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REVIEW

Do Not Resuscitate Order and Elderly

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Abstract
Cardiopulmonary resuscitation is a choice that must be made between the return of life and the end of life. It is still a matter of controversy when and where cardiopulmonary resuscitation will be implemented, and this discussion has brought the "Do Not Resuscitate" order to the agenda. For this reason, "Resuscitation" and "Do Not Resuscitate" order lead to many ethical and legal dilemmas. The "Do Not Resuscitate" order, which is a difficult decision to make, becomes more difficult in the old age when ethical problems are frequent. Because of chronic diseases and deterioration in cognitive functions, the ability to make decisions about health practices of elderly individuals who are becoming increasingly dependent in terms of physical and psychosocial dimensions are also diminishing. In addition, lack of awareness, sensory/emotional barriers and communication deficits prevent elderly people from participating in health care decisions; it makes difficult to determine care target among the elderly and health professionals. Especially to be adequate to the needs of nursing care for the elderly, the problems related to "Do Not Resuscitate" instruction which is an important part of end-of-life maintenance need to be solved. For this purpose, the "Do Not Resuscitate" order should be handled by health professionals and lawyers in a versatile manner and necessary legal arrangements should be made.
Key words: Elderly, Nursing, Do Not Resuscitate, DNR Order

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Introduction

Every moment of human life is very important. In modern societies, the common goal of all medical interventions is to protect life, to restore individual health, to relieve pain and to limit loss of function according to priority order (Yokusoglu et al., 2008; Cicekci and Atici, 2013). However, as a consequence of the directing of social values, the moment of birth and death has become more important for all people. In parallel with the rapid development of medical technology, the beginning and the end of life can be intervened, the moment and the shape of death, as well as birth, has also become a condition that can be intervened medically. Some medical interventions are separated from others. Because they make us feel that human life and moments in life are the most precious things. In numerous medical interventions, "cardiopulmonary resuscitation" (CPR), which has a separate importance in the thin line between life and death, is an error-free intervention that must be done correctly with

correct technique (Gonenc, 2015). CPR applied at a critical point between life and death; is defined as sustaining the airway opening and supporting the respiratory and circulatory system of the patient whose respiratory and circulatory system stop functioning for any reason (Karatas and Selcuk, 2012; Kozaci, 2013).

Today, the debate over whether CPR practices are implemented in patients who are at end-stage and with a life expectancy that is very short after the resuscitation is very common and frequent (Sert et al., 2007). The goal in CPR, which is as old as human history, is to return the clinical death when it is still in recovery (Yokusoglu et al., 2008). As a general approach, the decision to administer CPR should be based not only on the development of the arrest but on the individual evaluation of the underlying disease and the patient. This brings the implementation of "Do Not Resuscitate" (DNR) orders to the agenda (Kellum and Dacey, 2009; Tel, 2012). The changing age structure in the world and Turkey suggests that these discussions will focus on the elderly with the least life expectancy and with most frequent chronic illnesses in the coming years (Seder et al., 2014). In addition, the decision for CPR or DNR in the elderly is much more important because being elder reduces the chance of survival after CPR and the quality of life after survival (Glind et al., 2013).

Young people are more likely to give DNR orders than older people (Cherniack, 2002). It has been reported that older age is the strongest factor in making DNR decision, as well as facilitating various factors such as comorbid conditions, psychiatric disorders, oncologic diseases, low quality of life and poor prognosis (Glind et al., 2013). In recent studies, elder ages have laid the groundwork for DNR decision making by strengthening other factors (Chevaux et al., 2015); it was found that with increasing age, the rate of giving DNR order increased (Messinger-Rapport and Kamel, 2005). Cherniack states that, regardless of prognosis, older patients are given DNR order more often than younger patients (Cherniack, 2002). In addition, end-of-life care is an important part of overall patient care, and the DNR decision is an important part of end-of-life care. Together with DNR instruction, the elderly person himself, family or surrogates can actively participate in the treatment process, become involved in the care, and reduce useless medical interventions (Phillips et al., 2011; Yang et al., 2012).

