JHWCR JOURNAL OF HEALTH, WELLNESS AND COMMUNITY RESEARCH 3007-0570

https://doi.org/10.61919/8dc4kd86

Original Article

Perceptions of ICU Nurses Regarding Do Not Resuscitate (DNR) Orders in Tertiary Care Hospitals of Peshawar

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"Cite this Article" Received: 05 March 2026; **Accepted**: 03 April 2026; **Published**: 22 May 2026

Author Contributions: Concept: AU; Design: AU, MH; Data Collection: AM, MJ, AH; Analysis: MY, HAA; Drafting: AU, MH. **Ethical Approval**: Khyber Medical University, Peshawar, Pakistan. **Informed Consent**: Written informed consent was obtained from all participants; **Conflict of Interest**: The authors declare no conflict of interest. **Funding**: No external funding; **Data Availability**: Available from the corresponding author on reasonable request; **Acknowledgments**: N/A.

ABSTRACT

Background: Do-Not-Resuscitate (DNR) orders are ethically sensitive decisions in critical care settings, particularly in contexts where religious beliefs, family-centered decision-making, limited legal clarity, and institutional policy gaps influence end-of-life care. ICU nurses are directly involved in caring for critically ill patients under DNR orders and may experience emotional, moral, and professional challenges during implementation. Objective: This study aimed to explore ICU nurses' perceptions regarding DNR orders in tertiary care hospitals of Peshawar, Pakistan, with specific attention to ethical, emotional, communication-related, organizational, and legal challenges. Methods: A qualitative phenomenological study design was used. Thirteen registered ICU nurses working in adult intensive care units of tertiary care hospitals in Peshawar were recruited through purposive sampling. Data were collected through face-to-face semi-structured interviews lasting 30–45 minutes. Interviews were audio-recorded with consent, transcribed verbatim, anonymized, and analyzed using Braun and Clarke's six-step thematic analysis framework. Trustworthiness was addressed through credibility, dependability, confirmability, and transferability procedures. Results: The analysis generated 50 initial codes, which were organized into 12 categories, 6 subthemes, and 3 final themes: ethical, religious, and emotional burden; communication, family, and decision-making barriers; and organizational and legal challenges. Nurses reported emotional exhaustion, moral distress, religious uncertainty, family misunderstanding, physician dominance, exclusion from decision-making, lack of formal DNR protocols, documentation gaps, and fear of legal consequences. Conclusion: ICU nurses perceived DNR implementation as emotionally demanding, ethically complex, and institutionally under-supported. Clear hospital policies, structured documentation, family counseling, interdisciplinary decision-making, legal guidance, and ethics training are needed to support nurses and improve end-of-life care. Keywords: Do-Not-Resuscitate orders; ICU nurses; qualitative research; moral distress; end-of-life care; Pakistan.

INTRODUCTION

Do-not-resuscitate (DNR) orders are medical instructions indicating that cardiopulmonary resuscitation should not be initiated when a patient experiences cardiac or respiratory arrest. These decisions are most commonly considered in critically ill or terminally ill patients when resuscitation is unlikely to provide meaningful clinical benefit and may instead prolong suffering or compromise patient dignity (1). In intensive care units, DNR decisions are ethically complex because they require balancing clinical judgment, patient autonomy, family expectations, professional duties, and the moral responsibility to avoid non-beneficial treatment. Although end-of-life care has increasingly emphasized patient-centered decision-making, comfort, dignity, and avoidance of futile interventions, DNR implementation remains challenging in many critical care settings, particularly where legal and institutional guidance is unclear (2).

ICU nurses occupy a central position in the care of critically ill patients because they provide continuous bedside monitoring, recognize clinical deterioration, communicate frequently with families, and are directly involved in implementing medical orders during emergencies. Despite this close involvement, nurses are often excluded from formal DNR discussions and final decision-making processes, which may lead to ethical uncertainty, emotional distress, and professional dissatisfaction (3). When nurses are instructed not to perform resuscitation, they may experience moral conflict between their professional commitment to preserve life and their responsibility to respect end-of-life decisions intended to prevent unnecessary suffering. Previous studies have shown that nurses involved in end-of-life care may experience emotional exhaustion, moral distress, and uncertainty when treatment-limitation decisions are poorly communicated or insufficiently supported by institutional policy (4).

