data sources and online databases such as Medline, EMBASE, Springer, Blackwell Sengery, Elsevier, Scopus, Cochran Library as well as databases, including SID, Iran Medex, and Magiran were used. In addition, a manual search was done on articles references. The books on fatāwā (In the Islamic faith is the word for the legal opinion or learned interpretation of religious issues) and religious questions from respected Marja' taqlīdī - literally (Islamic experts in areas of jurisprudence (Fiqh) and Islamic law) means "Source to Imitate/Follow" or "Religious Reference" - were studied in an attempt to investigate legal issues regarding DNR. Any article containing the following key words with available full texts were included in the study: DNR, do not resuscitate, natural death, not for CPR, not for resuscitating, DNAR, Hollywood code, code blue, chemical code, show code, slow code, secret code, and do not attempt to resuscitate. After reviewing the literature, six categories were extracted that were the basis for setting an interview guideline and output codes resulted from the analysis were placed within the categories.

Data analysis

Each interview lasted between 40 and 60 minutes, and data were collected during September-March 2014. At the beginning of each interview, the purpose of the study and the right of the individuals to refuse to participate in the study or at any time during the interview were explained to the participants, and their oral informed consent was taken. The participants were also assured of the confidentiality of the collected data. The interviews were transcribed at the end of each session, and were read several times in order to achieve a correct understanding. Then, the text was broken to the smallest meaningful unit (code) and the codes were placed into six main categories extracted from the literature.

Ethical Consideration

This study was approved by the Ethics Committee of Tehran University of Medical Science (approval number: 92-03-28-24249). To ensure the credibility and acceptability of the data, the method of continuous involvement with the research subject was used. In addition, the participants' confirmation was used to verify the codes and the initial codes were controlled by the interviewees before categorization. To provide the coding ability in the categories, the observers review method was used (by the advisor and consultants and two PhD students).

FINDINGS

Participants' demographics

In this study, eight nurses working in the intensive care and oncology units with a mean age of 35.12 ± 4.24 were participated. All of the nurses worked in the ICU and oncology for at least 10 years. Three of them were clinical supervisors during the interview. Of the total respondents, 4 had master's and 4 had bachelor's degrees in nursing. In this interview, all participants stated that they could not register the DNR order in the patient's profile, but put a sign that is common between the staff, but is not confirmed by any institution or organ, on the cover of profiles and informed other colleagues orally.

Main data

A total of 504 codes were extracted from the interviews and were summarized in 13 codes in 6 categories for a conceptual approximation to categories. Futile care, fear of lack of trust, fear of the law, moral distress, protection of human dignity, and miracle were the codes extracted in content analysis of the texts. However, other codes were developed during the interview with Iranian nurses.

Category #1: Professional

The "professional" category is, in fact, the basic and true judgment and skills in the workplace that can be achieved following the individual-working environment interaction and interpersonal communication. From this perspective, nurses presented reasons for not implementing DNR orders in the following 4 codes:

a) *Futile care*: It is, in fact, the inability or ineffectiveness in achieving the desired result or purpose. Under these circumstances, survival alone may not be enough. It is a continuity of care for the person who seems unlikely to survive.

In this regard, participants in this study believed that the CPR of patients unlikely to survive was futile care. For example, one participant said:

"If we consider logic, we find that sometimes everything should not be conducted based on books for some patients and treatment will not be effective even if we break their ribs and use inotropic drugs and dialysis. He/she neither survives nor has a high quality of life. It is as if someone gives you a dry stick and tells you to water it and care for it to grow, is it possible?" (Participant 6)

Participants in the interview believed that it was practically useless and futile to care for patients unlikely to survive.

b) *Stereotyped care*: Routine and stereotyped care means repeated care without combining theoretical and technical skills. Today, it is in conflict with the spirit of care that is attention to holistic care based on individual needs. In fact, it is a pre-made care based on the learned theoretical skills that prevents rational judgment and knowledge of the treatment team in the application of appropriate treatment. In this regard, participants in this study believed that the current Iranian health care was a routine and stereotyped care.

"We do not have the critical thinking skills in dealing with patients; we have learnt a series of articles and think that we should do them step by step. We never wonder that CPR is good, but is it necessary to perform CPR for an end stage patient who has had three times of arrest since yesterday? Our disadvantage is that we do not think that this patient may need something other than CPR, according to the book, cardiorespiratory arrest means massage, so we apply massage." (Participant 3)

c) *Fear of distrust*: Confidence is the most important and most necessary component in all occupations, especially in the medical profession. It means that when patients enter the health care system, they need trust in care providers and the hospital to obey health recommendations with certainty more than anything. Building trust between the patient and care provider system will have a positive impact on service delivery and patient improvement. If this trust is undermined, the workload of the health system and costs will increase by several times. One of the reasons stated by nurses participating in this study as an important factor in not using the DNR order was the fear of the public distrust in the health system and the healthcare team.