There are more ethical problems in treatment and care due to the elderly person has chronic diseases, impairment of cognitive functions and decision making, economic, social, physical dependencies and inadequacies. As the elderly person can experience problems in monitoring and evaluating progress in treatment, care, technological development, ethical dilemmas can arise as a common problem in decisions about self (Karadakovan, 2014). For this reason, the dilemma of applying resuscitation in the elderly can be discussed with a long discussion about the rules in which the "DNR" order can be decided on the legal framework. In this review, the aim is to raise awareness of DNR instruction, attitudes towards the DNR order in the elderly, guidelines for the DNR instruction, recommendations and the ethical / legal dimension in relation to DNR, which is a controversial subject in the world and in Turkey.

“Do Not Resuscitate” Order, Physician Attitudes and Nursing

"Do Not Resuscitate" is defined as "Do not apply preventive supportive care for the life of patient whose cardiac and respiratory functions come to an end or do not apply all the measures in practice in this process " (Sert et al., 2007). However, DNR order is a treatment option written in treatment of the sick individual with poor prognosis and who wants to die clinical conditions (Glind et al., 2013; Sumrall et al., 2016).

Physicians' attitudes about DNR orders varies in many countries. Most physicians in the UK and Japan are ready to write and implement DNR orders even if the patient is against it. Doctors in Israel believe that more communication needs to be made about the treatments that keep patients alive. The attitudes of physicians regarding DNR orders vary according to the area of specialization of the physician. Geriatricologists in the UK are more likely to choose resuscitation than do other physicians. Many doctors in Saudi Arabia state that their own decisions and legal situations are also important, while not considering DNR orders for previously healthy patients (Cherniack, 2002).

American practitioners' attitudes towards DNR orders are contradictory. Half of all physicians and nurses reported that they acted against their consciences in the resuscitation of patients with end-stage illnesses. It is stated that most physicians

in USA want the patient's participation in the decision-making process, but many physicians are uncomfortable discussing DNR instructions and rarely discuss the possibility of CPR with patients other than special issues (eg fatal sickness). It is stated in the literature that 34% of physicians abandon CPR despite the request of the patient and only 40% of physicians in USA say that they will never regard the DNR order as valid even though it is requested by the patient or evaluate the CPR application useless. Also, physicians reported that hospitals had low levels of support and knowledge for DNR policies (Cherniack, 2002).

Nurses, who have an important place in the prevention of end-of-life interventions and the symptoms that may develop for the patient and the family, provide services directly to the patients and their families for their needs. Nurses who are leaders and advocates of decent care for human dignity should actively participate in the process of performing appropriate interventions for mediacal care and evaluating the outcomes in order to reduce the treatments that patients may not want or may suffer from (AHA, 2015). In addition, adequate informing of getting the constent of patients before care-related practices is one of the ethical obligations of nurses. As stated by the International Council of Nurses (ICN), ethical codes of nursing are based on ethical principles of "fundamental human rights, individual respect and justice". As stated in the Universal Declaration of Human Rights, which is the cornerstone of nursing ethical codes, the fundamental rights of a person, in particular 'the right to life', must be respected (ICN, 2012).

In addition, the American Nursing Association (ANA), which supports the right of patients to make free decisions, offers nursing care that protects patient autonomy, honor and rights that will contribute to the resolution of ethical problems. American Nurses Association; encourages nurses to support their patients and their families to make end-of-life decisions, including DNR instructions, and to make choices. ANA adopted the DNR procedure and nursing care report in 2003, on the basis of a report published in 1991 entitled "Providing comfort and relieving pain for the dying patient," which indirectly addressed the DNR order (ANA, 2012).

Nurse should play an active role in initiating discussions on DNR order with families and members of the health care team and be supportive in decision-making. However, despite all the facilities offered for making choices to patients, families and legal surrogates, the dilemmas and challenges of DNR instruction still exist. In this context, nurses find it difficult to discuss the DNR order with patients. The most important reason for this is the fear that patients may suffer from such disputes and refer patients to severe anxiety or hopelessness. Again elderly individuals; can not participate in decisions regarding their own health even if they want because of lack of awareness, fear and emotional hurdles, ineffective communication, lack of trust, inability to deputy assignment and cultural factors. This creates obstacles between the nurse and the patient in terms of understanding the care goals supported by the nurses and to give a decision for written DNR orders (ANA, 2012; Fadıloglu, 2014).