The complexity of DNR decision-making is further intensified in Muslim-majority and family-centered societies such as Pakistan, where religious beliefs, cultural expectations, and collective family decision-making strongly influence perceptions of life-sustaining treatment. In such contexts, DNR orders may be misunderstood as abandonment of care or intentional withdrawal of hope, particularly when families are not adequately counseled about prognosis, medical futility, and comfort-focused care. Religious concerns may also shape nurses' perceptions, as some may fear that withholding resuscitation conflicts with the belief that life and death are determined by Allah. These cultural and spiritual dimensions make DNR decisions especially sensitive and require clear communication, ethical guidance, and interdisciplinary support (5).

In Pakistan, the absence of widely standardized institutional DNR protocols and limited legal clarity create additional uncertainty for healthcare professionals working in critical care environments. In many hospitals, DNR decisions may depend heavily on physician judgment, informal communication, and family negotiation rather than structured policy, documented consensus, or multidisciplinary ethical review. This situation may leave ICU nurses vulnerable to fear of blame, legal consequences, family aggression, and moral distress, especially when they are expected to implement decisions in which they had limited participation. International evidence suggests that structured end-of-life decision-making models, interdisciplinary communication, and institutional protocols can improve clarity and reduce conflict in ICU care (6).

Although DNR and end-of-life care have been examined in international literature, limited qualitative evidence is available regarding how ICU nurses in Peshawar perceive, experience, and respond to DNR orders within local cultural, religious, legal, and organizational contexts. Understanding nurses' perspectives is essential because they are directly exposed to the practical, emotional, and ethical consequences of DNR implementation at the bedside. Therefore, this study aimed to explore the perceptions of ICU nurses regarding DNR orders in tertiary care hospitals of Peshawar, with particular attention to their ethical and emotional experiences, communication challenges with families and physicians, and perceived organizational and legal barriers to effective DNR implementation.

MATERIALS AND METHODS

This study employed a qualitative phenomenological research design to explore the lived experiences, perceptions, and challenges of intensive care unit nurses regarding Do-Not-Resuscitate orders in tertiary care hospitals of Peshawar, Pakistan. A phenomenological approach was considered appropriate because the study sought to understand how ICU nurses interpret and experience DNR decisions in real clinical practice, particularly in relation to ethical conflict, religious beliefs, family communication, professional hierarchy, and institutional policy limitations. The study was conducted in adult intensive care units of tertiary care hospitals in Peshawar, which provide specialized critical care services to patients from Peshawar and surrounding districts of Khyber Pakhtunkhwa. The target population consisted of registered nurses working in adult ICUs who had direct clinical exposure to critically ill patients for whom DNR decisions had been discussed, documented, or implemented.

Participants were recruited through purposive sampling to ensure the inclusion of ICU nurses with relevant clinical experience and direct exposure to end-of-life care situations. Nurses were eligible for inclusion if they were registered nursing professionals, had at least one year of experience in an adult ICU, were actively involved in bedside care of critically ill patients, and had encountered patients managed under DNR-related decisions. Nurses working outside ICU settings, student nurses, trainee nurses without independent clinical responsibility, and nurses who had no direct experience with DNR-related patient care were excluded. Recruitment continued until data saturation was achieved, defined as the point at which repeated interviews no longer produced new codes, categories, or themes relevant to the study objectives. A total of 13 ICU nurses participated in the study, including 11 male and 2 female nurses, reflecting the gender distribution commonly observed in ICU staffing within the study setting.

Data were collected through face-to-face semi-structured interviews conducted in a private and quiet area within the hospital environment to ensure confidentiality and allow participants to speak freely about sensitive ethical and professional experiences. The interview guide was developed in accordance with the study objectives and existing literature on DNR decisions, end-of-life care, nursing ethics, moral distress, and ICU communication.

