

AN ETHICAL PROBLEM FACING NURSES:  
THE SUPPORT OF PATIENT AUTONOMY IN THE  
DO NOT RESUSCITATE DECISION

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A DISSERTATION  
SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS  
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I am submitting herewith a dissertation written by Barbara Bristow Ott entitled "An Ethical Problem Facing Nurses: The Support of Patient Autonomy In The Do Not Resuscitate Decision". I have examined the final copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Nursing.

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## DEDICATION

To my husband, Ed, for his patience understanding, and love. And to our children, Brian and Dena, who reminded me to take time out for the important things.

#### ACKNOWLEDGEMENTS

I wish to express my sincere appreciation to Dr. Rose Nieswiadomy, my chairperson, for her support, guidance, and encouragement during this research. I would like to thank my committee members Dr. Marion Anema, Dr. Margaret Beard, Dr. Anne Gudmundsen, and Dr. Glen Jennings for their careful review and suggestions.

## ABSTRACT

The purpose of this study was to examine critical-care nurses beliefs concerning the support of patient autonomy in the Do Not Resuscitate (DNR) decision in patients whose health condition was irreversible and terminal.

The population for the study consisted of registered nurses who were active members of the American Association of Critical-Care Nurses (AACN). The instrument was mailed to 500 randomly selected members of AACN. The study sample consisted of the 251 nurses who returned the completed questionnaires.

The instrument was developed by the investigator and included four hypothetical cases involving the Do Not Resuscitate decision. Following each hypothetical case, the subject was asked to select the agent (patient, family, physician, or nurse) who would most likely support patient autonomy in the DNR decision. The subjects were then asked to select the agent (patient, family, physician, or nurse) whose opinion would actually be regarded as most appropriate for making the DNR decision if this case were to present on the clinical unit where the nurse was employed. Questions designed to describe the sample of nurses and their experience with the Do Not Resuscitate decision followed.

In each of the four hypothetical cases presented the nurses selected an agent as best able to support patient autonomy. Their choices varied from case to case, depending upon the different aspects of the cases; however, there was general agreement among the nurses as to the most appropriate agent to make the Do Not Resuscitate decision in each case. When asked whose opinion would actually be regarded as most appropriate to make the DNR decision if the case were to present on their units, the nurses responded most frequently that the physician's opinion would be regarded as most appropriate for making the DNR decision, regardless of the agent selected as best able to support patient autonomy in the case situation ( $p = <0.001$ ). An ethical conflict concerning the DNR decision appears to exist for the majority of the nurses in this study.

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## CHAPTER I

### INTRODUCTION

It has been a quarter of a century since the introduction of external chest compression by Kouwenhoven, Jude, and Knickerbocker in 1960 (American Heart Association and the National Academy of Sciences, 1980). There followed in this country a widespread acceptance of cardiopulmonary resuscitation (CPR) among health care professionals. Training of physicians first, then nurses, and finally lay persons in the technique of CPR spread throughout the United States. Since 1966 the American Heart Association has made a large contribution of monies and time to educate vast numbers of people in proper CPR procedures.

The American Heart Association regards CPR as a standard procedure in cases of cardiac arrest, and this position is supported by the majority of hospitals across the country (American Heart Association and the National Academy of Sciences, 1980). However, the use of CPR in instances of all hospital deaths has been determined to be inappropriate. The American Heart Association and the National Academy of Sciences (1980) stated "the purpose of CPR is the prevention of sudden, unexpected death. CPR is

not indicated in certain situations, such as in cases of terminal irreversible illness where death is not unexpected" (p. 506). In order to prevent the misuse of CPR in specific hospital situations, physicians developed the Do Not Resuscitate order.

The Do Not Resuscitate order is one of the most controversial issues in nursing and medicine. It is a complex issue that has evolved due to the tremendous technological advancements in the scientific community (Lee & Cassel, 1984). Major technological breakthroughs in medicine have made heroic life support measures commonplace. Physicians and nurses, working together, now have the capacity to sustain vital life processes by artificial means (Collins, 1979). This sustainment can be maintained for an indefinite period of time. The question of when to use this technology is the basis of the Do Not Resuscitate dilemma.

The patient, the family, the nurse, and the physician in the intensive care unit face this dilemma frequently (Adler, 1977). The decision to resuscitate or not to resuscitate is very complex. The underlying issue is whether CPR will constitute a reasonable attempt to prolong life or merely delay death (Annas, 1982).

Throughout this discussion, it is important to remember that the hospital, the nurse, and the physician are

committed both philosophically and ethically to preserving life. Acting to preserve life is part of the nature of nursing and medicine. However, of critical importance is the kind of life that is being preserved. Also, of importance is the determination of the person most appropriate to make the Do Not Resuscitate decision.

The patient should make the decision if he/she is competent (Yarling & McElmurry, 1983). Autonomous decision making is a basic tenet of western society today (Veatch, 1981a). When the patient is not competent, then who will ensure that the patient's autonomy is being protected? This study explored nurses' perceptions of the agent best able to support patient autonomy in the Do Not Resuscitate decision.

#### Statement of Problem

The problems of this study were to:

1. Examine critical-care nurses' beliefs concerning the agent best able to support patient autonomy in selected hypothetical cases involving the Do Not Resuscitate decision.

2. Compare the congruency between critical-care nurses' beliefs concerning the agent best able to support patient autonomy and the agent whose opinion would be regarded as most appropriate in making the Do Not Resuscitate decision if selected hypothetical cases were

actually to occur in the critical-care units where the nurses were employed.

#### Justification of Problem

The use of CPR in critical-care units has produced successes as well as defeats (Gillick, 1980). In a study done by Bedell and Delbanco (1984), it was reported that one out of every three patients who dies in the hospital undergoes cardiopulmonary resuscitation. Many of these patients are successfully resuscitated enabling them to return to happy, productive lives. Others, however, have had their hearts restarted with CPR but have not returned to a satisfactory life. The vastly different consequences of the use of CPR is of great concern to patients, nurses and other members of the health care team (Battin, 1983; McCarthy, 1975).

The determination of when CPR should be used and who should make the decision about CPR is of great concern to today's health care providers (Annas 1982; Benjamin 1981, Bok 1976; Yarling & McElmurry 1983). Choosing not to use an accepted life saving technique may at first seem to contradict the dedication of the health care team to the preservation of life. However, most people would agree that CPR is not always in the patient's best interest (American Heart Association and the National Academy of Sciences,

1980). The decision must be made as to when CPR is and is not appropriate.

When the patient is competent, there is less likelihood of confusion. The patient can identify the action that would be most beneficial (Davis 1981; Veatch 1981a; Yarling & McElmurry 1983). Sometimes, however, even if the patient is competent, the members of the health care team take on a paternalistic role and make the decision for the patient rather than allowing the patient to choose freely (Ashely 1976; Bedell & Delbanco 1984). At other times, the patient is not competent and is terminally ill. Another individual or individuals must then make the decision.

McCarthy (1975) stated that it is urgent for health care providers to understand the difference between the use and the abuse of CPR. The understanding of this difference is clearly derived from a compassion for the autonomous decision making ability of individual patients (McCarthy 1975; Veatch 1981a). The support and enhancement of patient autonomy is important to the patient and the health professional.

The very complex issue of the Do Not Resuscitate decision is intensified by the ethical dimensions involved. Nurses are drawn into the decision making process by the very nature of their work and their role as patient advocate



(Yarling & McElmurry, 1983). This study was conducted to determine how nurses view the support of patient autonomy in the Do Not Resuscitate decision. It is hoped that the results will add to the body of knowledge surrounding this ethical dilemma.

### Theoretical Framework

This study utilized the theoretical framework of ethical decision making presented by Robert Veatch. Veatch, in his book, A Theory of Medical Ethics, (1981a) has proposed a triple-contract theory of health care ethics. The first contract is between the individual members of the society and ascribes to the concepts and content that are of value to an ethical society. The second contract is between society and the profession, and the third contract is between professionals and patients.

Veatch's triple-contract theory is quite helpful in guiding practice because it narrows from a general contract to a specific contract. In the first contract, the concept of autonomy has a wide scope, with the autonomy of society being the focus. The second contract narrows the focus to autonomy of the profession and autonomy of society as they interact. The third contract narrows the focus of autonomy even further to display the specific relationship between the patient and the health care professional.

Veatch carefully described the triple-contract relationship by stating "the basic social contract or covenant expresses a moral community bound together in reciprocal pledges of trust and loyalty, but at the same time recognizing that the moral relationship affirmed by the contract will sometimes have more public, more formal, more legal ramifications" (p.126). There is a fundamental equality and reciprocity in the relationship.

Veatch has contended that it is possible to invent a universal base large enough to accommodate everyone involved in ethical decision making. The first concept to include that would allow people the ability to reach sound decisions would be freedom. This freedom would be an autonomous freedom that is necessary to think and act without constraint except to prevent impingement on the freedom of others. Veatch would also include the principle that each person's welfare should count equally. This equality of each person's welfare is essential to the development of a moral community. The equality of each person's welfare must be impartial. One way to test for this impartiality is the test of reversibility. The principles or practices established must "be acceptable to one standing on either the giving or the receiving end of a transaction" (p. 119).

Veatch's first contract specifies the content of an

ethical system, and the moral point of view is affirmed. The moral point of view or the impartial consideration of the other person's welfare is what the contractors should use as the basis for ethical principles for society.

The second contract described by Veatch, is one between society and the profession. This "spells out (again from the moral point of view) the special role-specific duties regarding interactions between lay people and professional" (p. 138). An example of these role-specific duties would be the confidentiality of information shared between patients and health-care professionals. Veatch stated that role specific duties cannot exist simply because a profession itself imposes them. They must flow from the desires of society. Society might also determine that special roles such as physician or patient should carry with them special rights and responsibilities. The only limitation to Veatch's second contract is the first contract because the first contract is the more basic moral contract.

The third contract is between the individual professional and the patient. Besides the moral aspect, this contract should contain various other aspects, including financial agreements, lifestyle preferences, and treatments. The third contract concerns a trusting, harmonious relationship at the individual level. Veatch

explained that "within the limit of the first two contracts, individual professionals and lay persons should develop a clear understanding of this right of access in their particular relationship" (p.136).

Veatch proposed the adoption of several principles. These principles are: contract keeping, autonomy, honesty, avoiding killing, and justice. He showed an example of how these principles should be used in his "Draft Medical Ethical Covenant". He stressed that this is only an example of what he would bring to the bargaining table if he was part of the group of citizens of the moral community trying to articulate an ethical covenant for the health care community. Veatch proposed this Medical Ethical Covenant:

We lay people and health professionals realizing the importance of health as an important part of human welfare articulate and affirm the following basic understanding of our mutual responsibility one to another:

The common starting point of our medical ethical commitment is our recognition that we are members of a common moral community of responsible people endowed with reason, dignity, and equality of moral worth. Thus, together we recognize the fundamental ethical principles.

--We acknowledge the moral necessity of keeping promises and commitments to one another, including the commitment of this covenant.

--We acknowledge the moral necessity of treating one another as autonomous members of the moral community free to make choices that do not violate other basic ethical requirements.

--We acknowledge the moral necessity of dealing honestly with one another.

--We acknowledge the moral necessity of avoiding actively and knowingly the taking of

morally protected life.

--We acknowledge the moral necessity of striving for equality in individual welfare and equality in the right of access to health care necessary to produce an opportunity for health equal insofar as possible to the health of others.

--We acknowledge the moral importance of producing good for one another and treating one another with respect, dignity, and compassion insofar as this is compatible with the other basic principles to which we are bound (p.327).

Veatch continued in his draft a discussion of specifics such as licensing of professionals, access by patients to their medical records, and information that lay people have a right to know. He emphasized the importance of autonomy throughout his theory of ethics for the health professional.

Veatch credited Kant (1964) as the person who provided the bridge from theology to secular notions of freedom and autonomy. He quoted Kant saying, "every rational human being exists as an end in himself not merely as a means for arbitrary use by this or that will" (p. 193).

Veatch described the autonomous person as one with a will to determine his own course of action. Such an autonomous person deliberates about and chooses his plans for the future. The individual is self directed and governs himself in the exercise of personal autonomy. People should not interfere with the autonomous decisions and actions of others. Control over the actions of others from society is only permissible if that control is exerted to prevent harm

to another.

Veatch characterized the physician - patient relationship in regard to patient autonomy by disclosing that "physicians themselves have begun to realize that doing what will benefit the patient may not be the same as preserving patient autonomy" (p. 3). He asserted that the Hippocratic tradition of doing no harm to the patient "may not mean precisely the same thing as doing what will benefit. Benefiting the patient is often not the same as doing good in general" (p. 4). The traditional professional medical ethics, as transmitted by physicians from generation to generation, is now being challenged by society and health professionals.