It is an opinion accepted by both the health care team and other individuals (family, close friends, etc.) that elderly people should participate in this decision about using or not using resuscitation (Fadıloglu, 2014). However, when the discussion of this order emerges as a need, the elderly person may no longer have the ability to participate in the decision-making process (Akpinar and Ersoy, 2012). In addition, because it is the choice which must be made between returning to life and ending the life, applying or not appliying CPR can lay the groundwork for complex ethical and legal problems. For this reason, it is important and necessary that DNR orders are prepared earlier. In this respect, if the report published by the American Health Association (AHA) for all sick individuals regardless of age about the preparation of the DNR order is examined, it appears that there are three main items in the preparation of this order. These are; "Taking the patient's choice as a basis for refusing to practice CPR", "Taking the choises of patients' relatives or surrogetes as a basis for refusing to practice CPR", and "Based on the judgment of the physician about the patient and not applying resuscitation to the patient" (AHA, 2015).

Preparation of "Do Not Resuscitate" Order

1. Taking the elderly patient preference as the basis for refusing to apply CPR:

Adequately informed individuals have the right to permit or deny the medical interventions, including CPR both ethically and legally (AHA, 2015). Although most elderly patients want to express

their desire for CPR, it is discussed by the physician whether resuscitation is requested (Cherniack, 2002). The data of Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment Project states that only one quarter of the approximately 1000 elderly patients seriously discuss CPR with physicians. In a study with approximately 400 elderly patients living in a nursing home, similarly one quarter of elderly people were asked by physicians whether they had a desire for CPR (Cherniack, 2002). The right to refuse medical treatment does not depend on whether the patient is in the end-stage, whether the family members agree or do not agree and the aproval of the physicians (AHA, 2015). The individual may have already reported in detail the desire of he or she does not want to undergo CPR in the event of a cardiac arrest, and this may form the basis for the preparation of this DNR order. DNR orders; facilitate autonomous movements, and allow treatments to extend their life span to be implemented in line with their own preferences with the condition that individuals have the ability to make decisions (AHA, 2015). When the cognitive abilities necessary for elderly individuals to decide on CPR practice deteriorate and CPR request stated before by the elderly patient and the current CPR request conflict with each other, physician and family members' requests are reported to be very important (Cherniack, 2002).

2. Taking as a basis for the decision of refusing resuscitation from relatives of patients or other surrogates:

Decision to stop resuscitation of elderly patient in a hospital with a severe condition is usually provided by family members rather than by the patient itself and the physician (Cherniack, 2002). If the individual does not have the capacity to make a DNR decision, the decision is made by the person designated as the surrogate (AHA, 2015). The choice of surrogates is determined by the preferences of the individual in advance. If the patient's preference is not known, the patient's beliefs and life expectancies are taken into consideration. In this case, the patient's physician may take into account the detailed preferences of the patient or decision resuscitation may be taken by a suitable surrogate. Detailed preferences include; speeches, written directives and witnesses. The most common form is the patients' speech with patients' relatives, friends or physicians before they lose their abilities. In some cases, the individual chooses the person who will be surrogate in the presence of a lawyer before losing his or her competence. If a surrogate is not selected by the patient in this way, the law will assign relatives as surrogates (AHA, 2015). However, family members may misinterpret the elders' wishes. It is stated in the literature that family members interpret patients' CPR preferences lower than they are, and even when they prefer DNR, they often do not realize this, but they understand CPR more than elderly patient and predict the probability of success of CPR (Cherniack, 2002).