The guide explored participants' understanding of DNR orders, emotional and ethical experiences while caring for DNR patients, perceptions of religious and cultural influences, family responses to DNR decisions, communication with physicians and relatives, involvement of nurses in decision-making, documentation practices, legal concerns, and perceived need for institutional policy or training. Interviews were conducted using open-ended questions with probing prompts to obtain detailed descriptions of participants' experiences. Each interview lasted approximately 30–45 minutes and was audio-recorded after obtaining permission from the participant. Field notes were maintained during and immediately after interviews to document contextual observations, non-verbal expressions, and preliminary analytic reflections.

Before each interview, participants were informed about the purpose of the study, voluntary participation, confidentiality of responses, and their right to withdraw at any stage without penalty. Written informed consent was obtained from all participants prior to data collection. To protect anonymity, names and identifying information were removed from transcripts, and participants were assigned coded identifiers during transcription and analysis. Audio recordings and transcripts were stored securely and were accessible only to the research team. The interviews were transcribed verbatim, and transcripts were reviewed against audio recordings to ensure accuracy. Data were organized in anonymized form before analysis, and participant quotations were selected in a way that preserved meaning while protecting identity.

Data were analyzed using Braun and Clarke's six-step thematic analysis framework, which included familiarization with the data, generation of initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the final report (7). The analysis began with repeated reading of interview transcripts to develop an overall understanding of participants' experiences. Meaningful units of text were then coded inductively, allowing codes to emerge from the data rather than imposing predetermined categories. Initial codes were compared across transcripts and grouped into broader categories based on conceptual similarity.

These categories were then refined into subthemes and final themes that represented recurring patterns in nurses' perceptions of DNR orders. The coding process generated 50 initial codes, which were organized into 12 categories, 6 subthemes, and 3 final themes: ethical and emotional burden, communication and family decision barriers, and organizational and legal challenges. Throughout analysis, codes and themes were repeatedly checked against the original transcripts to ensure that the final thematic structure remained grounded in participants' accounts.

Trustworthiness was ensured through credibility, dependability, confirmability, and transferability strategies. Credibility was strengthened by selecting participants with direct ICU and DNR-related experience, conducting in-depth interviews, using probing questions, and continuing recruitment until data saturation was reached. Dependability was supported by maintaining a clear record of data collection procedures, coding decisions, theme development, and analytic refinement. Confirmability was enhanced through transcript review, preservation of an audit trail, and repeated comparison of themes with participant narratives to reduce researcher bias. Transferability was supported by describing the study setting, participant characteristics, sampling approach, and clinical context in sufficient detail to allow readers to judge the applicability of findings to similar ICU environments. Ethical principles were followed throughout the study, including informed consent, voluntary participation, privacy during interviews, confidentiality of data, anonymization of transcripts, and respectful handling of participants' sensitive professional and emotional experiences.

RESULTS

Thirteen ICU nurses participated in the study. Most participants were male, with 11 male and 2 female nurses included in the final sample. All participants were registered nurses working in adult intensive care units of tertiary care hospitals in Peshawar and had direct clinical exposure to patients for whom Do-Not-Resuscitate orders had been discussed, documented, or implemented. Participants had sufficient ICU experience to describe the emotional, ethical, communication-related, and institutional challenges associated with DNR care. The demographic profile is summarized in Table 1.

Table 1. Demographic Characteristics of Participants

Characteristic	Frequency
Total participants	13
Male nurses	11
Female nurses	2
Clinical setting	Adult intensive care units
Hospital type	Tertiary care hospitals
Sampling approach	Purposive sampling
Data collection method	Semi-structured interviews
Interview duration	30–45 minutes
Final analytic output	50 codes, 12 categories, 6 subthemes, 3 final themes

Analysis of the interview data generated 50 initial codes, which were grouped into 12 categories and then refined into 6 subthemes and 3 final themes. The final themes were ethical and emotional burden, communication and family decision barriers, and organizational and legal challenges. These themes reflected how nurses experienced DNR orders not only as clinical instructions but also as emotionally demanding, ethically sensitive, socially contested, and institutionally uncertain decisions.