If the patient refuses medical care believed necessary by the physician, it is the patient's expression of his own value system. The right to refuse treatment is essentially an issue of autonomy. This right does not diminish even if the patient's condition is terminal. The right of self determination still applies. Veatch was quite clear in his position when he claimed that:

if there is any obligation to prolong life at all (independent of considerations of benefit and harm or of a duty to avoid killing), it cannot authorize professionals to violate the autonomy of the terminally ill. The society cannot let a minority of physicians who believe that they have a duty to prolong life override the principle of autonomy in such situations. (p. 208)

Veatch continued this discussion with regard to an individual who is not competent and, therefore, cannot function as his or her own moral agent. In the case of a formerly competent person, an agent for the patient must make the decisions. He contended that:

the decisions should be based on the person's beliefs and values as best as can be determined. The agent for the patient should be selected on the basis of ability to reflect and interpret those beliefs and values. Autonomy is preserved by the agent acting on the framework established by the person while competent. (p. 209)

Selection of an agent for an incompetent patient is very important. Determination must be made as to the appropriate individual best able to support patient autonomy in the Do Not Resuscitate decision.

#### Development of a Model

In an attempt to objectify the concept of autonomy in the Do Not Resuscitate situation, a Do Not Resuscitate Decision Model was developed by the researcher. The model is intended to depict and define the variables and their relationships. The model was developed by first identifying the variables from the theoretical framework and, second, deriving appropriate relationship statements from the theory to link the variables. The thrust of the model is to identify the agent best able to support patient autonomy in the Do Not Resuscitate decision. The model is depicted in

two forms: first, a logical format and, second, a schematic format (Figure 1 and Figure 2).

#### Definition of Terms for Model

Terminal and Irreversible Health Condition - a health condition which, because of its nature can be expected to cause the patient to die.

Competent - mentally qualified or capable of making decisions.

Do Not Resuscitate - the decision to prohibit the initiation of cardiopulmonary resuscitation.

Close Relationship with Next of Kin - a relationship in which the family member wishes only the best possible outcome for the patient.

Primary Physician - the physician most knowledgeable about the patient's response to his/her health condition and his/her wishes concerning that condition.

Primary Nurse - the nurse most knowledgeable about the patient's response to his/her health condition and his/her wishes concerning that condition.

Therapeutic Relationship - a goal directed, patient centered, nonsocial relationship responsibly directed by a health professional.

Collaborative decision - joint decision based on input from all individuals involved in the decision.



Figure 1. DO NOT RESUSCITATE (DNR) DECISION MODEL

Patient with terminal irreversible health condition diagnosed by physician and written as such on chart:

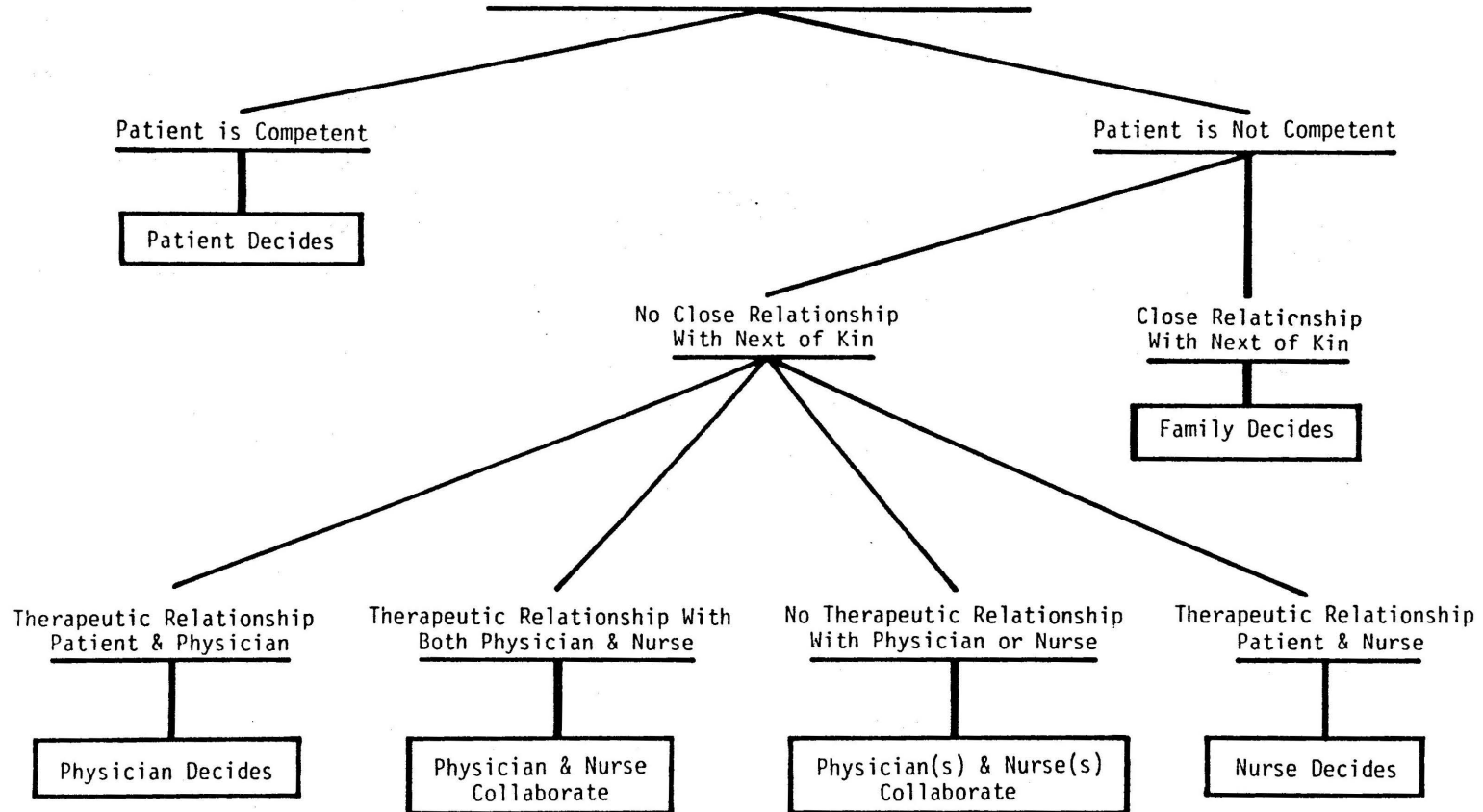
If A; then 1  
If not A; and B, then 2  
If not A; and not B; and C, then 3  
If not A; and not B; and D, then 4  
If not A; and not B; and C and D, then 5  
If not A; and not B; and not C; and not D;  
then 6

A = Patient is competent.  
B = Patient with close relationship with next of kin.  
C = Therapeutic relationship between patient and primary physician  
D = Therapeutic relationship between patient and primary nurse

1 = Patient makes DNR decision.  
2 = Family makes DNR decision as patient would wish.  
3 = Patient's primary physician makes DNR decision as patient would wish.  
4 = Patient's primary nurse makes DNR decision as patient would wish.  
5 = Collaborative decision of physician(s) and nurse(s).  
6 = Collaborative decision of physician(s) and nurse(s) or hospital ethics committee.

# DO NOT RESUSCITATE (DNR) DECISION MODEL

Patient with Terminal Irreversible Health Condition  
Diagnosed by Physician and Written on Chart



### Assumptions

This study was based on the following assumptions:

1. Registered nurses are interested in the welfare of patients.
2. Registered nurses place a high value on patient autonomy.
3. Ethical decision making is part of professional nursing practice.
4. The primary physician and/or the primary nurse have an established relationship with the patient and are knowledgeable regarding the patient's values and wishes concerning the Do Not Resuscitate situation.
5. The Do Not Resuscitate order is an option not philosophically opposed by the patient, family, nurse, or physician.

### Hypotheses

When presented with selected hypothetical case situations concerning the Do Not Resuscitate decision involving patients whose health condition is irreversible and terminal:

1. There is congruence between critical-care nurses' beliefs concerning the agent (patient, family member, physician, or nurse) best able to support patient autonomy and the agent deemed appropriate to make the Do Not

Resuscitate decision according to the model developed for this study.

2. There is congruence between critical-care nurses' beliefs concerning the agent whose opinion would be regarded as most appropriate in making the Do Not Resuscitate decision if these selected hypothetical cases were actually to occur on the critical-care units where the nurses are employed.

#### Definition of Terms

The following terms were defined for this study:

Patient Autonomy - the right of an individual to choose from alternative therapies or to choose to reject therapy while the individual is in the patient role.

Do Not Resuscitate - the decision to prohibit the initiation of cardiopulmonary resuscitation. Cardiopulmonary resuscitation is defined as closed chest compression and artificial ventilation (AHA, 1980).

Terminal and Irreversible Health Condition - a health condition which, because of its nature can be expected to cause the patient to die.

Critical-Care Nurse - a nurse that cares for the patient with real or potential life-threatening health problems and who requires continuous observation and intervention to prevent complications (AACN, 1981). In this

study, current membership in the American Association of Critical-Care Nurses was used to qualify a subject as a critical-care nurse.

Agent - the individual chosen to represent the patient's best interest (Veatch, 1981a).

Hypothetical Case Situation - a short summary of a typical patient history developed by the investigator.

#### Limitations

The following limitations may have influenced the results of this study:

1. The sample was limited to members of the American Association of Critical-Care Nurses, and the results can be generalized only to that group.
2. The data focused on decisions that would support patient autonomy in specific hypothetical cases. No attempt was made to identify how patient autonomy could be realistically achieved.
3. Only four hypothetical cases were utilized.
4. No control was made for subjects' educational preparation or previous life experiences with death or the Do Not Resuscitate situation.

### Summary

Rapid developments in medical technology have produced many new advancements in critical-care. Some of these developments enable the prolongation of biological life. The decision of when and how these procedures will be used is of ethical concern to all society. Veatch's (1981a) theory of medical ethics has placed a high value on autonomous decision making by the patient. The critical-care nurse is concerned about the patient's ability to make autonomous decisions while in the intensive care unit. This study examined the ethical issue of patient autonomy in the Do Not Resuscitate decision.

## CHAPTER II

### REVIEW OF LITERATURE

This chapter presents a review of literature relevant to this investigation. The review is organized into six sections: (1) Critical-Care Nursing, (2) the Do Not Resuscitate Issue, (3) Patient Autonomy in Terminal Illness, (4) Ethical Decisions in Nursing, (5) Agents in the Do Not Resuscitate Decision, and (6) Summary.

#### Critical-Care Nursing

Critical-care nursing practice is a dynamic process involving the care of acutely ill individuals. The American Association of Critical-Care Nurses (1981) has described the critically ill patient as being "characterized by the presence of real or potentially life-threatening health problems and by the requirements for continuous observation and intervention to prevent complications and restore health" (p. xi). This definition continues by stating that the concept of the critically ill patient also includes the family of the critically ill patient.

The intensive care unit (ICU), as a place of life or death, presents ethical dilemmas for nurses. Davis (1979) specified that ethical decision making is not unique to the

ICU; however, it does display itself more dramatically there. She continued, "ethical issues surrounding the definition of death, withholding treatment, terminating treatment, suffering, dignity, and autonomy as well as allocation of resources, combine to present profound ethical problems for the nurses caring for these seriously ill patients" (p. 45).

Davis contended that underlying the ethical problems faced by the nurse in the ICU was the nurse's social position in the hospital organization (a position with minimal prestige or power) and the problem of multiple loyalties. These multiple loyalties have historically included loyalty to the patient, the physician, and the institution where the nurse is employed. Stressful events in the ICU are frequently compounded when the event causes a clash between loyalty to the patient and loyalty to the physician or the institution (Davis, 1979).

Warner (1983) stated that there were very few professional groups more exposed to ethical dilemmas in their practice than critical-care nurses. Constantly, in their practice, critical-care nurses make ethical decisions, and frequently these decisions are not consciously recognized by the nurse as ethical in nature.



### The Do Not Resuscitate Issue

The prolongation of biological life is possible for an increasing number of hospitalized patients. The advancement in technology has brought to the medical community effective techniques for sustaining cardiac and respiratory function. For the most part, these advancements have been warmly welcomed; however, they have also brought problems (Miller, 1983).

Cardio-pulmonary resuscitation (CPR) is a technological advancement surrounded by ethical issues. CPR is a life saving procedure that artificially maintains circulation and respiration. This procedure involves manual chest compressions, that squeeze the heart and force blood through the arteries, and artificial ventilation by mouth to mouth breathing (American Heart Association & National Academy of Sciences, 1980). The American Heart Association and the American Red Cross have successfully trained millions of health care providers and lay persons in CPR. In 1981, the American Heart Association alone trained 2,620,000 people in CPR (American Heart Association & National Academy of Sciences, 1983).

Nursing administration in almost all acute care facilities requires nurses to be certified in CPR. Most hospital policies require that CPR be initiated whenever a

patient dies in the hospital, unless a written order for Do Not Resuscitate (DNR) is in the patient's chart (Collins, 1979).