3. Taking as a basis for the decision of not to apply resuscitation for the patients based on physician's judgment about the patient:

The decision of physician, which is making the CPR application useless, is the basis for the preparation of the DNR order. All health professionals are asking patients to be actively involved in making this decision when a DNR decision is made. However, this is not practiced literally in practice. The absence of individual at the decision stage, the failure of application of medical procedures during resuscitation, the probable prognosis of CPR, and the failure to take into account the individual's own values and preferences during the application of decisions may lead to false impressions (AHA, 2015). The inability of physicians to provide the participation of patients and even family members in the decision to DNR order for elderly patients may suggest that physicians are biased towards elderly and make ageism (Cherniack, 2002). Therefore, a guide has been prepared by the AMA to help the health team in order to make a decision about whether CPR is appropriate, or not for the patient and be able to prepare DNR intructions in this direction. This guide, first published in 1973 by the Council on Ethical and Judicial Affairs-CEJA and American Medical Association-AMA, was updated in 2005 as the last.

Guidelines Prepared by the American Medical Association for the Proper Use of the DNR Order:

1. CPR is administered in patients with cardiac or respiratory arrest, or is not administered when CPR administration is considered to be ineffective or inconsistent with the patient's wishes and values.

2. Health professionals should discuss the possibility of cardiopulmonary arrest with appropriate patients (AMA, 2016). In the United States, elderly outpatients want to discuss CPR with their physicians and expect that their physicians bring the issue to the agenda when their health is better. However, most older people do not talk to their physicians about their CPR, and those who speak about CPR stated that they are able to understand very little about what CPR is exactly (Cherniack, 2002). Elderly individuals at risk for cardiac or respiratory insufficiency should be encouraged to report their CPR preferences in detail. These discussions and all other procedures within the CPR should be described and should be made at the earliest stage, if possible, at the outpatient clinic or hospital admission, and most importantly when the elderly has mental decision-making capability (AMA, 2016). The majority of elderly patients who are treated as outpatients, who are in severe condition and who live in nursing homes in the United States want CPR and want to be part of the CPR decision-making process (Cherniack, 2002). Early discussions on CPR can help patients actively participate in decision-making. In addition, periodic interviews can change the patient's preferences, along with the treatment alternatives that can change over time (AMA, 2016). In a study of approximately 1000 elderly patients with a critical condition, it was determined that one of five elderly patients changed their mind after two months (Cherniack, 2002).

3. If the elderly is unable to make a decision about the use of CPR, and if the preference of the elderly is not known before, a surrogate is assigned taking into account the most valuable aspects of the patient.

4. The health team must adhere to the ethical preferences set by the elderly or surrogate. The own value judgments about the quality of life of health professionals should not interfere with the preferences of the patient or his / her surrogate regarding the use of CPR (AMA, 2016). However, older people with lower quality of life may also have a lower CPR preference due to illness. In the US, CPR preferences of the elderly have been found to be associated with some demographic variables such as "being younger, being more functional, being less educated, believing in technology and male gender" (Cherniack, 2002). In addition, if CPR treatment is deemed ineffective according to the physician, the DNR instruction must be written in the patient's file. In addition, if CPR treatment is deemed ineffective according to the medicine, the DNR instruction must be written in the patient's file. If sufficient time is available, the elderly person should be informed and if the elderly can not decide, the content and application of the DNR order should be explained to the surrogate with its basic reasons (AMA, 2016). Elderly individuals have low CPR desires in terminal illness, permanent cognitive or functional impairment (Cherniack, 2002).

5. Resuscitation is deemed ineffective if it can not restore cardiac or respiratory functions or if the intended purposes of the informed elderly can not be achieved.

6. DNR order should be written by the patient's physician in the patient's file as it is in practice.

7. DNR guidelines foreseeing limiting the applications bringing back to life only in cardiopulmonary arrest situations and should not affect other medical interventions appropriate for the patient.

8. The hospital medical personnel should periodically repeat their experience with the DNR procedure, and the hospital's DNR policy should be appropriately renewed. In addition, physicians should be trained in accordance with the role in the DNR decision-making process (AMA, 2016). It is reported that physicians may sometimes ignore DNR instructions, may be reluctant to practice CPR, and may develop uncertainty or opposition to hospital DNR policies (Cherniack, 2002).