Table 2. Thematic Matrix of ICU Nurses' Perceptions Regarding DNR Orders

Final Theme	Subtheme	Key Categories	Example Codes
Ethical and Emotional Burden	Psychological burden of DNR care	Emotional distress, helplessness, burnout	Emotional trauma, sadness, anxiety, emotional exhaustion, feeling helpless
Ethical and Emotional Burden	Moral, religious, and dignity-related conflict	Moral conflict, religious concern, patient dignity	Moral distress, religious guilt, fear of committing sin, conflict with personal values, desire to preserve dignity
Communication and Family Decision Barriers	Family misunderstanding and resistance	Family pressure, disagreement, aggression	Family misunderstanding, family disagreement, pressure from relatives, verbal abuse, family aggression
Communication and Family Decision Barriers	Professional communication and hierarchy	Poor communication, physician dominance, exclusion of nurses	Poor physician communication, lack of nurse involvement, hierarchical decision-making, exclusion from discussions
Organizational and Legal Challenges	Policy and documentation uncertainty	Lack of policy, poor documentation, unclear protocols	Lack of protocols, unclear hospital policy, lack of documentation
Organizational and Legal Challenges	Legal fear and training needs	Legal concern, fear of blame, training deficit	Fear of legal blame, fear of litigation, need for clear guidelines, lack of ethical training

Theme 1: Ethical and Emotional Burden

The first major theme reflected the internal burden experienced by ICU nurses when caring for patients under DNR orders. Participants described DNR care as emotionally difficult because they continued to provide bedside care while knowing that cardiopulmonary resuscitation would not be initiated if the patient deteriorated. This created sadness, helplessness, anxiety, and emotional fatigue. Nurses reported that repeated exposure to end-of-life situations made them emotionally attached to patients and their families, particularly when patients remained critically ill for several days in the ICU.

A recurring pattern across interviews was that nurses did not perceive DNR orders as simple clinical instructions. Instead, they experienced them as morally charged decisions. Many participants felt caught between their professional identity as life-saving healthcare workers and the clinical decision to withhold CPR when resuscitation was considered medically inappropriate or non-beneficial. This conflict was especially strong during emergencies, when nurses were trained to respond immediately but were required to follow DNR instructions.

Participants also linked DNR decisions with religious and spiritual uncertainty. Some nurses expressed discomfort because withholding resuscitation was perceived as potentially interfering with divine will. The belief that life and death are determined by Allah shaped how nurses understood the moral meaning of DNR orders. For some participants, this created religious guilt and fear of doing something ethically or spiritually wrong. At the same time, nurses also recognized that repeated invasive interventions could increase suffering and reduce patient dignity near the end of life. This produced a complex tension between preserving life, preventing suffering, respecting dignity, and remaining faithful to personal religious beliefs.

Participant Accounts Supporting Theme 1

Subtheme	Participant-account summary to replace with verbatim transcript quote
Emotional exhaustion	Nurses described feeling emotionally tired after repeatedly caring for critically ill patients whose condition continued to deteriorate despite intensive treatment.
Helplessness	Participants reported feeling helpless when they remained at the bedside but could not initiate CPR because a DNR decision had been made.
Moral conflict	Nurses described conflict between their professional training to save lives and the instruction not to resuscitate patients under DNR orders.
Religious concern	Participants reported uncertainty about whether withholding CPR was compatible with religious beliefs about life, death, and divine will.
Patient dignity	Nurses also expressed concern that aggressive resuscitation in terminally ill patients could prolong suffering and compromise dignity.

Theme 2: Communication and Family Decision Barriers

The second major theme concerned communication difficulties among nurses, physicians, patients' families, and the wider healthcare team. Nurses reported that families often misunderstood DNR orders and interpreted them as abandonment of care, refusal of treatment, or loss of hope. This misunderstanding created distress for nurses because they continued to provide care but were sometimes perceived by relatives as neglecting the patient.