"I was at the bedside of a patient receiving CPR repeatedly that was 100% useless. However, we did CPR so that the patient's companions did not think we did nothing for the patient. The patient's companions told us that they brought the patient to our hospital for the reputation of the hospital and Dr. ... so do not make me regret my decision. When the patient's companions say such a thing, of course we do not say it is useless to perform CPR on the patient." (participant4)

d) *Moral distress*: One of the common issues in the medical field is moral distress. In this case, despite having the knowledge and ability for a moral act, the person will become incapable of undertaking the appropriate moral action. Under these circumstances, a negative effect will be imposed on the medical staff that affects the quality of their service.

"Oh my God, the useless and vain things that we do, sometimes it won't be effective but harmful, and then we will have a guilty conscience. A year ago, I did something evil that still makes me have nightmares. God should have mercy on me. We had a metastatic patient for a week, he was infectious and his smell was awful. I was his nurse for three days. He had two cardiac arrests, our anesthesiologist was inexperienced and resuscitated him again and again. One day I was absolutely tired. I swore it took me from 3 to 5:30 pm to dress him up. After 2:30 hours, I went to another patient. The physician had ordered STAT for him, I did not pay attention. I was tired and irritated and instead of metronidazole, I took a vial of potassium. I was very lucky that my colleague saw it and prevented potassium from entering the bloodstream of the patient, a patient who went to the neurological department with GCS = 13 two days later." (Participant8)

Category #2: Patient and family

In developing hospital standards, one of the most important things is informing the patients and their families about the care services provided by the hospital. The patients and their families are the most important component in decision-making about a DNR order and without their permission, making decisions in this regard is hampered. According to the nurses in this study, sometimes the application or non-application of a DNR order only depends on the patient's family. This category appeared in code no. 2.

a) *Selfishness Vs. sacrifice*: Participants believed that some families are reluctant to ask for DNR because of strong attachment to their patients, and do whatever they can to save the live of their patients until the last moment. However, some other families consider a DNR order a kind of sacrifice.

"We had an end stage patient whose family insisted that he should survive. Drtalked to them. The elder son of the family shouted: " why do you bother our father so much, please do not hurt him, do not resuscitate him anymore, and let him die in peace. We ignored our right. We give what we should spend on our father to a patient in need, may our father receive its reward." "(Participant 6)

b) *Protection of human dignity*: Dignity means to cherish and honor others, and appreciate humanity. Human beings have dignity and the right to live respectfully. Protecting the human dignity becomes more difficult when someone is sick, but it is a fundamental right of the patients. In this regard, participants in the study considered the protection of human dignity as the most important reason for the family's choice of a DNR order.

"We had a patient who was an important person. We did CPR on him a couple of times. One day his wife came to visit him and when she went, she was not well at all. The day after, she came with her brother-in-law and said that she did not want to see her husband humiliated anymore and asked us to protect his dignity and respect his privacy. She said: "If there is really no choice, do not continue, stop it". "(Participant8)

Category #3: Moral

Based on the literature review, four principles of medical ethics are the most important principles in a DNR order decision. These principles include respect for autonomy, beneficence, justice, and non-maleficence. However, in our study, the code of "lack of understanding of the meaning of morality" was extracted.

The important point in this study was that participants believed the most essential principle in the DNR decision was non-maleficence, and considered CPR as the harming the patient's body and soul in vain, and did not consider the three other principles important.

"Unfortunately, we still have not understood the real meaning of 4 moral principles. When we say our care should not hurt the patients, or should be beneficial for the patients, how can we do CPR that hurts the patient both physically and mentally, especially when it is totally useless. Please think, is this what ethics says? "(Participant1)

Category #4: Legal

Fear of the law and accusation of the nurse were 2 codes extracted in the "legal" category.

Nurses believed that having a legal writing in the field of resuscitation helped the medical team to make the right decision. They believed that the lack of supportive laws was the most important reason for non implementation of the DNR order. They stated that a written law should be approved by the parliament; otherwise, they were condemned by default since they were not supported compared to physicians. Even if there is a written law in this regard, it must consider the immunity of the nurses.