Similar to the guidelines prepared by the American Medical Association, the American Nurses Association also make suggestions to nurse practitioners to overcome the difficulties in the implementation of DNR orders;

Recommendations of the American Nurses Association:

1. Clinical nurses should discuss the changing care goals with patients, families and other important persons on a timely and frequent basis and actively initiate the discussion of DNR treatment (AORN, 2016). Nurses in the United States indicated that they would like to participate more in the DNR decision process (Cherniack, 2002).

2. Nurses should register the patient's DNR orders clearly and update this order at regular intervals to determine the care goals that vary according to the circumstances of the patient.

3.Admin nurses should support practitioner nurses to start the discussion of DNR order.

4.Nursing home managers and hospital nursing managers should develop a standard form that can be used between institutions in DNR order.

5.Admin nurses should provide palliative care support for all patients.

6.The nurses providing education should teach practitioner nurses that DNR order does not mean stopping or reducing the treatment and other practices. DNR does not mean “do not cure”. Attention to this point is the most important thing and different naming such as “do everything”, “do nothing”, or “reduce treatment and care” should not be used to indicate the presence or absence of the DNR order.

7.The trainer nurses should develop and implement special education programs for physicians and other members of the interdisciplinary health care team for DNR order including conversations and discussions about DNR order, achieving natural death.

8.Researcher nurses must investigate the DNR process in all directions to create a proof-based practice.

9.All nurses should be sure that the DNR decision is a clear discussion between the health care team, the patient and the family (or a designated surrogate), and that decisions are made in line with the request of the patient (AORN, 2016). British and American nurses indicate that patient requests should never be invalidated and that the patient preference should be strongly considered in the DNR or CPR practice (Cherniack, 2002).

10.All nurses; should be able to participate in interdisciplinary mechanisms for the resolution of disputes between patients, their families and clinicians and should facilitate the DNR order (AORN, 2016). German nurses are more inclined to resuscitation than British and Swedish nurses; Australian nurses believe that their effects for resuscitation decisions are high; almost half of the Japanese nurses participate in the DNR decision, and one-third of them believe that the DNR order should not be written without the patient's consent (Cherniack, 2002).

11. All nurses should actively participate in the work for the development of DNR policies at the institutions they work. In particular, policies should be addressed or explained as follows:

•Patients who have evidence that they do not want CPR but who do not give written DNR order should be directed to apply to health professionals.

•Medical documents should be established stating how this decision was made for the DNR order.

•The duties and responsibilities of the various health professionals who will communicate with the patient and the family in relation to the DNR order should be determined.

•It should be ensured that the DNR order is explained effectively to the other institution during patients' transfer between institutions.

•Effective communication between health personnel should be made in order to prevent stigmatization and confidentiality violations for the patient who give DNR order.

•The practitioner should be guided for special cases (such as patients who are to be operated or undergone invasive procedure etc.) for which the DNR order needs to be revisited.

•The needs of the patients with special status such as pediatrics or geriatrics for the DNR order should be determined.

Legal Dimension of the "DNR" Order

The limitation of CPR practice in the world was considered a professional mistake before 1990, but after 1990, the US Senate issued a law requiring patients to make their own decisions about treatments to be applied to their own names. It has been stated in this law that came into force since December 1991 that individuals have the right to "refuse medical treatment and formulate their detailed preferences". In addition, it has been stated that health institutions should pass written documents containing advanced directives to the records (Sert et al., 2007).

Although there is no special provision or section regarding the restriction of DNR or resuscitation in the Turkish Penal Code (TPC), there is a section under the name of "euthanasia" dealing with the question of whether the right to refuse treatment is available or not, or if it is, to what extent and who can use these rights. The article 25 of the Turkish Penal Code includes this state that “The patient has the right to refuse or stop treatment." (Yuksek Saglik Surası, 1970). The first principle for this is autonomy. Autonomy means that an individual has

the right to determine interventions to his or her body or health according to their own values and priorities. According to this principle prerequisite for medical intervention is the patient's informed consent; the patient has the right to refuse his or her life-sustaining treatment (Fadıloglu, 2012). However, there are provisions for euthanasia and passive euthanasia and Article 13 of the TPC states that euthanasia is prohibited (Yuksek Saglik Surası, 1970).