Family resistance was described as a major source of stress. Participants reported that relatives sometimes disagreed with DNR decisions, pressured staff to "do everything," or became verbally aggressive during critical moments. Nurses often found themselves in the middle of conflict between physicians' clinical decisions and families' emotional expectations. This was especially difficult when family members had not received clear explanations about prognosis, medical futility, or the purpose of comfort-focused care.

Communication barriers within the healthcare team also shaped nurses' experiences. Participants reported that DNR discussions were often physician-led, with limited involvement of nurses despite their continuous bedside role. Nurses felt that they understood the patient's condition, family concerns, and bedside realities, but their observations were not always included in final decision-making. This

hierarchical structure reduced nurses' confidence, increased frustration, and contributed to feelings of professional exclusion.

The findings suggested that DNR-related communication challenges operated at two levels: family-level misunderstanding and professional-level hierarchy. At the family level, nurses faced emotional reactions, disagreement, and pressure from relatives. At the professional level, they experienced limited voice in decisions that they were later expected to implement. Together, these barriers increased moral distress and made DNR care more difficult to manage in ICU practice.

Participant Accounts Supporting Theme 2

Subtheme	Participant-account summary to replace with verbatim transcript quote
Family misunderstanding	Nurses reported that families often understood DNR as stopping all treatment rather than withholding CPR during cardiac or respiratory arrest.
Family pressure	Participants described pressure from relatives who wanted all possible interventions even when prognosis was poor.
Aggression from attendants	Nurses reported that emotionally distressed attendants sometimes blamed or verbally abused staff during end-of-life situations.
Poor physician-family communication	Participants indicated that inadequate explanation from physicians increased family confusion and conflict.
Nurse exclusion	Nurses reported that DNR decisions were commonly made by physicians, while nurses were informed later and expected to implement the decision.

Theme 3: Organizational and Legal Challenges

The third major theme reflected the institutional and legal uncertainty surrounding DNR implementation. Participants reported that the absence of clear hospital protocols created confusion about how DNR orders should be discussed, documented, communicated, and implemented. Nurses felt vulnerable when DNR decisions were not supported by standardized forms, written policy, or clear documentation pathways.

Fear of legal consequences emerged repeatedly. Nurses worried that they could be blamed by families, hospital authorities, or legal systems if a patient died under a DNR order. This fear was stronger when documentation was incomplete or when family members were not fully informed. Participants described feeling professionally exposed because they were directly present at the bedside during emergencies, even though they were not always involved in the decision-making process.

Training deficits were also identified as an important institutional issue. Nurses reported that they needed structured education on DNR orders, end-of-life ethics, communication with families, legal documentation, and religiously sensitive care. Participants believed that regular workshops, ethics training, and clear institutional guidelines would improve confidence and reduce uncertainty during DNR implementation.

Overall, this theme showed that nurses' difficulties with DNR orders were not only personal or interpersonal. They were also produced by wider system-level gaps. The absence of formal protocols, legal protection, documentation standards, and ethics training left nurses feeling unsupported and undervalued in end-of-life care.

Participant Accounts Supporting Theme 3

Subtheme	Participant-account summary to replace with verbatim transcript quote
Lack of hospital policy	Nurses reported uncertainty because DNR decisions were not always guided by clear institutional protocols.
Documentation gaps	Participants described concern when DNR decisions were communicated verbally or documented inconsistently.
Fear of blame	Nurses feared being held responsible by families if CPR was not performed during arrest.
Legal uncertainty	Participants reported concern about legal consequences due to unclear national or institutional frameworks.
Need for training	Nurses emphasized the need for ethics training, communication workshops, and clear guidelines for DNR implementation.

The findings showed that ICU nurses perceived DNR orders through three interconnected dimensions. First, DNR care created an internal emotional and moral burden because nurses had to reconcile professional duty, religious belief, patient dignity, and the reality of medical futility. Second, DNR implementation was shaped by communication barriers, particularly family misunderstanding, emotional resistance, physician dominance, and limited nurse involvement in decision-making. Third, nurses experienced organizational vulnerability because of unclear policies, weak documentation practices, legal uncertainty, and limited training.