The American Heart Association and the National Academy of Sciences (1980) specified that "the purpose of CPR is the prevention of sudden, unexpected death. CPR is not indicated in certain situations, such as in cases of terminal irreversible illness where death is not unexpected" (p. 457). The statement is concluded with, "it has even been suggested that resuscitation in some circumstances may represent a positive violation of a person's right to die with dignity" (p. 506).

Miles, Cranford, and Schultz (1982) reported that before the techniques of CPR were perfected, resuscitation of patients had such a low success rate that it was rarely of ethical concern. They continued by stating that now, however, the success rate is high and the technology is available to support cardiac and respiratory function. This has expanded the application of resuscitation and has presented increasing ethical problems for health care professionals.

Rabkin, Gillerman, and Rice (1976) clarified that the general policy of hospitals is to preserve life, even the life of a terminally ill patient. This is a statement of

philosophy as well as a standard of medical care. However, regardless of the hospital's pro-life policy, the right of a patient to refuse available treatment must be respected by the hospital and the health care professional.

Spencer (1979) asserted that:

there is general agreement that people who experience sudden death in the setting of good health or a reversible medical condition should be resuscitated, and that patients whose underlying condition is one of rapid and inevitable progression to death should not be resuscitated when that event finally occurs. (p. 139)

Statistics from the National Center of Health Statistics (personal communication 1984) indicated that 38,544,000 patients were admitted to nonfederal short term hospitals in 1981. Of those admitted, 36,905,000 were discharged alive, and 982,000 died during their hospitalization. The condition of the remaining 657,000 was unknown. Since a DNR order is required if CPR is not to be performed, it is suspected that CPR procedures were utilized with a large portion of those clients who eventually died. There was probably also a portion of the total number that were successfully resuscitated, but that number is not known. In reviewing studies to determine success of CPR, Lee and Cassel (1984) stated "the fraction of resuscitated patients who are ultimately discharged from the hospital ranges from 8.2% to 24%" (p. 140).

Miles, Cranford, and Schultz (1982) reminded the health care community that there are more than just two outcomes to the performance of CPR (successful and unsuccessful). If CPR succeeds in its primary purpose of restoring cardiac contractions, the end result can still be less than satisfactory. He stated that it is important for the patient to understand that resuscitation may be followed by the need for life support, including intratracheal tube, a respiratory ventilator, constant surveillance by monitoring devices, continuous intravenous medication, and other such care. This care could continue for an indeterminate period of time.

Spencer (1979) submitted this statement: "Resuscitation is a traumatic event for the patient and for any family and friends who may be present. It is a violent intrusion into what otherwise may be the peaceful final stage of life or early stage of death" (p. 139). The decision not to attempt CPR is clearly as important a decision, in terms of patient welfare, as the decision to undertake resuscitation.

Withholding CPR or any treatment is an ethical decision. Lo and Jonsen wrote in 1980 that physicians frequently offer four reasons for limiting treatment: The treatment is futile, the patient declines treatment, the quality of life is unacceptable, and the costs are too

great. There is no moral or legal obligation imposed upon the physician to provide medical therapy that will not cure the disease or relieve symptoms. He gave the example that some patients are clearly moribund, soon to die no matter what treatment is given. In such cases, the physician's duty is to make the patient as comfortable as possible. Another reason for withholding treatment is that the patient wishes it withheld. This decision requires informed consent or, more appropriately, informed refusal by the patient. The elements of informed consent are disclosure, comprehension, and competence. Lo and Jonsen continued that the acceptability of limiting treatment because of quality of life depends on who is making the decision. "A patient may decide to limit treatment because of the anticipated quality of his own life, but it would be inappropriate for the physician to do so" (p. 765). Only the patient has the experience and the standards to evaluate the quality of his or her life.

Siegler, (1982) questioned the policy of CPR as standard practice in hospitals and asserted:

should health professionals perform CPR on every patient who is about to die in a hospital? This approach -- equal CPR for all regardless of medical condition or patient preference -- is indefensible, counterintuitive, and unethical, and would signal the ultimate transformation of medicine from an art based upon clinical discretion into an unthinking, unfeeling bureaucratic system (p.28).

Lo and Steinbrook (1983) clarified and reminded the health care team that a DNR order only means that CPR will not be performed; other medical and nursing care will continue as appropriate, including emotional support, relief of symptoms and medical treatment. A DNR order should not influence the quality of care given, only the goals of care.

#### Patient Autonomy in Terminal Illness

Jackson and Younger (1979) claimed that the issues of patient autonomy and the right to die with dignity are two of the most important issues facing society today. Discussion by all factions of society is necessary before any consensus can be reached.

According to Childress (1982), autonomy means that a person chooses and acts freely and rationally based on his/her own life plan. He contended that there is a conflict between professional paternalism and patient autonomy. He defined paternalism as a refusal to acquiesce to a person's choices, wishes, or actions for that person's own benefit. Paternalism attempts to meet the needs of another person, even against that person's wishes. Paternalistic acts by health care providers restrict patient autonomy.

Cassell (1977) declared that "autonomy is not something that patients should have to seize from physicians"

(p. 334). A therapeutic doctor-patient relationship is necessary for the survival of patient autonomy. The relationship between the sick patient and the physician must be in the spirit of a partnership (Cassell, 1977).

Childress (1982) argued that "nowhere is paternalism more rampant than in the care of patients who are terminally ill" (p. 162). Childress continued by saying that the withholding of information from dying patients denies them the right to make autonomous decisions. He stated that physicians simply fail to discuss the possibility of death with their patients because it is uncomfortable and difficult to talk about. Also, the patient may have difficulty in communicating meaningfully with the physician during the short daily visits in the hospital.

Evans (1981) has agreed with asserted that no amount of professional skill, or good intention can justify substituting the will of the physician for the will of the patient. Evans continued by stating that there is an emerging consensus in today's society to support the wishes of the patient in the Do Not Resuscitate decision.

Illich (1976) complained that the modern world of medicine has taken all autonomy from the dying patient. He stated:

traditionally, the person best protected from death was the one whom society had condemned to

die. Society felt threatened that the man on Death Row might use his tie to hang himself. Authority might be challenged if he took his life before the appointed hour. Today, the man best protected against setting the stage for his own dying is the sick person in critical condition. Society, acting through the medical system, decides when and after what indignities and mutilations he shall die. The medicalization of society has brought the epoch of natural death to an end. Western man has lost the right to preside at his act of dying. Health, or the autonomous power to cope, has been expropriated down to the last breath. Technical death has won its victory over dying. (p. 207)

#### Ethical Decisions in Nursing

Historically, ethical decision making in nursing has followed a slow, deliberate, steady path. Florence Nightingale (1868) promoted stiff discipline, long hours and devotion to duty. Strict adherence to the physician's instruction was expected. The nurse of the 1920s, as described by Lamb (1981) was one whose qualities, motives and virtues were good. Characteristics such as "tactful, devoted and kind" were those attributes considered to be most important.

Moore's 1935 work titled Principles of Ethics described the nurse-patient relationship. Patient autonomy was not highly valued. The valued concept in this era was obedience to the physician. This obedience could include lying to the patient, if the physician desired. Nurses were to act in the patient's best interest as defined by the physician.



Curtin (1982) wrote that nurses' relationships with patients or clients were founded in and formed by the physician and not by either the patient or the nurse. According to Curtin, the ethical nurse of the past was the honorable nurse who fulfilled a Christian duty by caring for the sick.

In the 1970s nursing ethics changed to reflect a focus on actions and duties rather than on traits and virtues (Frankena, 1973). The nurse was no longer considered to be an arm of the physician. The nurse of the 1980s has emphasized patient autonomy in decision making, and the role of the nurse includes acting as a patient advocate (Yarling & McElmurry, 1983).

The 1980 Social Policy Statement of the American Nurses' Association (ANA) defines nursing as "the diagnosis and treatment of human responses to actual or potential health problems" (p.3). The Code for Nurses with Interpretive Statements (1976), also authored by the ANA, states:

the nurse provides services with respect for human dignity and the uniqueness of the client unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems. Whenever possible, clients should be fully involved in the planning and implementation of their own health care. Each client has the moral right to determine what will be done with his/her person; to be given the information necessary for making informed judgements; to be told the possible effects of care; and to accept, refuse, or terminate treatment. (p. 4)

Veatch (1981a) wrote that the nurse should not be considered as one who only follows orders and performs tasks without moral reflection. He stated that, in reality, there is a moral question for the nurse that is the same as the moral question for the physician. Are the wishes of the patient known to the health care team and are these wishes being followed?

Veatch (1981b) continued discussing the physician-nurse relationship by asserting that an ethical problem exists when a person feels an act is wrong, but this act has been ordered by someone else. Nurses often face this problem. In contrast, Veatch stated, physicians are typically in positions of power. Their ethical problem has not been one of power deficit, but of power surplus. Therefore, abuse of power and authority may occur. Recently, this traditional balance of physicians' power surplus and nurses' power deficit has begun to change.

According to Veatch (1981b) , physicians are able to act from a position of relative moral autonomy while nurses are more frequently and more realistically faced with the problem of being expected to engage in practices that violate their own consciences. Nurses frequently find themselves in situations where they must decide whether or not to carry out an act to which they morally object but

which has been ordered by the physician. Pinch (1985) contended that if restrictions exist in the work setting that prevent autonomous actions, "anxiety from an ethical dilemma might result, not necessarily from the inability to resolve the situation, but from the inability to implement the desired solution" (p. 372). The difference between nursing ethics and physician ethics is mostly one of power and authority (Veatch, 1981b).

Davis (1981) discussed an example of the nurse in a position of power deficit. She recalled a case where the patient told the nurse that he did not wish to be resuscitated but the physician would not write an order to withhold resuscitation. The nurse was faced with an ethical decision. She could follow the physician's order to resuscitate as part of her role obligation to the physician or she could decide not to resuscitate the patient, if the need should arise.

Yarling and McElmurry (1983) submitted that because of the historical domination of nursing by the medical profession, the nurse is not free to be moral. The nurse is not able to act on her professional commitment to the patient because of repressive institutional policy. They avowed that the patient would be best served if there was a balance of power around the bedside.

### Agents in the Do Not Resuscitate Decision

Miles et al. (1982) stated that the physician, as the medical expert, is responsible for assessing and evaluating the clinical information necessary to identify the medical condition of the patient. It is the physician who must determine that the patient's condition is irreversible and terminal before any discussion of the Do Not Resuscitate order takes place. Yarling and McElmurry (1983) have contended that this medical judgement is a "necessary, but not sufficient, condition for the DNR decision" (p. 2). The physician is then responsible for presenting to the patient an understandable, balanced analysis of the clinical findings, prognosis, and treatment options available.

Lo and Steinbrook (1983) warned that decisions regarding the medical futility of the treatment options are frequently laced with value judgements. Determining medical diagnoses that are reversible, how much treatment is necessary, and what risks are acceptable require value judgements by the physician. Judgements about futility may be confounded by assessments of the patient's quality of life and by the physician's emotional reaction to caring for the patient. Lo and Steinbrook contended that "it is unavoidable that physicians will make value judgements: they should be recognized explicitly, discussed openly, and not

confused with scientific fact" (p. 1562).

Annas (1982), Rabkin (1976) and Veatch (1981a) agreed that when the responsible physician (after consulting with other health care providers) has reached the decision that a patient's condition is irreversible and terminal, a discussion should be initiated with the patient to define the overall management objectives. If the patient is competent, he or she has the clear right to refuse any treatment, including resuscitation. This right remains even if the consequences of such refusal may result in death.

Yale New Haven Hospital (1983) developed a policy concerning the patient's right to refuse CPR. According to their policy, if the patient is competent and fully understands the consequences of the situation and the alternatives, his right to determine his treatment should be upheld, even if the decision is opposed by one or more of the patient's family members.

Miles et al. (1982) and Lo (1983) addressed the Do Not Resuscitate situation when the patient is not competent. They wrote that the physician should ask the family to state the patient's wishes. This is different than asking the family to make the decision themselves. Lo stated that this distinction often reduces guilt and stress in family members.

Miles et al. (1982) declared that the primary physician should take a central role in the implementation of DNR orders. He stated that the responsibility of the DNR decision is not assigned to the primary physician as a matter of convenience but is rightfully assumed by the very nature of the primary care relationship. The primary physician is most familiar with all the facets of the patient's medical and emotional condition and, through discussion with the patient, usually has established a trusting and open relationship that is desirable in making a decision of this type.

A trusting and open relationship between the physician and the client is not always attainable in our modern health care delivery system. Yarling and McElmurry (1983) claimed that this physician-client relationship is hard to find in large teaching hospitals. They proposed that "the writing of a DNR order should be regarded as an overlapping function of medicine and nursing, which may be performed either by the physician or the nurse, depending upon the situation" (p. 5). Because of the frequent and ongoing interaction between the patient and the nurse, the discussion about the DNR situation often takes place first between these two individuals. It is common for the patient to tell the nurse that he or she does not wish to continue treatment and wants

to be allowed to die. Due to the nature of the role of the nurse, these conversations often occur more naturally with the nurse than with the physician. "In such situations, it makes good sense for the nurse, after consultation with the physician and other appropriate persons, to write the DNR order and its justification in the progress notes" (p. 5).