In the Patient Rights Regulations, consisting of nine sections and 51 items and prepared based on Basic Law on Health Services No. 3359 dated 5/15/1987, Updated in May 2014, and the eighth and 40th articles of Decree-Law No. 663 dated 10/11/2011 on the Organization and Duties of the Ministry of Health and its Affiliates;

"Article 13- Euthanasia is forbidden. Regardless of medical requirements or whatever the circumstances, life can not be waived. No one's life can be discontinued even if he or someone else's request is made."

"Article 14- The healthcare professional demonstrates the medical care required by the condition of the patient. Even if it is not possible to save the patient's life or protect his or her health, it is imperative to try to reduce or relieve suffering."

However, even if the exact equivalent of the DNR order is not included in the TPC, in the same regulation;

"Article 24- The consent of the patient is required for the medical interventions."

"Article 25- Apart from the cases that are legally obligatory and when the responsibility of the negative consequences that may arise belong to the patient; the patient has the right to refuse or to stop the treatment that is planned or being applied to him / her" (Mevzuati Gelistirme ve Yayin Genel Mudurlugu, 1998).

Conclusion

It is anticipated that CPR, which is known to be widely applied all over the world, will need to be implemented more and more with the changing population structure. This will raise questions more frequently about the conditions under which CPR should be applied. In this regard, health care team, patients, patients' relatives and patients' surrogates have important responsibilities. This decision brings as much difficult and heavy responsibilities as it is important. Because it can create dilemmas for health professionals in terms of ethical and moral values as well as legal responsibilities. Again, high-probability situations such as impairment of cognitive functioning and lack of mental competence to give these instructions in the elderly stand out against the health care team as a background to other problems. There are guidelines and recommendations that have been prepared by health associations such as AMA, AHA and ANA for DNR decision to minimize all these difficulties and to overcome the controversy. Health professionals should use frequently these guidelines and recommendations when preparing DNR instructions the instruction system should be structured to determine the advanced directives that elder people can give the DNR instructions first. In order to make this decision, patient autonomy, values and individual priorities should be taken into account and patients should be actively involved in this decision. "Hospital Ethics Committees" should be established to consult especially for elderly patients for surrogates if the patient does not have the ability to make decisions, for health care team in order to consult other colleagues if the patient does not have surrogate. At the same time, these initiatives mentioned should be addressed by health professionals and lawyers in a multi-faceted way by taking into account their own values of the society and ethical principles should be set forth. These principles should be supported by legal regulations and should lead to practices in health institutions.

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References

Akpinar A, Ersoy N. Life-sustaining treatment: when should it be withheld or withdrawn? Turkish Journal of Oncology 2012; 27(1):37-45.

American Heart Association requests that this document be cited as follows: Neumar RW, Shuster M, Callaway CW, Gent LM, Atkins DL, Bhanji F, Brooks SC, et all. Part 1: executive summary: 2015 American Heart Association Guidelines Update for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care. Circulation 2015; 132(2):315-367.

American Medical Association (2016). Do-Not-Resuscitate Orders. Accessed June 20, 2016, at http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion222.page

American Nurses Association (2012). Nursing Care and Do Not Resuscitate (DNR) and Allow Natural Death (AND) Decisions. Ascessed February 21, 2016, at http://www.nursingworld.org/MainMenuCategories/EthicsStandards/ Ethics-Position-Statements/Nursing-Care-and-Do-Not-Resuscitate-DNR-and-Allow-Natural-Death-Decisions.pdf

Association of PeriOperative Nurses (2010). AORN position statement on perioperative care of patients with do-not-resuscitate or allow-natural-death orders. Accessed 12 February, 2016, at http://www.aorn.org/PracticeResources/AORNPositionStatements/

Cherniac EP. Increasing use of DNR orders in the elderly worldwide: whose choice is it? J Med Ethics 2002; 28:303-307.