"I think we shall not start it, we should not intervene because we do not have legal support. When no one defends us, why should we raise an issue of this importance, if they come and document that nurses are legally immune, it will be ok. Otherwise, even now, we're the scapegoat, so actually we'd better not interfere. "(Participant5)

Category #5: Religious

In the care of dying patients, considering the religious beliefs of the patients is their most important right. Religious behaviors such as believing in God and prayer have positive values in spiritual life, and lead to inner peace of the person. Care and support for patients who are dying is easier with religious beliefs. Three codes were extracted in this category.

a) *Fate*: Fate means belief in the certainty and crucial order of God in in the universe . According to Islamic beliefs, nothing would occur without a cause, and human activities do not occur by accident and at random. Any event in the world has a cause, and this system is inevitable as it is decreed by God. Accordingly, nurses participating in this study believed that the death of any person was predetermined on the basis of a divine fate, and a DNR order was not in contrast to the will of God.

"Fate of every person is predetermined. It is predetermined who should go. Now you order CPR; when the death of a person is determined by God, he will die and you can't do anything. I think it's just an entertainment for us."(Participant 5)

b) *Forgiveness of sins*: According to Islamic beliefs, disease is one of the ways of purification and forgiveness of sins, and every person is in fact purified with illness and disease. Based on this belief, some of the participants opposed the DNR order since they believed prolonged disease was a way for forgiveness of the sins.

"When our Prophet believes that disease and suffering are some sort of purification, why do we not believe? So when it comes to death, the longest is the best, the dead person will become more pure. If you want to go to a party, don't you consider the host in how you dress? "(Participant6)

c) *Miracle*: It is an incredible thing that cannot be done by normal and ordinary human beings. In fact, many people believe that praying creates the possibility of a miracle from God. Some participants in the study disagreed with DNR orders since they believed the power of God was above all and humans should not interfere. If God wants someone to live, the person will survive even in the worst situation.

"You cannot deny the power of a superior entity. God who created us from nothing of course will let us breathe. What happens if we do not do CPR and in doom's day, the patient claims that God wanted to give me a second chance? Haven't we heard repeatedly that Imams cured patients? Then we cannot deny miracles, I believe we should do CPR until the last moment."(Participant 7)

Category #6: Economic

Considering the cost of admission is the most important factor in treatment decisions. Keeping dying patients in the intensive care unit is associated with high costs. Sometimes, huge treatment costs force some families to stop the treatment. Financial problems may be a cause of accepting a DNR order. Some of the participants said that some families, especially those who had good financial conditions, wanted the medical staff to resuscitate their patients until the last moment. Therefore, the code of "money as a facilitating or hindering factor" was extracted.

"Money is like a double-edged sword; the lack of money sometimes forces you to accept the order while sometimes having lots of money makes you say now that I have money, I spend it to keep my patient alive until the last penny, regardless of the results."(Participant4)

"We had a patient who was the owner of several gardens and villas in Fereidounkenar. It is unbelievable but his wife told me that she could get the best and most expensive equipment for the United States to save her husband. When we talked to her about DNR, she almost killed herself. She said she would pay twice the hospital costs to keep him alive. I also work in a public hospital. I swear to God in the same days, we had a 14-15 year-old patient, his father was a construction worker who had no money. When we said he would not survive, he accepted the DNR order because he really did not have any money. He said he could at least get his son's corpse from the hospital in this way "(Participant8)

DISSCUSION

Based on the categories extracted from content analysis of the literature review, participants' interviews were coded and placed in categories.

In the "professional" category, 4 codes of "futile care", "stereotyped care", "fear of distrust" and "moral distress" were extracted. The futile care code was frequently seen in the literature, showing that the nurses believe taking care of patients who do not benefit from care is rather futile.

Therefore, Bahramnezhad et al. in a study in 2014 stated nurses considered caring for patients whose chance of life was less than 5% rather futile [10].

Regarding the stereotype care, in a study aimed to evaluate the quality of nursing care, Neill et al. found care services had an inferior quality in nursing houses, were not performed according to the patient's needs and desires, and were repetitive and routine[11]. In this regard, Papes et al. reported that being a routine was a serious defect in nursing, and attempts are being made to replace it with patient-oriented approaches with an emphasis on maintaining the patients' integrity and satisfying their unique needs through provision of specialized nursing processes[12].

Fear of distrust by the patient and their family was one of the main reasons stated by nurses regarding non-implementation of DNR orders. They stated that speaking with families and patients regarding DNR may make them think that the care providers cannot provide appropriate care for their patients which results in damage to the name of the hospital and its medical staff, especially physicians, and interference with the treatment of other patients.