Yarling and McElmurry (1983) argued that when the patient refuses resuscitation efforts, this decision is a human response to a terminal illness that has resulted or could result in a radically reduced quality of life. The determination that the patient is coherent and capable of making such a decision is the responsibility of the nurse. The writing of the DNR order in the progress notes reflects the patient's decision. Yarling and McElmurry concluded that writing a DNR order is clearly within the domain of nursing as defined by the ANA. They contended that it is inconsistent to believe that the nurse who dutifully bears the responsibility of life and death when initiating CPR is not responsible enough to write the DNR order after the patient has made the DNR decision.

Veatch (1981b) acknowledged that many people look at the physician as the captain of the team, while the nurse is only a player on the team. He rejected this notion and argued that both the physician and the nurse have a limited

sphere of responsibility and independent decision making authority, and neither should be the captain of the team. It is the patient to whom the team is dedicated and around whom the team is organized. It is the patient who should be the captain of the team.

Diane Adler (1977), past president of the American Association of Critical-Care Nurses, addressed the DNR situation. She contended, "we cannot save everyone, and for some patients, it is cruel, inhumane, and even wasteful to even try. Let us discuss this issue as colleagues and decide on an acceptable solution together" (p.213).

#### Summary

Critical-care nurses care for clients with life-threatening health problems in a highly specialized technical arena. This care is influenced by inherent ethical dilemmas that abound in the critical-care setting. Because of the modern technical advancements in the area of life support, the Do Not Resuscitate issue has emerged. The determination of the appropriate person to make the Do Not Resuscitate decision was the focus of this study. The results of the study will contribute to the literature on the nurse's role in the Do Not Resuscitate decision.



## CHAPTER III

### PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

This study was conducted in order to investigate nurses' beliefs concerning the support of patient autonomy in the Do Not Resuscitate situation. This study employed an exploratory, correlational approach described by Campbell & Stanley (1963). The data for the study were gathered through the use of four hypothetical case situations in which nurses were asked to identify the agent best able to support patient autonomy in the Do Not Resuscitate decision. Congruent with an exploratory, correlational study, the data analysis employed both descriptive and inferential statistics.

#### Population and Sample

The population for the study consisted of Registered Nurses who were active members of the American Association of Critical-Care Nurses (AACN). This national organization had a membership of 41,000 nurses at the time of this study. The sample was comprised of 500 Registered Nurses randomly selected from the membership list of AACN. Roscoe (1975) stated that:

there are few occasions in behavioral research where samples smaller than 30 or larger than 500 in size can be justified. A sample of size 500 assures that the sampling error will not exceed the standard deviation divided by 10 about 98 percent of the time. Within these limits -- from about 30 to 500 -- the use of a sample about one-tenth as large as the parent population is recommended. (p.184)

Those nurses who participated in the pilot study for this research or who were identified by the investigator as having prior knowledge of this research were eliminated from the sample.

#### Protection of Human Subjects

This investigation was classified as Category I (no risk) research because only questionnaires were used, and the subjects could not be identified (Appendix A). Permission was received from the graduate school to conduct this study. Permission was also received from AACN to use their mailing list and to conduct the study (Appendix B).

The names and addresses of members were randomly selected by the research staff of AACN. These names and subsequent mailing labels were forwarded to Taubenpost Inc., a mailing service employed by AACN. The researcher did not see the mailing list or names of the sample members; thus, anonymity was assured.

Subjects were given written information about the

researcher, and the study, as well as instructions for participation (Appendix C). They were informed that all information would be anonymous and that returning the questionnaire constituted informed consent to act as a subject.

### Instrument

The instrument that was used in this research was a questionnaire developed by the investigator (Appendix D). This questionnaire is divided into two parts. The first part consists of four hypothetical cases describing the Do Not Resuscitate situation. The cases described different critical aspects of the Do Not Resuscitate Decision Making Model. Following each case there are three questions. Question #1 asks the participants to select the person they believe would most likely support patient autonomy in the Do Not Resuscitate decision. Question #2 is open-ended and asks the participants the reason for the response selected in question #1. Question #3 asks the participants to select the person whose opinion would be regarded as most appropriate for making the Do Not Resuscitate decision if the hypothetical case were to actually occur on their unit.

The second part of the questionnaire consists of 29 demographic and experiential questions designed to describe

the sample and their experience with the Do Not Resuscitate situation.

### Validity and Reliability

The questionnaire was evaluated for content validity by a panel of three nurse experts in critical-care and ethics. The panel was asked to evaluate each case by answering the following questions: (a) Is it clear that the construct being measured is patient autonomy in the Do Not Resuscitate situation? (b) Is there enough information provided in each hypothetical case to determine if the response given by the participant is congruent or incongruent with the Do Not Resuscitate Decision Making Model? (c) Will these two instruments elicit data sufficient to test the research hypotheses?

The panel agreed that the questionnaire clearly measured the construct of patient autonomy in the Do Not Resuscitate situation and that there was enough information provided in each hypothetical case to determine if the response given by the participant was congruent or incongruent with the model. They also agreed that the instrument would elicit data sufficient to test the research hypotheses. Suggestions made by the panel for minor editorial changes were incorporated in the instrument.

Reliability was established using a test-retest method. The reliability for each hypothetical case was established by data received from 17 registered nurses. The time between the first administration of the questionnaire and the second administration was one week. The correlation coefficients varied for the four cases from .72 to 1.00.

#### Pilot Study

A pilot study was conducted to determine whether the hypothetical cases contained enough information to enable the participants to answer the questions that follow each case. It was also used to determine if the questions following each case were clear and would elicit the type of response for which they were designed. The length of time required to answer the questionnaire was also evaluated.

The questionnaire was administered to 47 nurses who volunteered to participate in the study. The setting was one AACN monthly chapter meeting in each of two cities in the southwestern United States.

The findings indicated that in all four case situations which called for respondents to select the person most appropriate to support patient autonomy in the Do Not Resuscitate decision, nurses chose the answer that was proposed by the Do Not Resuscitate Decision Making Model.

However, when asked whose opinion would actually be regarded as most appropriate for making this decision if the case presented in their own unit, most of the nurses selected the physician in all four case situations.

It was concluded from the pilot study that the answers provided by the respondents were in agreement with the Do Not Resuscitate Decision Making Model as to which agent was best able to support patient autonomy. There was a difference between the person nurses believed best able to support patient autonomy in three of the hypothetical cases and the person whose opinion would be regarded as most appropriate for making the Do Not Resuscitate decision if the case actually were to occur on their units. In the fourth case, the nurses were in agreement that the physician was the person best able to support patient autonomy and the person whose opinion would be regarded as most appropriate for making the Do Not Resuscitate decision if the case were actually to occur on their work units.

There were four different demographic questions left unanswered from the responses of four different subjects. There was no evidence of questions that were confusing to the respondents. There was nothing written in the margins next to the questions nor were there any notations suggesting unclear questions. Subjects did not express any

dissatisfaction with the tool to the researcher.

#### Data Collection

Data collection was accomplished through mailed questionnaires. Each subject received a cover letter (Appendix C) comprising of: (a) a brief explanation of the purpose of the study, (b) a brief explanation of the means by which the subject was chosen for participation, (c) a description of the means for providing anonymity of the individual, and (d) a statement informing the participant that returning the questionnaire was to be construed as informed consent to act as a subject. Included with the letter was a return envelope, instructions to the participant, and the questionnaire (Appendix D). The participant was instructed not to sign the questionnaire.

#### Treatment of Data

Demographic data were obtained on the sample using a 29 item questionnaire that produced nominal and interval data. These data were analyzed using frequencies and percentages. The hypotheses were tested using the chi square analysis. The level of significance was set at 0.05.

## CHAPTER IV

### ANALYSIS OF DATA

This chapter presents the findings of the study. The sample is described and then data are presented in relation to the hypotheses. Data from each of the four hypothetical cases are presented separately.

#### Description of the Sample

Five hundred stamped envelopes, each containing a questionnaire, an introductory letter, instructions to the participant and a stamped, addressed envelope to the researcher, were sent to Taubenpost. The American Association of Critical-Care Nurses sent a list of 500 randomly selected registered nurse members' names to Taubenpost to be used in this study. The questionnaires were mailed by Taubenpost in late February, 1985. Completed questionnaires were received by the investigator from early March through June of 1985.

The study sample consisted of 251 persons whose completed questionnaires were received by the investigator. A 50.2% response rate was obtained. Demographic data on the subjects were obtained from responses to the 29 demographic questions.



The data indicated that 100% of the 251 respondents were registered nurses. There were 236 (94.0%) females and 15 (6.0%) males in the sample. There were respondents in each of the six age groups listed. See Table 1.

Table 1

Age of Subjects

| Age     | Frequency | Percent |
|---------|-----------|---------|
| 20-24   | 8         | 3.2%    |
| 25-29   | 75        | 29.9%   |
| 30-34   | 69        | 27.5%   |
| 35-39   | 55        | 21.9%   |
| 40-44   | 18        | 7.2%    |
| Over 44 | 26        | 10.4%   |
| Total   | 251       | 100.0%  |

Variation existed in the highest level of education completed by the respondents. The majority of the nurses had Bachelor's degrees or higher. See Table 2.

Table 2  
Highest Degree Held by Subjects

| Degree                     | Frequency | Percent |
|----------------------------|-----------|---------|
| Diploma                    | 45        | 17.9%   |
| Associate's in Nursing     | 41        | 16.3%   |
| Associate's in Other Field | 1         | 0.4%    |
| Bachelor's in Nursing      | 89        | 35.5%   |
| Bachelor's in Other Field  | 19        | 7.6%    |
| Master's in Nursing        | 40        | 15.9%   |
| Master's in Other Field    | 12        | 4.8%    |
| Doctorate in Nursing       | 1         | 0.4%    |
| Doctorate in Other Field   | 3         | 1.2%    |
| Total                      | 251       | 100.0%  |

There were 68 subjects (27.1%) who were enrolled in higher education. Subjects were enrolled in several different types of educational programs. See Table 3.

Table 3  
Subjects Enrolled in Higher Education

| Degree                    | Frequency | Percent |
|---------------------------|-----------|---------|
| Bachelor's in Nursing     | 28        | 11.2%   |
| Bachelor's in Other Field | 6         | 2.4%    |
| Master's in Nursing       | 21        | 8.4%    |
| Master's in Other Field   | 7         | 2.8%    |
| Doctorate in Nursing      | 4         | 1.6%    |
| Doctorate in Other Field  | 2         | 0.8%    |
| Not Enrolled              | 170       | 67.7%   |
| Missing Data              | 13        | 5.2%    |
| Total                     | 251       | 100.0%  |

The number of years the respondents had been an R.N. varied. The majority of the respondents (65.4%) had been an R.N. for less than 12 years. See Table 4.

Table 4

Subjects' Length of Time as an R.N.

| Years R.N.  | Frequency | Percent |
|-------------|-----------|---------|
| 0-3         | 23        | 9.2%    |
| 4-7         | 60        | 23.9%   |
| 8-11        | 81        | 32.3%   |
| 12-15       | 31        | 12.4%   |
| 16-19       | 27        | 10.8%   |
| 20-23       | 10        | 4.0%    |
| 24-27       | 8         | 3.2%    |
| 28 or above | 11        | 4.4%    |
| Total       | 251       | 100.0%  |

Almost all (96.8%) of the subjects had at least nine months experience working in a critical-care unit. Of the 235 respondents who said that they had 9 months (or more) experience in a critical-care unit, 126 (50.2%) worked in an adults only unit, 8 (3.2%) worked in a unit specifically for children, and 101 (40.2%) worked in a critical-care unit for both adults and children.

The American Association of Critical-Care Nurses offers a certification (CCRN) to nurses who have a minimum of nine months experience in a critical-care unit and have passed a

written examination testing their knowledge of critical-care nursing. There were 90 individuals (35.9%) who possessed a CCRN and 158 (62.9%) who did not. Three respondents did not answer the item.

Religious preference of the respondents was as follows: 107 subjects (42.6%) were Protestant, 101 subjects (40.2%) were Catholic, 7 (2.8%) were Jewish, and 22 (8.8%) indicated that they had no religious preference. A total of 14 respondents indicated other religions than those listed on the questionnaire. Episcopalian was the choice of 6 subjects who wrote in their responses.

The majority of subjects (82.9%) believed that some form of life occurs after death, while 31 subjects (12.4%) did not believe in life after death and 12 subjects (4.8%) did not respond to the item.

Less than half of the subjects (39.4%) had a close friend or relative who had undergone CPR. An even smaller percentage of respondents (26.7%) reported that a close relative or friend had died in a hospital within the last twelve months.

The greatest number of subjects (45.8%) listed their primary position as a staff nurse. See Table 5.