Chevaux F, Gagliano M, Waeber G, Marques-Vidal P, Schwab M. Patients' characteristics associated with the decision of "do not attempt cardiopulmonary resuscitation" order in a Swiss hospital. Eur J Intern Med 2015; 26(5):311-316.

Cicekci F, Atici SS. The evaluation of the results of cardiopulmoner resusitation associated with code-blue. Genel Tıp Dergisi 2013; 23(3):70-76.

Fadiloglu C. Advance directive in geriatrics. Ege Journal of Medicine 2014; 53(10):48-52.

Gonenc I. Hukuki ve etik acıdan resusitasyon. Saglık Dusuncesi ve Tıp Kulturu Dergisi 2015; 36:50-51.

International Council of Nurses ICN (2012). Code of Ethics for Nurses. Accessed Mach 18, 2016. Available From:http://www.icn.ch/who-we-are/code-of-ethics-for-nurses/

Karadakovan A. Elderly Problems and Policies. In: Elderly Health and Care, Akademisyen. 1rd ed. Ankara: Tip Publishing; 2014. p.88.

Karatas M, Selcuk EB. History of the Cardiopulmonary Resuscitation. Kafkas J Med Sci 2012; 2(2):84-87.

Kellum JA, Dacey MJ (2009). Ethics in the intensive care unit: Informed consent; withholding and withdrawal of life support; and requests for futile therapies. Acessed May 10, 2016, at http://www.uptodate.com/contents/ethics-in-the-intensive-care-unit-informed-consentwithholding-and-withdrawal-of-life-support-and-requests-for-futile-therapies.

Kozaci N, Ay MO, Icme F, Akturk A, Satar S. Are We Successful in Cardiopulmonary Resuscitation? Cukurova Med J 2013; 38(4):601-609.

Messinger-Rapport BJ, Kamel HK. Predictors of do not resuscitate orders in the nursing home. J Am Med Dir Assoc 2005; 6:18-21.

General Directorate of Legislation Development and Publication (1998). Patient Rights Management. Accessed June 20, 2016. Available From: at http://www.mevzuat.gov.tr/Metin.Aspx?MevzuatKod=7.5.4847&MevzuatIliski=0&sourceXmlSearch=hasta%20haklar%C4%B1.

Phillips JL, Halcomb EJ, Davidson PM. End-of-life care pathways in acute and hospice care: an integrative review. J Pain Symptom Manag 2011; 41(5):940-955.

Seder DB, Patel N, McPherson J, McMullan P, Kern KB, Unger B, Dziodzio J et al. Geriatric experience following cardiac arrest at six interventional cardiology centers in the United States 2006–2011: interplay of age, do-not-resuscitate order, and outcomes. Crit Care Med 2014; 42(2):289-295.

Sert H, Gozdemir M, Isik B. Is It Ethich That Do Not Cardiopulmonary Resuscitation? Journal of Yeni Tip 2007; 24(2):85-9.

Sumrall WD, Mahanna E, Sabharwal V, Marshall T. Do Not Resuscitate, Anesthesia, and Perioperative Care: A Not So Clear Order. The Ochsner Journal 2016; 16(2): 176-179.

Tel H. Ethical Problems Frequently Encountered in the Intensive Care Units. Cumhuriyet Nurs J 2012; 1:30-38.

van de Glind EM, van Munster BC, van de Wetering FT, van Delden JJ, Scholten RJ, Hooft L. Pre-arrest predictors of survival after resuscitation from out-of-hospital cardiac arrest in the elderly a systematic review. BMC Geriatrics 2013; 13(1):1.

Yang GM, Kwee AK, Krishna L. Should patients and family be involved in" Do not resuscitate" decisions? Views of oncology and palliative care doctors and nurses. Indian Journal of Palliative Care 2012; 18(1):52.

Yokusoglu M, Eryilmaz M, Baysan O. Cardiopulmonary resuscitation in the view of ethics and law. Anatol J Cardiol 2008; 8(5):374.

Yuksek Saglık Surası 25.2.1970/ 6324, Yargıtay 4. Ceza Dairesi 28.2.1970, 28.2.1945/1394.6. 1970.