In this regard, Radwin (2000) reported trust and optimism that the patients achieves due to knowledge, attitude and cooperation of nurses make them feel relaxed and accelerates the recovery process [13].

In a study entitled "Nurses experience in providing end of life care," Espinosa et al. (2010) stated that it was necessary to build a trust-based relationship with families to provide better care, and the mutual trust would lead to the better effect of information on both sides [14].

From the perspectives of the patients and their families, ethical codes of "selfishness vs. sacrifice" and "protection of the dignity of patients" were extracted.

Elliott and Olver (2008) reported that in most cases, families made this decision as the guardians of the patients, and the main reason for the rejection of the decision by the families was the moral challenges that families faced with [15].

One of the main issues stated by the participants in this study was protection of the human dignity of the patients. In fact, they considered. In this regard, Anthonypilla et al. (2014) reported that if CPR decision was not helpful for a patient, implementation of DNACPR might help the patient die with dignity and reduced the patient's and his family's distress [16]. However, Calam et al. (2000) stated the family would accept a DNR order only if they were informed about it since the beginning of the admission process; otherwise, they would resist this decision [17].

from the moral perspective, the code of "lack of understanding of the meaning of morality" was extracted. The participants stated that physicians and nurses do not understand the real meaning of moral principles. The patient's family members do not receive information about the patient's condition but they are expected to decide. One of the most important moral principles is non-maleficence while with futile CPR, the patients and their families are emotionally, physically, and financially hurt. Despite the findings of the present study that only suggests the principle of non-maleficence, other studies suggest that the patient's independence is the most important principle. Hall believes the most important factor in DNR is the principle of independence, and no legal provision is required in this area. With autonomy and independence, patients can refuse treatment. If moral principles are properly considered, the law has no place in decision-making [18].

Reynold and Croft (2012) believe that there are moral challenges in the context of the DNR, and the care provider team does not have the ability to meet 4 key moral principles and it is required to consult interdisciplinary experts to evaluate and implement these four principles [19].

The researcher suggests that nurses participating in this study may consider support for dying patients some sort of the principle of non-maleficence, and believe that if non-maleficence is observed, other principles are also met. Moreover, the participants in this study could have considered the principle of independence unnecessary due to lack of facilities and human resources.

In the legal category, codes of fear of the law and accusation of nurses were extracted.

Nurses participating in this study believed that in order to not have any legal problems, it is important to have written documents in this field. Even if the patients or their legal guardians ask for DNR, they should have it written in a legal document to prevent any legal problems for the treatment team. This code was also seen in the literature review, and the researcher did not find any studies that ignored the importance of law in such decisions.

In this regard, in a study entitled "providing a good death for patients in intensive care units from nurses' view", Beckstrand et al. stated one of the main issues in implementation of the DNR order for the patients was having a legal will of the patient [20].

Regarding the fear of law, the results of this study are also consistent with the results of a study by Sibblad et al. (2007) on the understanding of care providers in the intensive care unit. In that study, the participants considered fear of law and lack of legal protection the most important factors in performing futile care including CPR [21].

In an investigation entitled "attitude about DNR," O'Hanlon (2013) stated that the majority of the nurses participating in the study were willing to participate in decision-making but argued it was the physician's duty to inform the patients and their family, and did not want to give the news for fear of legal issues [22].

To prevent possible problems such as distrust in the treatment team or legal problems, nurses stated the best time to talk about end of life care was before the acute phase of the disease. In 2012, ANA Center for Ethics and Human Rights announced that the patient should decide about end of life care before life-threatening diseases. The patient should also be independent in this regard[23].

In the religious category, codes of fate, forgiveness of sins, the miracle, and beauty of human nature were extracted. Some of the participants argued the disease and prolongation of the death were necessary for forgiving the sins. They believed that although repeated CPR prolonged the process of death, it purified the patient of sins. In this regard, al-Khenaizan and al-Shahri, in a study entitled "Palliative care for patients Muslim", stated that Islam encourages Muslims to treat their illnesses; however, Muslims believe suffering is a fate that God has intended for them, and increases the spirit of patience and spirituality in them[24].

The Prophet of Islam (PBUH) says: "*Men have certain degrees before God, but will not reach that degree only by their actions until their body faces with a problem and in this way, they achieve that degree*". Muslims also consider the diseases as atonement for sins[24].