These themes were not isolated. Emotional distress increased when families misunderstood DNR decisions. Family conflict became more difficult when physicians did not communicate clearly or when nurses were excluded from discussions. Legal fear became stronger when documentation was unclear or when hospital policies were absent. Therefore, nurses' perceptions of DNR orders reflected a combined ethical, emotional, interpersonal, and institutional experience rather than a single clinical concern.

Core Finding	Interpretation
Ethical and emotional burden	Nurses experienced DNR orders as emotionally painful and morally complex, especially when decisions conflicted with professional identity or religious beliefs.
Communication and family decision barriers	Nurses faced pressure from families and exclusion from physician-led decisions, making implementation stressful and conflict-prone.
Organizational and legal challenges	Lack of protocols, documentation systems, legal clarity, and training made nurses feel exposed while implementing DNR decisions.

The thematic analysis indicated that ICU nurses in tertiary care hospitals of Peshawar perceived DNR orders as ethically sensitive, emotionally demanding, and institutionally under-supported. Their accounts showed that DNR implementation required more than clinical judgment; it required clear communication, family counseling, interdisciplinary decision-making, legal protection, and formal hospital policy.

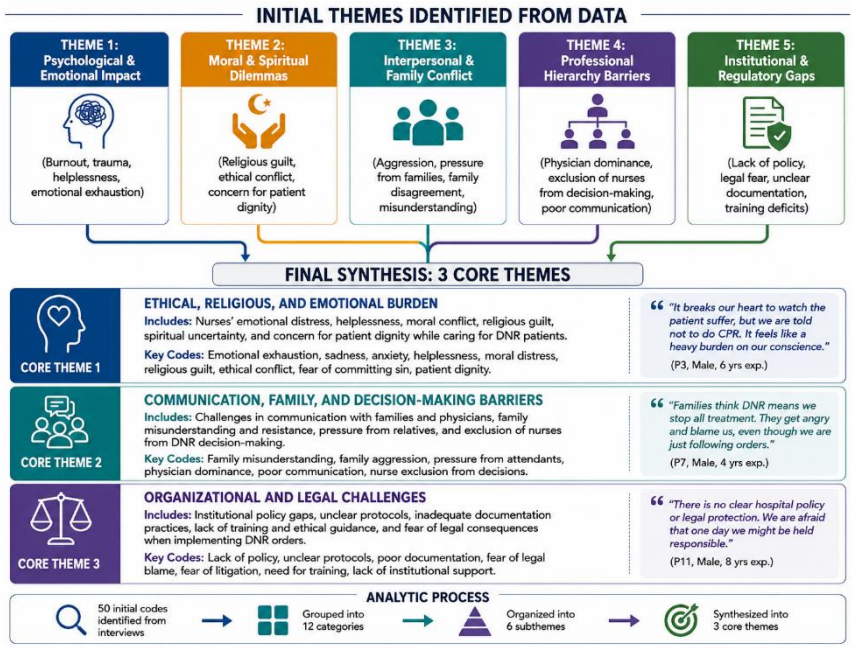
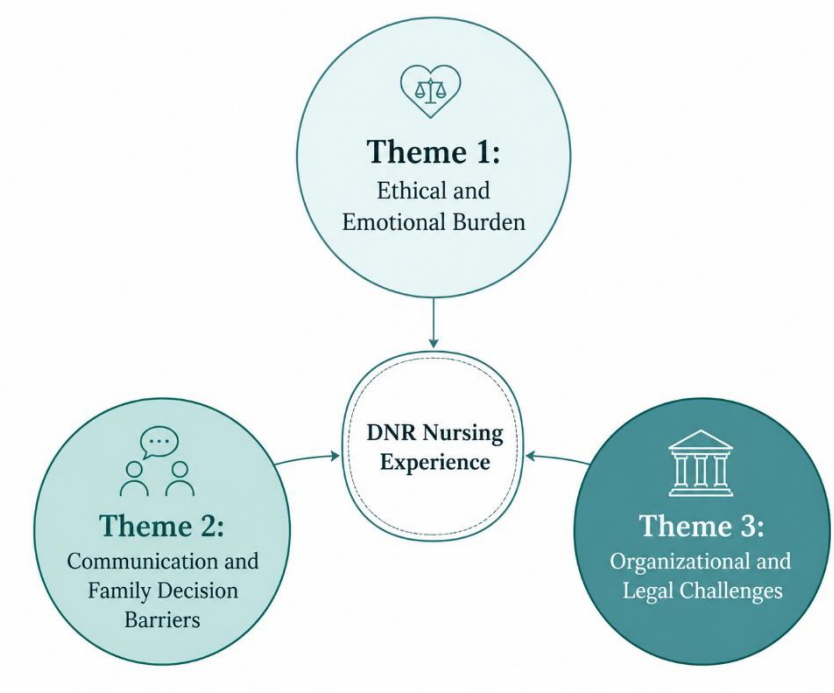