Table 5  
Primary Nursing Position of Subjects

| Position                   | Frequency | Percent |
|----------------------------|-----------|---------|
| Staff Nurse                | 115       | 45.8%   |
| Assistant Head Nurse       | 15        | 6.0%    |
| Head Nurse                 | 19        | 7.6%    |
| Primary Nurse              | 15        | 6.0%    |
| Clinical Unit Coordinator  | 4         | 1.6%    |
| Clinical Nurse Specialist  | 12        | 4.8%    |
| Faculty, School of Nursing | 16        | 6.4%    |
| Staff Development          | 14        | 5.6%    |
| Full Time Student          | 6         | 2.4%    |
| Unemployed & Not a Student | 3         | 1.2%    |
| Other                      | 30        | 12.0%   |
| Total                      | 250       | 100.0%  |

Most of the subjects had studied ethics. Ethics was part of the nursing course work for 72.1% of the respondents. Only 30.7% had taken a formal course in ethics. There were 56.2% who said they had taken an inservice program in ethics and 49.4% who had attended a continuing education conference on ethics. Personal readings in ethics was reported by 82.1%, and ethics was part of a religion course for 17.9%. Only 10.4% of the subjects had ever given a lecture on ethics.

The vast majority (98.4%) of the nurses acknowledged having performed CPR. Many (89.6%) had performed CPR on a patient who was later discharged home.

Responses were given to ethical questions surrounding

the use of CPR. A great majority (92.4%) stated that they had performed CPR on a patient when, in their opinion, CPR should not have been performed. Patients had discussed the Do Not Resuscitate situation with 82.5% of the nurses. Furthermore, family members of patients had asked 90.4% of the nurses about the Do Not Resuscitate situation. There were 86.1% of the respondents who said that patients had told them that they did not wish to be resuscitated. Most of the nurses (90.8%) had asked a physician to write a Do Not Resuscitate order on a patient, and 71.7% of the nurses reported that a physician had refused to write a Do Not Resuscitate order when the nurse knew the patient wanted one. Most of the nurses (81.7%) indicated that they have helped a physician make the Do Not Resuscitate decision, and 76.1% have helped the family make the Do Not Resuscitate decision.

About half (57.0%) of the nurses reported that they have written guidelines on their unit regarding the Do Not Resuscitate order. Of those who have guidelines, 19.5% reported that nurses have input into the Do Not Resuscitate decision. Most nurses (71.1%) contended that patients who have a written Do Not Resuscitate order receive the same quality and quantity of nursing care as other patients in the critical-care unit.

## Presentation of the Findings

### Case A

Case A is repeated here to assist the reader.

Mr. Jones is a 68 year old bank president with a wife and 2 grown children. He has metastatic lung cancer. He and his family have known of his diagnosis for 8 months. He has been admitted to the hospital on several occasions for treatment. This is usually to the oncology unit where Ms. Heinz is his primary nurse. Dr. Smith, an oncologist, has been rendering medical care to Mr. Jones since the diagnosis of his cancer was made.

Mr. Jones has undergone chemotherapy and radiation therapy with minimal repression of the cancer. He is admitted to the oncology unit at this time, alert and oriented to person, place and time. Dr. Smith has assessed Mr. Jones and finds his condition is terminal.

The first study hypothesis read: When presented with selected hypothetical case situations concerning the Do Not Resuscitate decision involving patients whose health condition is irreversible and terminal: There is congruence between critical-care nurses' beliefs concerning the agent (patient, family member, physician, or nurse) best able to support patient autonomy and the agent deemed appropriate to make the Do Not Resuscitate decision according to the model developed for this study.

To test this hypothesis for Case A, data were analyzed on responses to the question: Whose opinion regarding the appropriateness of a "Do Not Resuscitate" order would most

likely support patient autonomy? Five choices were given: the nurse, the physician, the patient, the family (wife), or other (please specify). See Tables 6 and 7.

Table 6 presents subjects' responses concerning the agent best able to support patient autonomy in Case A. As shown in Table 6, the patient was chosen by 219 of 251 subjects as the person best able to support patient autonomy in this case. The subjects strongly supported the patient's right to make his own decision.

Table 6

Case A

Subjects' Choice of Agent Best Able to Support Patient  
Autonomy

| Category  | Frequency | Percent |
|-----------|-----------|---------|
| Nurse     | 4         | 1.6%    |
| Physician | 8         | 3.2%    |
| Patient   | 219       | 87.2%   |
| Family    | 5         | 2.0%    |
| Other     | 15        | 6.0%    |
| Total     | 251       | 100.0%  |

Table 7 provides the data used to test the first study hypothesis for Case A. The data were analyzed to determine the congruence between the responses of the nurses concerning the agent best able to support patient autonomy



in the DNR decision and the Do Not Resuscitate Decision Model. In Case A, nurses selected the agent identified in the model as the agent best able to support patient autonomy a significant number of times. Therefore, subjects' responses were congruent with the model.

Table 7

Case A

Congruency of Agent Selected as Best Able to Support Patient Autonomy and the DNR Model's Proposition of Appropriate Agent

---

| Category             | Cases<br>Observed | Expected | Residual   |
|----------------------|-------------------|----------|------------|
| Congruent            | 219               | 125.50   | 93.50      |
| Incongruent          | 32                | 125.50   | -93.50     |
| Total Cases          | 251               |          |            |
| <hr/>                |                   |          |            |
| Chi Square = 139.319 |                   | D.F. = 1 | p = <0.001 |

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The second study hypothesis stated: When presented with selected hypothetical case situations concerning the Do Not Resuscitate decision involving patients whose health condition is irreversible and terminal: There is congruence between critical-care nurses beliefs concerning the agent best able to support patient autonomy and the agent whose opinion would be regarded as most appropriate to make the Do

Not Resuscitate decision if these selected hypothetical cases were actually to occur on the critical-care units where they are employed.

To test this hypothesis, the subjects were queried in Case A to answer the following question: If this hypothetical case were to present in your unit, whose opinion would actually be regarded as most appropriate for making this decision? Five choices were given: the nurse, the physician, the patient, the family or other (please specify).

As seen in Table 8, of the 250 nurses who responded to this question, 100 said the physician's opinion and 99 said the patient's opinion would actually be regarded as most appropriate for making this decision.

Table 8

Case A

Agent Selected as One Whose Opinion Would Actually be Regarded as Most Appropriate to Make DNR Decision

---

| Category  | Frequency | Percent |
|-----------|-----------|---------|
| Nurse     | 0         | 0.0%    |
| Physician | 100       | 40.0%   |
| Patient   | 99        | 39.6%   |
| Family    | 17        | 6.8%    |
| Other     | 34        | 13.6%   |
| Total     | 250       | 100.0%  |

---

Table 9 depicts subjects' responses to the question concerning whose opinion would actually be regarded as most appropriate to make the Do Not Resuscitate decision in this case and how these responses are congruent or incongruent with the model. Table 9 indicates that 99 nurses believed that the person identified in the model as the agent best able to support patient autonomy would be the one whose opinion would actually be regarded as most appropriate to make the decision if this case were to present on the unit where these nurses were employed. Also, 152 nurses indicated that the person best able to support patient autonomy in the Do Not Resuscitate decision would not be the one whose opinion would actually be regarded as most appropriate to make the decision in the critical-care units where they were employed. Therefore, the subjects' responses were incongruent with the model. See Table 9.

Table 9

## Case A

Congruency of Agent Selected as One Whose Opinion Would Actually be Regarded as Most Appropriate to Make DNR Decision and the DNR Model's Proposition of Appropriate Agent

| Category    | Frequency | Percent |
|-------------|-----------|---------|
| Congruent   | 99        | 39.6%   |
| Incongruent | 152       | 60.4%   |
| Total       | 251       | 100.0%  |

The second research hypothesis for Case A used a chi square to test the congruence between critical-care nurses' beliefs concerning the agent best able to support patient autonomy and the agent these nurses indicated would actually be regarded as most appropriate for making the Do Not Resuscitate decision in their clinical units. The computed chi square was 54.06 with 12 degrees of freedom yielding a  $p < 0.001$ .

Table 10 has three columns. Column one shows the agent selected as best able to support patient autonomy. Column two shows observed congruent values representing nurses who selected the same agent as best able to support patient autonomy and as the agent whose opinion would actually be

regarded as most appropriate for making the Do Not Resuscitate decision. Column three shows observed incongruent values representing nurses who selected the agent indicated as best able to support patient autonomy but selected a different agent as the agent whose opinion would actually be regarded as most appropriate for making the DNR decision. Congruent responses were reported by 111 subjects while 139 subjects reported incongruence responses.

Table 10

## Case A

Congruency of Responses Between Agent Best Able to Support Patient Autonomy and Agent Whose Opinion Would Actually be Regarded as Most Appropriate for Making the DNR Decision

---

|           | Supports<br>Patient<br>Autonomy | Observed<br>Congruent | Observed<br>Incongruent |
|-----------|---------------------------------|-----------------------|-------------------------|
| Nurse     | 4                               | 0                     | 4                       |
| Physician | 8                               | 3                     | 5                       |
| Patient   | 218                             | 97                    | 121                     |
| Family    | 5                               | 2                     | 3                       |
| Other     | 15                              | 9                     | 6                       |
| Total     | 250                             | 111                   | 139                     |

---

## Case B

Mr. Paul is a 37 year old married college professor who was healthy until he was hit by a car while riding his bicycle. Because of the severity of his condition, he was transported to the trauma center 80 miles from his home. He was admitted at that time to the surgical ICU with a severe closed head injury, several long bone fractures, and a crushed pelvis. As part of his treatment, he was placed on a respirator.

It is nine weeks since his admission. He has had numerous neurological assessments and diagnostic tests. The physician has written in the progress notes that in his opinion, Mr. Paul has no chance of regaining consciousness due to the severity of the brain tissue damage.

Mr. Paul's wife of 15 years has been at his bedside much of the time. The medical staff and the nursing staff have worked closely with Mrs. Paul. They feel that Mr. and Mrs. Paul have shared a close, loving relationship.

The subjects in this study were asked to review Case B and answer the same questions that followed Case A. Essentially, the nurses were asked who is best able to support patient autonomy and whose opinion would be regarded as most appropriate to make the DNR decision on the clinical unit. The same two research hypotheses were tested in this case. Frequency distributions and chi square analyses were used to describe the results and to test the hypotheses. See Tables 11, 12, 13, 14, and 15.

Table 11 presents subject's responses concerning the agent best able to support patient autonomy in Case B. As shown in table 11, the family was chosen by 209 nurses as

the person best able to support patient autonomy in this case. The subjects strongly support the family as the appropriate agent in this case.

Table 11

Case B

Subjects' Choice of Agent Best Able to Support Patient Autonomy

| Category  | Frequency | Percent |
|-----------|-----------|---------|
| Nurse     | 3         | 1.2%    |
| Physician | 13        | 5.2%    |
| Patient   | 0         | 0.0%    |
| Family    | 209       | 83.6%   |
| Other     | 25        | 10.0%   |
| Total     | 250       | 100.0%  |

Table 12 provided the data used to test the first study hypothesis for Case B. The data were analyzed to determine the congruence between the responses of the nurses concerning the agent best able to support patient autonomy in the DNR decision and the Do Not Resuscitate Decision Model. In Case B, nurses selected the agent identified in the model as the agent best able to support patient autonomy a significant number of times. Therefore, subjects' responses were congruent with the model.

Table 12

## Case B

Congruency of Agent Selected as Best Able to Support  
Patient Autonomy in the DNR Model's Proposition of  
Appropriate Agent

---

| Category                                            | Cases<br>Observed | Expected | Residual |
|-----------------------------------------------------|-------------------|----------|----------|
| Congruent                                           | 209               | 125.50   | 83.50    |
| Incongruent                                         | 42                | 125.50   | -83.50   |
| Total                                               | 251               |          |          |
| Chi-Square = 111.112      D.F. = 1      p = <0.001. |                   |          |          |

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The second question asked the nurses, in regard to Case B, whose opinion would actually be regarded as most appropriate in making the DNR decision in the clinical area. Their answers and how these answers reflect the model are depicted in Tables 13, 14, and 15.

Table 13 displays the same unusual distribution that was seen in Table 8 for Case A. The nurses were fairly equally divided as to whose opinion would actually be regarded as most appropriate in making the DNR decision if this case were to occur on their critical-care units. The physician is reported by 101 of the nurses and the family is reported by 111 of the nurses as the agent whose opinion



would actually be regarded as most appropriate to make the DNR decision.