The code of fate was another finding of this study. In this code, the participants believed that many events in the life were controlled by God's power, not the humans'. Therefore, Aramesh and Shadi in a study entitled "euthanasia in Islam" stated that the concept of independence, freedom, and choice were meaningless about death for two reasons: life does not belong to humans, and the accelerating death damages the community[25].

Also, God speaks about death in the Quran repeatedly:

"Humans have two pending and imminent death. Imminent death is when the final decision of God to end the life in the material world is issued irreversibly. This means that the death does not occur before and after its particular time and place".(Sura Al-Imran verse 185)

Some participants stated that they or the family members of the patients believed in miracles; therefore, they tried to keep the patient alive through CPR until the last moment of his/her life. In this regard, LO et al. (2002) asked the physicians about spirituality and religion in the final stages of life and found that in their opinion, God might help them to return to life. The God's power to save lives is above all powers. Also, the medical team said they could not discontinue treatments in some cases for the patients' family's beliefs in the miracle [26].

In a study entitled "The religious background and its relation to decisions about DNR", Jaul et al. stated DNR orders were prevented by religious beliefs[27]. However, in the present study, none of the participants believed religious beliefs prevented DNR and were of the opinion that DNR complied with religious beliefs, since Islam is careful about dying or dead persons.

According to the Presidency of the Administration of Islamic Research and Ifta, Riyadh, Kingdom of Saudi Arabia, in the fatwa no. 12086 issued on 30.06.1409, if three reliable physicians and scientist say that the patient will not improve, life-support machines can be stopped. The family members' views are not involved in this case. The statement allows the medical team to execute a DNR order without the consent of patients' family members while in the United States, physicians are not allowed to execute DNR without the consent of the patient or his/her family.

Many Muslim experts also believe that if adverse effects outweigh benefits, it is not recommended (Makrooh) to continue treatment and if many experts conclude that the treatment is useless, continuing the treatment is not recommended[28].

In terms of jurisprudence, CPR has major challenges, and there is no consensus among scholars. These challenges have led to the formation of a variety of legal terminologies that have created a special religious concept. At the time of interference between some necessities, there are serious disagreements among the experts in saving the life of a patient who has an unestablished life and is enjoying medical facilities, against a patient who has an established life and is need of the equipment[29]. Some jurisprudents believe that if patients reach a stage where there is no cure, the family is not required to spend time and money and the death process should not be extended. Measures to provide governmental health services for patients should be prioritized[30].

In the economic category, the code of “money as a facilitating or hindering factor in CPR” was extracted. In this regard, Bahramnezhad et al considered financial problems as the most influential reason for deciding on interruption or non-commencement of the end of life treatments. Based on the principles of Islamic jurisprudence, if there are severe financial problems, these problems must be checked by a team of experts and a judge in accordance with religious regulations [30]. Mani argues that maintaining patients in late stages of their lives, i.e. vegetative state, in intensive care units causes families and the health system to bear heavy costs[31]. Contrary to the findings of the aforementioned studies, Karnik believes that the influence of economic factors in decision-making about DNR is inappropriate and states that financial problems should not have a role in decision making in this regard[32].

The researcher suggests that the important role of economic issues may be for the fact that in Iran, the majority of the costs are covered by families. However, the recent Health System Reform Plan has covered a major part of the costs that may affect the trend to consider a DNR order.

Limitation

Lack of access to competent individuals who have completed specialized courses was one of the limitations of the research. However, the researchers tried to use experts who met the conditions (clinical specialists in this field who had scientific publications on the subject) but it was not sometimes possible. In addition, since this issue has moral challenges, the participants did not have a tendency to speak in this regard in the early stages and preferred not to talk about their personal experiences. However, the researchers tried to solve this problem through providing assurance about confidentiality of the information.

CONCLUSION

As mentioned earlier, 6 categories were extracted from the texts reviewed. interviews were conducted with participants based on these categories. The codes of futile care, fear of distrust, fear of the law, moral distress, protecting human dignity, and miracles were shared in the context of Iran and other countries, which shows that in other countries, people believe in miracles according to their religions. Legal support was also considered a way for their immunity. As discussed earlier, trust was also one of the most important principles in the care of patients. However, in the Iranian context, codes such as stereotyped care, selfishness vs. sacrifice, lack of understanding of the morality, fate, and forgiveness of sin were extracted, which may be because of the religious background and the participation of Muslims in this study that suggests attention should be paid to religious issues in drafting DNR guidelines. Moreover, in the economic category, the code of money as a facilitating or hindering factor was extracted, which is necessary to be discussed with the participation of competent authorities that will be held in the later stages to consider the position of economic issues in developing the guideline?

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