Figure 1. Thematic synthesis of ICU nurses' perceptions regarding DNR orders

Five initial themes derived from interview data were analytically refined into three core themes—ethical, religious, and emotional burden; communication, family, and decision-making barriers; and organizational and legal challenges—illustrating how nurses' DNR experiences were shaped by personal moral distress, family and professional communication barriers, and institutional policy gaps.



DISCUSSION

This qualitative study explored ICU nurses' perceptions regarding Do-Not-Resuscitate orders in tertiary care hospitals of Peshawar and found that DNR implementation was experienced as an ethically sensitive, emotionally demanding, and institutionally under-supported aspect of critical care nursing. The findings showed that nurses did not perceive DNR orders merely as clinical instructions; rather, they understood them through the combined influence of emotional distress, moral responsibility, religious beliefs, family expectations, professional hierarchy, and uncertainty regarding hospital policy and legal protection. These findings are consistent with previous literature indicating that end-of-life decisions in intensive care are complex, emotionally burdensome, and dependent on communication, ethical clarity, and institutional support (1,2).

The first major finding was the ethical, religious, and emotional burden experienced by ICU nurses while caring for patients under DNR orders. Participants described sadness, helplessness, guilt, emotional exhaustion, and moral distress when they were required to withhold CPR from critically ill patients. This reflects the tension between nurses' professional identity as life-saving caregivers and their responsibility to follow end-of-life decisions intended to avoid non-beneficial interventions. Similar concerns have been reported in studies on withdrawal of life-sustaining treatment and end-of-life care, where nurses experienced emotional strain while continuing bedside care after decisions to limit aggressive treatment (2,8). The emotional burden in the present study was intensified by nurses' close and continuous contact with patients and families, which increased their attachment to patients and made DNR implementation personally difficult.

Religious and moral concerns were particularly prominent in this study. Participants frequently described uncertainty about whether withholding CPR was compatible with their personal religious beliefs and ethical duty to preserve life. In a Muslim-majority setting such as Peshawar, the belief that life and death are determined by Allah appeared to influence how nurses interpreted DNR decisions. This finding adds an important cultural and spiritual dimension to the international literature on DNR and end-of-life care. While previous studies have discussed ethical uncertainty and moral distress among nurses, the present study highlights that spiritual guilt and fear of moral wrongdoing may be especially influential in settings where religious beliefs strongly shape perceptions of death, suffering, and medical decision-making (3,5). At the same time, participants also recognized that aggressive resuscitation in

terminally ill patients could prolong suffering and compromise dignity, showing that their moral reasoning involved both preservation of life and protection of patient comfort.

The second major finding concerned communication, family, and decision-making barriers. Nurses reported that families often misunderstood DNR orders and interpreted them as stopping treatment, abandoning the patient, or giving up hope. This misunderstanding created conflict during critical situations and increased pressure on nurses, particularly when relatives demanded that all possible interventions be continued despite poor prognosis. Family resistance in the present study reflected the strong role of collective decision-making in Pakistani society, where families often act as primary decision-makers in serious illness. Poor communication between physicians and families appeared to worsen these tensions, leaving nurses to manage relatives' emotional reactions at the bedside. Previous evidence has emphasized that models of end-of-life decision-making in ICU settings require structured communication, shared understanding of prognosis, and clear explanation of treatment limitations to reduce conflict and uncertainty (6).