Table 13

Case B

Agent Selected as One Whose Opinion Would Actually be Regarded as Most Appropriate to Make the DNR Decision

---

| Category  | Frequency | Percent |
|-----------|-----------|---------|
| Nurse     | 2         | 0.8%    |
| Physician | 101       | 40.4%   |
| Patient   | 1         | 0.4%    |
| Family    | 111       | 44.4%   |
| Other     | 35        | 14.0%   |
| Total     | 250       | 100.0%  |

---

Table 14 depicts subjects' responses to the question concerning whose opinion would actually be regarded as most appropriate for making the Do Not Resuscitate decision in this case and how these responses agree or disagree with the model. Table 14 indicates that 111 nurses believed that the person identified in the model as the agent best able to support patient autonomy would also be the agent whose opinion would actually be regarded as most appropriate for making the decision if this case were to present on the unit where these nurses were employed. Also, 140 nurses indicated that the person best able to support patient

autonomy in the Do Not Resuscitate decision would not be the person whose opinion would actually be regarded as most appropriate for making the decision on the critical-care units where they were employed. Therefore, the subjects' responses were incongruent with the model. See Table 14.

Table 14

Case B

Congruency of Agent Selected as One Whose Opinion Would Actually be Regarded as Most Appropriate to Make DNR Decision and the DNR Model's Proposition of Appropriate Agent

| Category    | Frequency | Percent |
|-------------|-----------|---------|
| Congruent   | 111       | 44.4%   |
| Incongruent | 140       | 55.6%   |
| Total       | 251       | 100.0%  |

The second research hypothesis for Case B used a chi square to test the congruence between critical-care nurses' beliefs concerning the agent best able to support patient autonomy and the agent these nurses indicated would actually be regarded as most appropriate for making the Do Not Resuscitate decision in their clinical units. The computed chi square was 96.797 with 12 degrees of freedom yielding a

$p = <0.001$ .

Table 15 has three columns. Column one shows the agent selected as best able to support patient autonomy. Column two shows observed congruent values representing nurses who selected the same agent as best able to support patient autonomy and as the agent whose opinion would actually be regarded as most appropriate for making the Do Not Resuscitate decision. Column three shows observed incongruent values representing nurses who selected the agent indicated as best able to support patient autonomy but selected a different agent as the agent whose opinion would actually be regarded as most appropriate for making the DNR decision. Congruent responses were reported by 128 subjects while 122 subjects reported incongruent responses.

Table 15

## Case B

Congruency of Responses Between Agent Best Able to Support Patient Autonomy and Agent Whose Opinion Would Actually be Regarded as Most Appropriate for Making the DNR Decision

|           | Supports<br>Patient<br>Autonomy | Observed<br>Congruent | Observed<br>Incongruent |
|-----------|---------------------------------|-----------------------|-------------------------|
| Nurse     | 3                               | 1                     | 2                       |
| Physician | 13                              | 7                     | 6                       |
| Patient   | 0                               | 0                     | 0                       |
| Family    | 209                             | 105                   | 104                     |
| Other     | 25                              | 15                    | 10                      |
| Total     | 250                             | 128                   | 122                     |

## Case C

Mrs. Smith is a 74 year old widow with no children and no siblings. She has had several M.I.'s and is now in deteriorating congestive heart failure. She has been a patient of Dr. Johnson's since he began his cardiology practice sixteen years ago. This has been a positive primary care relationship demonstrated by open and meaningful discussion.

One evening, Mrs. Smith is admitted to the hospital in acute distress, suffering from another M.I. She is stabilized in the coronary care unit but is quite confused. Her condition deteriorates during the next three weeks of her hospitalization. She has remained confused, not recognizing her physician or friends that come to visit. She is quite stuporous much of the time.

The subjects in this study were asked to review Case C and answer the same questions that followed Case A. Essentially, the nurses were asked who is best able to support patient autonomy and whose opinion would be regarded as most appropriate to make the DNR decision on the clinical unit. The same two research questions were tested in this case. Frequency distributions and chi square analyses were used to describe the results and to test the hypotheses. See Tables 16, 17, 18, 19, and 20.

Table 16 shows strong agreement among the nurses as to which agent is best able to support patient autonomy in Case C. The physician is viewed by a vast majority of the nurses as the agent whose opinion would be regarded as most appropriate to make the DNR decision.

Table 16

Case C

Subjects' Choice of Agent Best Able to Support Patient  
Autonomy

---

| Category  | Frequency | Percent |
|-----------|-----------|---------|
| Nurse     | 5         | 2.0%    |
| Physician | 201       | 81.0%   |
| Patient   | 5         | 2.0%    |
| Family    | 6         | 2.4%    |
| Other     | 31        | 12.5%   |
| Total     | 248       | 100.0%  |

---

Table 17 provided the data used to test the first study hypothesis for Case C. The data were analyzed to determine the congruence between the Do Not Resuscitate Model and the responses of the nurses. In Case C, nurses selected the agent identified in the model as the agent best able to support patient autonomy a significant number of times. Therefore, subjects' responses were congruent with the model.

Table 17

Case C

Congruency of Agent Selected as Best Able to Support Patient Autonomy and the DNR Model's Proposition of Appropriate Agent

---

| Category     | Cases<br>Observed | Expected | Residual   |
|--------------|-------------------|----------|------------|
| Congruent    | 201               | 125.50   | 75.50      |
| Incongruent  | 50                | 125.50   | -75.50     |
| Total        | 251               |          |            |
| <hr/>        |                   |          |            |
| Chi-Square = | 90.841            | D.F. = 1 | p = <0.001 |

---

The second question asked of the nurses in regard to Case C is whose opinion would actually be regarded as most appropriate in making the DNR decision in the clinical area. Their answers and how these answers reflect the model are

depicted in Tables 18, 19, and 20.

Table 18 displays agreement among the nurses for Case C that the physician's opinion would actually be regarded as most appropriate for making the Do Not Resuscitate decision in the clinical unit.

Table 18

Case C

Agent Selected as One Whose Opinion Would Actually be  
Regarded as Most Appropriate to Make DNR Decision

| Category  | Frequency | Percent |
|-----------|-----------|---------|
| Nurse     | 0         | 0.0%    |
| Physician | 215       | 86.7%   |
| Patient   | 0         | 0.0%    |
| Family    | 4         | 1.6%    |
| Other     | 29        | 11.7%   |
| Total     | 248       | 100.0%  |

Table 19 depicts subjects' responses to the question concerning whose opinion would actually be regarded as most appropriate for making the Do Not Resuscitate decision in this case and how these responses agree or disagree with the model. Table 19 indicates that 217 nurses believed that the person identified in the model as the agent best able to support patient autonomy would actually be regarded as most appropriate for making the decision if this case were to

present on the critical-care unit. Therefore, the subjects' responses were congruent with the model in Case C. See Table 19.

Table 19

Case C

Congruency of Agent Selected as One Whose Opinion Would Actually be Regarded as Most Appropriate to Make DNR Decision and the DNR Model's Proposition of Appropriate Agent

| Category    | Frequency | Percent |
|-------------|-----------|---------|
| Congruent   | 217       | 86.8%   |
| Incongruent | 33        | 13.2%   |
| Total       | 250       | 100.0%  |

The second research hypothesis for Case C used a chi square to test the congruence between critical-care nurses' beliefs concerning the agent best able to support patient autonomy and the agent these nurses indicated would actually be regarded as most appropriate for making the Do Not Resuscitate decision in their clinical units. The computed chi square was 121.4 with 8 degrees of freedom yielding a  $p = <0.001$ .

Table 10 has three columns. Column one shows the agent



selected as best able to support patient autonomy. Column two shows observed congruent values representing nurses who selected the same agent as best able to support patient autonomy and as the agent whose opinion would actually be regarded as most appropriate for making the Do Not Resuscitate decision. Column three shows observed incongruent values representing nurses who selected the agent indicated as best able to support patient autonomy but selected a different agent as the agent whose opinion would actually be regarded as most appropriate for making the DNR decision. Congruent responses were reported by 201 subjects while 47 reported incongruent responses.

Table 20

## Case C

Congruency of Responses Between Agent Most Able to Support Patient Autonomy and Agent Whose Opinion Would Actually be Regarded as Most Appropriate for Making the DNR Decision

|           | Supports<br>Patient<br>Autonomy | Observed<br>Congruent | Observed<br>Incongruent |
|-----------|---------------------------------|-----------------------|-------------------------|
| Nurse     | 5                               | 0                     | 5                       |
| Physician | 201                             | 186                   | 15                      |
| Patient   | 5                               | 0                     | 5                       |
| Family    | 6                               | 3                     | 3                       |
| Other     | 31                              | 12                    | 19                      |
| Total     | 248                             | 201                   | 47                      |

## Case D

Mr. Hall is a 75 year old patient with Chronic Obstructive Pulmonary Disease (COPD) who has no family. He has had repeated admissions to the respiratory ICU. These admissions last usually from 2 weeks to 2 months. Ms. Clark has been Mr. Hall's primary nurse for the last 8 of these admissions. During this time, Mr. Hall's physical condition has steadily deteriorated. Ms. Clark and Mr. Hall have established a close, trusting relationship. They have discussed many issues including life, death, and the quality of life. They have also enjoyed many lighter moments keeping up with the local football team.

Mr. Hall has asked Ms. Clark not to "do anything heroic when my time comes". He complains of being very tired. "I spend all the energy I can muster just managing to breathe." "Death will be a relief". Ms Clark has charted this information.

Dr. Austin is the new pulmonary resident on call for Mr. Hall's case. Dr. Austin has not yet examined Mr. Hall. During the night Mr. Hall has a severe episode of respiratory distress. He becomes confused and lethargic as his arterial blood gases deteriorate profoundly.

The subjects in this study were asked to review Case D and answer the same questions that followed Case A.

Essentially, the nurses were asked who is best able to support patient autonomy and whose opinion would actually be regarded as most appropriate for making the DNR decision on the clinical unit. The same two research hypotheses were tested in this case. Frequency distributions and chi square analyses were used to describe the results and to test the hypotheses. See Tables 21, 22, 23, 24, and 25.

Table 21

## Case D

Subjects' Choice of Agent Best Able to Support Patient  
Autonomy

| Category  | Frequency | Percent |
|-----------|-----------|---------|
| Nurse     | 184       | 74.2%   |
| Physician | 17        | 6.9%    |
| Patient   | 26        | 10.5%   |
| Family    | 1         | 0.4%    |
| Other     | 20        | 8.1%    |
| Total     | 248       | 100.0%  |

Table 22 provided the data used to test the first study hypothesis for Case D. The data were analyzed to determine the congruence between the responses of the nurses concerning the agent best able to support patient autonomy in the DNR decision and the Do Not Resuscitate Decision Model. In Case D, nurses selected the agent identified in the model as the agent best able to support patient autonomy a significant number of times. Therefore, subjects' responses were congruent with the model.

Table 22

## Case D

Congruency of Agent Selected as Best Able to Support  
Patient Autonomy and the DNR Model's Proposition of  
Appropriate Agent

---

| Category    | Cases<br>Observed | Expected | Residual |
|-------------|-------------------|----------|----------|
| Congruent   | 185               | 125.50   | 59.50    |
| Incongruent | 66                | 125.50   | -59.50   |
| Total       | 251               |          |          |

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Chi Square = 56.418      D.F. = 1      p = <0.001.

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The second question asked the nurses in regard to Case D, whose opinion would actually be regarded as most appropriate in making the DNR decision in the clinical area. Their answers and how these answers reflect the model are depicted in Tables 23, 24, and 25.

Table 23 shows that there is agreement among the nurses that the physician is the agent whose opinion would actually be regarded as most appropriate in making the DNR decision on the clinical unit.

Table 23

## Case D

Agent Selected as One Whose Opinion Would Actually be  
Regarded as Most Appropriate to Make the DNR Decision

---

| Category  | Frequency | Percent |
|-----------|-----------|---------|
| Nurse     | 23        | 9.3%    |
| Physician | 183       | 73.8%   |
| Patient   | 11        | 4.4%    |
| Family    | 0         | 0.0%    |
| Other     | 31        | 12.5%   |
| Total     | 248       | 100.0%  |

---

Table 24 depicts subjects' responses to the question concerning whose opinion would actually be regarded as most appropriate for making the Do Not Resuscitate decision in this case and how these responses agree or disagree with the model. Table 24 indicates that only 23 nurses believed that the person identified in the model as the agent best able to support patient autonomy would also be the agent whose opinion would actually be regarded as most appropriate for making the DNR decision on the unit where these nurses were employed. Also, 228 nurses indicated that the person best able to support patient autonomy in the Do Not Resuscitate decision would not be the person whose opinion would actually be regarded as most appropriate for making the DNR

decision on the critical-care units where they were employed. Therefore, the subjects' responses were incongruent with the model. See Table 24.

Table 24

Case D

Congruency of Agent Selected as One Whose Opinion Would Actually be Regarded as Most Appropriate to Make DNR Decision and the DNR Model's Proposition of Appropriate Agent

| Category    | Frequency | Percent |
|-------------|-----------|---------|
| Congruent   | 23        | 9.2%    |
| Incongruent | 228       | 90.8%   |
| Total       | 251       | 100.0%  |

The second research hypothesis for Case D used a chi square to test the congruence between critical-care nurses' beliefs concerning the agent best able to support patient autonomy and the agent these nurses indicated would actually be regarded as most appropriate for making the Do Not Resuscitate decision in their clinical units. The computed chi square was 141.406 with 12 degrees of freedom yielding a  $p = <0.001$

Table 25 has three columns. Column one shows the agent

selected as best able to support patient autonomy. Column two shows observed congruent values representing nurses who selected the same agent as best able to support patient autonomy and as the agent whose opinion would actually be regarded as most appropriate for making the Do Not Resuscitate decision. Column three shows observed incongruent values representing nurses who selected the agent indicated as best able to support patient autonomy but selected a different agent as the agent whose opinion would actually be regarded as most appropriate for making the DNR decision. Congruent responses were reported by 59 subjects while 189 subjects reported incongruent responses.

Table 25

## Case D

Congruency of Responses Between Agent Most Able to Support Patient Autonomy and Agent Whose Opinion Would Actually be Regarded as Most Appropriate for Making the DNR Decision

---

|           | Supports<br>Patient<br>Autonomy | Observed<br>Congruent | Observed<br>Incongruent |
|-----------|---------------------------------|-----------------------|-------------------------|
| Nurse     | 184                             | 21                    | 163                     |
| Physician | 17                              | 15                    | 2                       |
| Patient   | 26                              | 10                    | 16                      |
| Family    | 1                               | 0                     | 1                       |
| Other     | 20                              | 13                    | 7                       |
| Total     | 248                             | 59                    | 189                     |

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### SUMMARY

A sample of 251 nurses who were members of the American Association of Critical-Care Nurses completed and returned questionnaires. Demographic data were presented to describe the sample. Four hypothetical case situations were used to represent parts of the Do Not Resuscitate Decision Model.

Subjects were asked to select an agent in each hypothetical case whose opinion would most likely support patient autonomy in the Do Not Resuscitate decision. Subjects' choices in individual cases were in general agreement as to the agent who would support patient autonomy; however, these choices varied from case to case according to the different aspects of the case.

The agent whose opinion would actually be regarded as most appropriate to make the DNR decision if the case were to present in the clinical area was identified by the subjects as the physician in all cases. The physician was not identified as the agent who would most likely support patient autonomy in three cases, but was still selected as the agent whose opinion would actually be regarded as most appropriate for making this decision.



## CHAPTER V

### SUMMARY OF THE STUDY

This chapter contains the summary of the investigation. The findings are discussed. Conclusions and implications are presented. Finally, recommendations for further research are considered.

### SUMMARY

The problem of this study was two-fold. First, an examination was made of critical-care nurses' beliefs concerning the agent best able to support patient autonomy in selected hypothetical cases involving the Do Not Resuscitate decision. The second aspect of the problem was to compare the congruency between critical-care nurses' beliefs concerning the agent best able to support patient autonomy and the agent whose opinion would actually be regarded as most appropriate to make the Do Not Resuscitate decision if these selected hypothetical cases were actually to occur in the critical-care units where the nurses were employed.

The study was descriptive in nature and surveyed critical-care registered nurses. The population consisted of nurses who were members of the American Association of

Critical-Care Nurses (AACN) at the time of the study. The sample was composed of 500 randomly selected members of the AACN. Questionnaires were mailed to these nurses. Responses were obtained from the 251 subjects who returned completed questionnaires.

The theoretical framework of the study was based on Robert Veatch's (1981a) theory. From this theory and from a review of the literature, a Do Not Resuscitate Decision Model was developed by the investigator. The model suggests that there are different agents best able to support patient autonomy in various situations. Four hypothetical cases were developed; each one addressed a different part of the model. Demographic data were also gathered on the subjects.

In each of the four hypothetical cases presented, the respondents were asked to select the most appropriate agent to support patient autonomy. Their choices varied from case to case, depending upon the different aspects of the cases; however, there was general agreement among the nurses as to the most appropriate agent to make the Do Not Resuscitate decision in each case.

When asked whose opinion would actually be regarded as most appropriate to make the DNR decision if the case were to present on their units, the nurses responded most frequently that the physician's opinion would be regarded as

most appropriate for making the DNR decision, regardless of the agent selected as best able to support patient autonomy in the case situation.

#### DISCUSSION OF THE FINDINGS

In all of the discussion surrounding the Do Not Resuscitate decision in this paper, the patient's condition is irreversible and terminal. The irreversible and terminal condition of the patient is a foundation upon which the model was developed.

Case A tested a proposition in the model that if the patient is competent, the patient should make the Do Not Resuscitate decision. This proposition was supported by the subjects in the study. A significant number of subjects selected the patient as the agent best able to make the Do Not Resuscitate decision in Case A. However, the physician was selected by 100 out of 250 subjects as the person whose opinion would actually be regarded as most appropriate to make the Do Not Resuscitate decision if the case were to present on units where the subjects were employed. The patient was selected by 99 subjects.

Case B was used to test a statement in the model that if the patient is not competent and there is a good relationship with the next of kin, the family should make

the Do Not Resuscitate decision as he/she believes the patient would have wished. The wife of the patient in Case B was selected by 209 of 250 subjects; therefore, these responses supported the model.

The person whose opinion would actually be regarded as most appropriate for making the Do Not Resuscitate decision in Case B followed a pattern similar to the responses in Case A. The physician was selected 101 times and the family 111 times as the agent whose opinion would be considered as most appropriate to make the decision on their units.

Case C tested a statement from the model that if the patient was not competent, and if there was no family, and if there was a therapeutic relationship between the physician and the patient, the physician should make the Do Not Resuscitate decision as he/she believes the patient would have wished. The physician was selected as the agent best able to support patient autonomy in this hypothetical case by 201 respondents out of 251. These choices were in agreement with the Do Not Resuscitate Decision Model. Also, the physician was selected by 217 subjects as the person whose opinion would be regarded as most appropriate for making the DNR decision on the clinical unit.

Case D also tested a portion of the model. The model states that at specific times, the nurse is the agent best

able to support patient autonomy in this decision. If the patient is not competent, and there is no family, and if there is a therapeutic relationship between the patient and the nurse, the nurse should make the Do Not Resuscitate decision. These conditions were present in Case D. The nurse was selected as the agent best able to support patient autonomy by 185 of the 251 subjects. However, the physician was selected by 183 of 251 subjects as the agent whose opinion would actually be regarded as most appropriate for making the DNR decision if the case were to present in the clinical area.

The data show that patient autonomy in the Do Not Resuscitate decision is best supported by different agents in different cases. The subjects indicated that the physician is the agent who would actually decide in most cases on their units.

In case C the person whose opinion supports patient autonomy is the same one selected by the subjects as the agent whose opinion would actually be regarded as appropriate to make the decision. This case demonstrated the ideal situation because the person best able to support patient autonomy was also the person who in reality would probably make the decision. No ethical conflict was demonstrated.

There was an interesting split in subjects' responses to both Case A and Case B. There was almost unanimous agreement in both cases as to the agent best able to support patient autonomy in these case situations. However, a split occurred in the responses to the second question in each case concerning who would actually make the decision on the clinical unit. Approximately half of the subjects selected the physician as the agent whose opinion would actually be regarded as most appropriate to make the DNR decision on their work setting. Responses to Case D indicated an even greater difference between the agent selected as most appropriate to support patient autonomy and the agent whose opinion would be considered in the Do Not Resuscitate decision. The nurse was selected by 185 subjects as the agent who would support patient autonomy. However, the majority of the subjects (183) said that the physician's opinion, not the nurse's opinion, would be most important in making the DNR decision in their clinical work settings.

There seems to be some ethical conflict demonstrated in response to cases A, B, and D. However, the greatest ethical dilemma appears in response to case D. The subjects overwhelmingly chose the nurse, the agent indicated by the model, as best able to support patient autonomy in the Do Not Resuscitate decision, but selected the physician as the

agent who would probably make the decision.

### Conclusions and Implications

Within the limitations of this study, two conclusions can be drawn from the data:

1. It appears that nurses are not acting as patient advocates to support patient autonomy in the Do Not Resuscitate decision issue.

2. An ethical conflict concerning the Do Not Resuscitate decision appears to exist for the majority of subjects in this study.

The implications of this study focus on the ethical dilemma occurring in the clinical units surrounding the Do Not Resuscitate decision. The nursing role of patient advocate requires a clear understanding of the decision making process surrounding this issue. The nursing profession, through the American Nurses' Association, has placed more emphasis on ethical issues in the last few years. This emphasis must be a continuing endeavor. The American Nurses' Association's 1976 code for Nurses with Interpretive Statements and the 1980 Social Policy Statement both foster patient autonomy.

The data from the study seem to indicate support for the decision making process to be closely linked to the

patient's perspective as possible, thus supporting patient autonomy. However the data also indicate that even when the agent best able to support patient autonomy can be identified, that agent's opinion may not be considered when the DNR decision is made.

The nursing profession seems to be facing a dilemma. The incongruence between who should make the DNR decision and who does make the DNR decision creates stress in all concerned. The practicing nurse needs to identify the conflicting loyalties of profession, institution and patient and emerge with the rights and wishes of the client as the primary goal of care.

Careful attention to informed decision making in the DNR situation must be of primary importance to health care professionals. Nursing educators face the challenge of preparing students to be clinically competent professionals as well as ethical decision makers. Nursing administration may wish to carefully examine patient care to determine if autonomous decision making by the patient is directing care.

#### Recommendations for Further Study

Based on the results of this study, the following recommendations are made:

1. The study should be repeated with a different



population of nurses in other specialty groups.

2. The study should be repeated with a population of physicians.

3. Different hypothetical cases should be developed to determine if similar responses would be elicited.

4. A descriptive survey should be conducted to examine the decision making process that has been used with Do Not Resuscitate patients.

5. A descriptive study should be conducted to examine the decision making process of family members of Do Not Resuscitate patients.

6. Conduct additional reliability and validity studies to further develop the instrument.

#### Questions From the Study

This study raised the following questions:

1. Why are nurses not acting as the patient advocate in the Do Not Resuscitate decision?

2. Are nurses willing to take the responsibility of the agent for the patient in the Do Not Resuscitate decision?

3. Are physicians and hospital administrations willing to allow the nurse to act as agent for the patient in the Do Not Resuscitate decision?

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APPENDIX A

Human Subjects Review Committee  
Statement to Accompany Prospectus

TEXAS WOMAN'S UNIVERSITY  
COLLEGE OF NURSING

92

PROSPECTUS FOR DISSERTATION

This prospectus proposed by: Barbara Bristow Ott B.S.N., M.S.N.

\_\_\_\_\_ and entitled:

An Ethical Problem Facing Nurses: The Support

Of patient Autonomy in the Do Not Resuscitate Decision

Has been read and approved by the members of (his/hers) Research Committee.

This research is (check one):

X Is exempt from Human Subjects Review Committee review  
because this study qualifies as category I research since data  
will be collected through a mailed questionnaire

\_\_\_\_\_ Requires Human Subjects Review Committee review  
because \_\_\_\_\_

Research Committee:

|             |                            |
|-------------|----------------------------|
| Chairperson | <u>Rose M. Nieswiadomy</u> |
| Member      | <u>Marion Anema</u>        |
| Member      | <u>Margaret T. Beach</u>   |
| Member      | <u>Ellen Jennings</u>      |
| Member      | <u>Theresa J. McDonald</u> |

APPENDIX B  
Agency Permission



TEXAS WOMAN'S UNIVERSITY  
COLLEGE OF NURSING

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AGENCY PERMISSION FOR CONDUCTING STUDY\*

THE American Association of Critical-Care Nurses

GRANTS TO Barbara Bristow Ott R.N., M.S.N., CCRN

a student enrolled in a program of nursing leading to a Doctoral Degree at Texas Woman's University, the privilege of its facilities in order to study the following problem.

An Ethical Problem Facing Nurses: The Support of  
Patient Autonomy in the Do Not Resuscitate Decision

The conditions mutually agreed upon are as follows:

1. The agency (may) (may not) be identified in the final report.
2. The names of consultative or administrative personnel in the agency (may) (may not) be identified in the final report.
3. The agency (wants) (does not want) a conference with the student when the report is completed.
4. The agency is (willing) (unwilling) to allow the completed report to be circulated through interlibrary loan.
5. Other \_\_\_\_\_

Date: 3/5/85

Sara Lujan, R.N., MN  
Signature of Agency Personnel

Barbara B Ott 2-14-85  
Signature of student

Rose M. Niemiedomy  
Signature of Faculty Advisor

\* Fill out & sign three copies to be distributed as follows:

Original - Student: First Copy - Agency; Second copy - TWU College of Nursing.

## APPENDIX C

### Instructions to Participants

Dear AACN Member,

Recent advancements in medicine, nursing, and technology have made the prolongation of biological life possible. Critical-care nurses face the ethical dilemmas of these advancements in their practice on a daily basis. The question of when and if to prolong biological life has given rise to the "Do Not Resuscitate" decision. I am conducting research to examine nurses' beliefs concerning the support of patient autonomy in the "Do Not Resuscitate" situation.