Professional hierarchy also emerged as a major barrier to effective DNR implementation. Participants reported that DNR decisions were often physician-led, while nurses were informed after decisions had been made and were expected to implement orders without meaningful involvement in the discussion. This exclusion was problematic because nurses remained continuously present at the bedside, observed patient suffering directly, and frequently communicated with families. The finding is consistent with international evidence showing that nurses are often insufficiently involved in DNR decision-making despite their central role in patient care (7). Limited nurse participation may reduce professional confidence, increase moral distress, and weaken interdisciplinary decision-making. Including nurses in DNR discussions may improve communication, strengthen documentation, and ensure that bedside realities are considered before final decisions are implemented.

The third major finding was the presence of organizational and legal challenges. Participants repeatedly described uncertainty due to lack of formal hospital protocols, inconsistent documentation, limited institutional guidance, and fear of legal consequences. Nurses felt vulnerable when they were required to follow DNR orders without clear policy support or legal protection. This fear was especially strong when families were dissatisfied or when DNR decisions were not clearly documented. Similar concerns have been reported in the broader end-of-life literature, where unclear institutional systems and lack of structured decision-making models can increase ethical uncertainty among healthcare professionals (6,10). The present findings suggest that DNR-related distress among ICU nurses is not only an individual emotional response but also a system-level problem shaped by gaps in policy, training, documentation, and legal clarity.

The findings have important implications for critical care practice in Pakistan. Hospitals should develop clear DNR policies that define eligibility, decision-making authority, documentation requirements, communication procedures, and the role of nurses in interdisciplinary discussions. Structured ethics training should be provided to ICU nurses and physicians to improve understanding of DNR orders, medical futility, patient dignity, religiously sensitive communication, and legal responsibilities. Family counseling should be strengthened so that relatives understand that DNR does not mean withdrawal of all care, but rather avoidance of CPR when it is unlikely to provide meaningful benefit. Institutional support systems, such as ethics committees, standardized DNR forms, and documented family meetings, may reduce conflict and protect both patients and healthcare professionals.

This study also highlights the need to recognize nurses as active contributors to end-of-life decision-making rather than passive implementers of physician orders. Nurses' continuous bedside presence gives them important insight into patient suffering, family concerns, and practical challenges during DNR care. Their inclusion in decision-making can improve communication, reduce moral distress, and promote more ethically balanced care. Training programs should therefore focus not only on clinical

knowledge but also on communication skills, emotional resilience, ethical reasoning, and culturally sensitive end-of-life care.

The study has some limitations. The sample was limited to ICU nurses from tertiary care hospitals in Peshawar, which may affect transferability to other regions, private hospitals, or non-ICU settings. The gender distribution was predominantly male, reflecting local ICU staffing patterns, but female nurses' experiences may not have been fully represented. As DNR is an ethically and religiously sensitive topic, participants may have moderated their responses because of social desirability or fear of professional judgment. The study also explored nurses' perceptions only; perspectives of physicians, patients, family members, hospital administrators, and religious scholars were not included. Despite these limitations, the study provides valuable qualitative insight into how ICU nurses experience DNR orders in a culturally, religiously, and institutionally complex critical care environment.

CONCLUSION

ICU nurses in tertiary care hospitals of Peshawar perceived Do-Not-Resuscitate orders as ethically complex, emotionally distressing, and institutionally challenging decisions. Their experiences were shaped by moral distress, religious uncertainty, emotional exhaustion, family misunderstanding, limited involvement in physician-led decision-making, unclear documentation, and fear of legal consequences. The findings suggest that DNR implementation in ICU settings requires more than individual clinical judgment; it requires clear institutional policies, structured documentation, interdisciplinary decision-making, family counseling, ethical training, and legal guidance. Including nurses in DNR discussions is essential because of their continuous bedside role and direct involvement in patient and family care. Strengthening hospital-based DNR protocols, improving communication between healthcare teams and families, and providing regular ethics and end-of-life care training may reduce nurses' moral distress and support more dignified, culturally sensitive, and ethically sound care for critically ill patients..

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