Your name was randomly selected from the membership of the American Association of Critical-Care Nurses (AACN) to be a potential subject in this study. The list was generated by AACN and given, along with the materials for my study, to Taubenpost, Inc., a mailing service company used by AACN. Therefore your anonymity will be protected.

There are four hypothetical cases in the questionnaire. Each case is followed by three questions. There are 29 demographic and experience-related questions. It should take approximately 25 minutes to complete the questionnaire. The risk to the participant is only the time it takes to fill out the questionnaire. You would benefit by knowing that you are contributing to the advancement of knowledge in the area of patient autonomy in the "Do Not Resuscitate" decision. Participation in this study is strictly voluntary.

A return envelope is included with the questionnaire and this letter. If you are willing to participate in the study, please fill out the questionnaire, but Do Not Sign the questionnaire. This will insure that not even the researcher will be able to make a connection between the individual and his or her responses. If you do not wish to participate, please destroy this questionnaire. The return of this questionnaire will be construed as your consent to act as a subject. If you desire a copy of the results of the study, please contact me at my home address. Also, I plan to present the results of this research at AACN's National Teaching Institute in 1986.

Thank you for your cooperation.

Barbara Bristow Ott, R.N., M.S.N., CCRN  
Doctoral Candidate  
Texas Woman's University  
Denton, Texas 76204

Home:  
6324 Wallingford Drive  
Fort Worth, Texas 76133

RETURN OF THIS QUESTIONNAIRE WILL BE CONSTRUED AS YOUR CONSENT TO PARTICIPATE.

#### INSTRUCTIONS TO PARTICIPANTS

This study is examining an ethical issue in critical-care. It involves an aspect of the very complicated "Do Not Resuscitate" situation. Specifically, the study asks nurses for their beliefs concerning the support of patient autonomy in the "Do Not Resuscitate" situation. Patient autonomy is defined as the patient's right to choose, without outside control, from alternative therapies or to choose to reject therapy.

There are four hypothetical cases. Each case is followed by three questions. The first two of these questions asks for your belief concerning the support of patient autonomy. There are no right or wrong answers to these questions. These beliefs may or may not conform to current law, current clinical practice, or the beliefs of others.

The third question following each hypothetical case asks what would happen if this case was to actually present in your unit. This question requires more of a factual answer as you believe it would happen.

Please read the following cases and answer the questions at the end of each case. Demographic and experience-related questions follow the hypothetical cases.

Thank you.

APPENDIX D  
Instrument

RETURN OF THIS QUESTIONNAIRE WILL BE CONSTRUED AS YOUR CONSENT TO PARTICIPATE.

Case A

Mr. Jones is a 68 year old bank president with a wife and 2 grown children. He has metastatic lung cancer. He and his family have known of his diagnosis for 8 months. He has been admitted to the hospital on several occasions for treatment. This is usually to the oncology unit where Ms. Heinz is his primary nurse. Dr. Smith, an oncologist, has been rendering medical care to Mr. Jones since the diagnosis of his cancer was made.

Mr. Jones has undergone chemotherapy and radiation therapy with minimal repression of the cancer. He is admitted to the oncology unit at this time alert and oriented to person, place and time. Dr. Smith has assessed Mr. Jones and finds his condition is terminal.

1. Whose opinion regarding the appropriateness of a "Do Not Resuscitate" order would most likely support patient autonomy? Please circle your response.

- a. the nurse
- b. the physician
- c. the patient
- d. the family (wife)
- e. other (please specify) \_\_\_\_\_

2. Please write a few sentences telling why you selected your answer.

3. If this hypothetical case was to present in your unit, whose opinion would actually be regarded as most appropriate for making this decision? Please circle your response.

- a. the nurse
- b. the physician
- c. the patient
- d. the family (wife)
- e. other (please specify) \_\_\_\_\_

RETURN OF THIS QUESTIONNAIRE WILL BE CONSTRUED AS YOUR CONSENT TO PARTICIPATE.

Case B

Mr. Paul is a 37 year old married college professor who was healthy until he was hit by a car while riding his bicycle. Because of the severity of his condition, he was transported to the trauma center 80 miles from his home. He was admitted at that time to the surgical ICU with a severe closed head injury, several long bone fractures, and a crushed pelvis. As part of his treatment, he was placed on a respirator.

It is nine weeks since his admission. He has had numerous neurological assessments and diagnostic tests. The physician has written in the progress notes that in his opinion, Mr. Paul has no chance of regaining consciousness due to the severity of the brain tissue damage.

Mr. Paul's wife of 15 years has been at his bedside much of the time. The medical staff and the nursing staff have worked closely with Mrs. Paul. They feel that Mr. and Mrs. Paul have shared a close, loving relationship.

1. Whose opinion regarding the appropriateness of a "Do Not Resuscitate" order would most likely support patient autonomy: Please circle your response.

- a. the nurse
- b. the physician
- c. the patient
- d. the family (wife)
- e. other (please specify) \_\_\_\_\_

2. Please write a few sentences telling why you selected your answer.

3. If this hypothetical case was to present in your unit, whose opinion would actually be regarded as most appropriate for making this decision?  
Please circle your response.

- a. the nurse
- b. the physician
- c. the patient
- d. the family (wife)
- e. other (please specify) \_\_\_\_\_

RETURN OF THIS QUESTIONNAIRE WILL BE CONSTRUED AS YOUR CONSENT TO PARTICIPATE.

Case C

Mrs. Smith is a 74 year old widow with no children and no siblings. She has had several M.I.'s and is now in deteriorating congestive heart failure. She has been a patient of Dr. Johnson's since he began his cardiology practice sixteen years ago. This has been a positive primary care relationship demonstrated by open and meaningful discussion.

One evening, Mrs. Smith is admitted to the hospital in acute distress, suffering from another M.I. She is stabilized in the coronary care unit but is quite confused. Her condition worsens during the next three weeks of her hospitalization. She is on vasopressors to maintain her systemic blood pressure. She has remained confused, not recognizing her physician or friends that come to visit. She is quite stuporous much of the time.

1. Whose opinion regarding the appropriateness of a "Do Not Resuscitate" order would most likely support patient autonomy? Please circle your response.

- a. the nurse
- b. the physician
- c. the patient
- d. the family
- e. other (please specify) \_\_\_\_\_

2. Please write a few sentences telling why you selected your answer.

3. If this hypothetical case was to present in your unit, whose opinion would actually be regarded as most appropriate for making this decision?

Please circle your response.

- a. the nurse
- b. the physician
- c. the patient
- d. the family
- e. other (please specify) \_\_\_\_\_



RETURN OF THIS QUESTIONNAIRE WILL BE CONSTRUED AS YOUR CONSENT TO PARTICIPATE.

Case D

Mr. Hall is a 75 year old patient with Chronic Obstructive Pulmonary Disease (COPD) who has no family. He has had repeated admissions to the respiratory ICU. These admissions last usually from 2 weeks to 2 months. Ms. Clark has been Mr. Hall's primary nurse for the last 8 of these admissions. During this time, Mr. Hall's physical condition has steadily deteriorated. Ms. Clark and Mr. Hall have established a close, trusting relationship. They have discussed many issues including life, death, and the quality of life. They have also enjoyed many lighter moments keeping up with the local football team.

Mr. Hall has asked Ms. Clark not to "do anything heroic when my time comes". He complains of being very tired. "I spend all the energy I can muster just managing to breathe." "Death will be a relief". Ms. Clark has charted this information.

Dr. Austin is the new pulmonary resident on call for Mr. Hall's case. Dr. Austin has not yet examined Mr. Hall. During the night Mr. Hall has a severe episode of respiratory distress. He becomes confused and lethargic as his arterial blood gases deteriorate profoundly.

1. Whose opinion regarding the appropriateness of a "Do Not Resuscitate" order would most likely support patient autonomy? Please circle your response.

- a. the nurse
- b. the physician
- c. the patient
- d. the family
- e. other (please specify) \_\_\_\_\_

2. Please write a few sentences telling why you selected your answer.

3. If this hypothetical case was to present in your unit, whose opinion would actually be regarded as most appropriate for making this decision?

- a. the nurse
- b. the physician
- c. the patient
- d. the family
- e. other (please specify) \_\_\_\_\_

RETURN OF THIS QUESTIONNAIRE WILL BE CONSTRUED AS YOUR CONSENT TO PARTICIPATE.

#### DEMOGRAPHIC DATA

Directions: Please circle or fill in the correct answer.

1. Are you a registered nurse?
  1. yes 2. no
2. Your age is:
  1. 20-24 2. 25-29 3. 30-34 4. 35-39 5. 40-44 6. above 44
3. What is the highest level of education you have completed?
  1. Diploma 5. Bachelor's Degree in other field
  2. Associate's Degree in Nursing 6. Master's Degree in Nursing
  3. Associate's Degree in other field 7. Master's Degree in other field
  4. Bachelor's Degree in Nursing 8. Doctoral Degree in nursing
  9. Doctoral Degree in other field
4. If you are currently enrolled in nursing education, in what program are you enrolled? If not enrolled, circle "not enrolled".
  1. Diploma 6. Master's Degree in Nursing
  2. Associate's Degree in Nursing 7. Master's Degree in other field
  3. Associate's Degree in other field 8. Doctoral Degree in Nursing
  4. Bachelor's Degree in Nursing 9. Doctoral Degree in other field
  5. Bachelor's Degree in other field 10. Not Enrolled
5. How many years have you been a registered nurse? If not a registered nurse, circle "not an R.N.".
  1. 0-3 2. 4-7 3. 8-11 4. 12-15 5. 16-19
  6. 20-23 7. 24-27 8. 28 or above 9. not an R.N.
6. Do you have at least nine months experience working in a critical-care unit?
  1. yes 2. no
7. If you do not have nine months experience in a critical-care unit, go to question #9. If you do have at least nine months experience in a critical-care unit, was this unit:
  1. adults only 2. children only 3. adults and children.
8. Are you a CCRN?
  1. yes 2. no
9. Your sex is:
  1. female 2. male
10. Your religious preference is:
  1. Protestant 2. Catholic 3. Jewish 4. No Preference
  5. Other (Please Specify) \_\_\_\_\_
11. Do you believe that some form of life occurs after death?
  1. yes 2. no

RETURN OF THIS QUESTIONNAIRE WILL BE CONSTRUED AS YOUR CONSENT TO PARTICIPATE.

12. Has a close relative or good friend of yours undergone cardiopulmonary resuscitation (CPR), in a hospital?  
1. yes 2. no
13. Has a close relative or good friend of yours died in a hospital within the last 12 months?  
1. yes 2. no
14. What primary position in nursing do you now hold? (Select only one).  
1. staff nurse 6. clinical nurse specialist  
2. assistant head nurse 7. faculty, school of nursing  
3. head nurse 8. inservice/staff development  
4. primary nurse 9. full time student  
5. clinical unit coordinator 10. unemployed and not a student  
11. other (please specify)
15. Did you ever participate in any of the following programs in ethics?  
a. part of my nursing course work 1. yes 2. no  
b. a formal course in ehctics 1. yes 2. no  
c. an inservice program 1. yes 2. no  
d. continuing education conference 1. yes 2. no  
e. personal reading 1. yes 2. no  
f. gave a lecture 1. yes 2. no  
g. part of a religious program 1. yes 2. no  
h. other (please specify) \_\_\_\_\_
16. Have you ever performed CPR?  
1. yes 2. no
17. Have you ever participated in CPR where the patient was later discharged home?  
1. yes 2. no
18. Have you ever performed CPR on a patient when, in your opinion, CPR should not have been performed?  
1. yes 2. no
19. Has a patient ever discussed the "do not resuscitate" situation with you?  
1. yes 2. no
20. Has a family member ever asked you about the "do not resuscitate" situation?  
1. yes 2. no
21. Has a patient ever told you that he/she did not want to be resuscitated?  
1. yes 2. no
22. Has a family member ever told you that he/she did not want CPR performed on the patient?  
1. yes 2. no

RETURN OF THIS QUESTIONNAIRE WILL BE CONSTRUED AS YOUR CONSENT TO PARTICIPATE.

23. Have you ever asked a physician to write a "do not resuscitate" order?  
1. yes 2. no
24. Has a physician ever refused to write a "do not resuscitate" order when you knew the patient wanted one?  
1. yes 2. no
25. Have you ever helped the physician make the "do not resuscitate" decision?  
1. yes 2. no
26. Have you ever helped the family make the "do not resuscitate" decision?  
1. yes 2. no
27. Does your unit have written guidelines regarding the "do not resuscitate" order? If your answer is no, skip question # 28.  
1. yes 2. no
28. If you answered yes to question #27, according to these written guidelines, does the nurse have any input into the "do not resuscitate" decision?  
1. yes 2. no
29. Do you believe that patients who have a written "do not resuscitate" order receive the same quality and quantity of nursing care as other patients in the critical-care unit?  
1. yes 2. no