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ORIGINAL ARTICLE

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Palestinian community perceptions of do-not-resuscitation order for terminally Ill patients: A qualitative study

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Aim and objectives: To illustrate the Palestinian community's views, opinions and stances about the concept of do-not-resuscitate for terminally ill patients.

Background: Do-not-resuscitate orders are practised in many countries worldwide, but there is no consensus on their practice in the Middle East. Do-not-resuscitate orders may be applied for terminally ill paediatric patients. Some studies have been conducted describing people's experiences with these do-not-resuscitate orders. However, few studies have considered community perspectives on do-not-resuscitate orders for terminally ill patients in Palestine.

Design: A descriptive-qualitative design was adopted.

Methods: A purposive sample of 24 participants was interviewed, with consideration of demographical characteristics such as age, gender, education and place of residency. The participants were recruited over a period of 6 months. Individual semistructured interviews were utilised. These interviews were transcribed and analysed using thematic analysis.

Findings: Significantly, the majority of the participants did not know the meaning of do-not-resuscitate and thought that removal of life-sustaining devices and do-not-resuscitate were the same concept. Most of the interviewees adopted stances against do-not-resuscitate orders. Several factors were suggested to influence the decision of accepting or rejecting the do-not-resuscitate order. The majority of the participants mentioned religion as a major factor in forming their viewpoints. The participants expressed different views regarding issuing a law regarding do-not-resuscitate orders.

Conclusion: Our findings provide a unique understanding that there is a general misunderstanding among our participants regarding the do-not-resuscitate order. Further research with policymakers and stakeholders is still required.

KEYWORDS

accepting DNR, cardiopulmonary resuscitation, do-not-resuscitate, ethical issues, Palestine, qualitative, refusing DNR

1 | INTRODUCTION

Over recent decades, methods and procedures to improve health care and reduce mortality among patients in hospitals have multiplied (Bunker, 2001). One of these improvements is cardiopulmonary resuscitation (CPR), developed in 1960 (American Heart Association [AHA], 2014). CPR was defined as "integrated chest compressions and rescue breathing with the goal of optimising circulation and oxygenation" (Travers et al., 2010, p. 677). Along with the evolution of cardiopulmonary resuscitation, ethical questions arose

about the dignified aspects of this possibly life-saving procedure, especially for patients with terminal illnesses (Rakas, 2008).

According to Ditillo (2002), CPR guidelines indicate that CPR can avoid sudden death. In 1974, the AHA recognised that many patients who received CPR survived with considerable morbidities, and recommended that physicians should document when CPR is not indicated after obtaining patient or surrogate consent (Venneman, Narnor-Harris, Perish, & Hamilton, 2008), causing the development of do-not-resuscitate (DNR) orders, first legalised in the mid-1970s (Santonocito, Ristagno, Gullo, & Weil, 2013).

Do-not-resuscitate orders are practised in many countries worldwide, but there is no consensual practice in the Middle East (Santonocito et al., 2013). Moreover, there is no explicit policy for DNR in the Palestinian hospitals.

Along with the widespread practice of DNR in other countries, DNR orders may be applied to terminally ill patients (Meert, Thurston, & Sarnaik, 2000). Some studies have been conducted describing the families' experiences with these DNR orders (Hileli, Weyl Ben Arush, Hakim, & Postovsky, 2014; Meert et al., 2000). However, few studies have considered community perspectives on DNR orders for terminally ill patients in Palestine (Hileli et al., 2014). This study aims to illustrate the Palestinian community's views, opinions and stances about the concept of DNR for terminally ill patients. The word community refers to group of individuals, who live in a particular area, and share the same beliefs and interests (McCreddin, Nancarrow, & Syme, 1995). In this study, the focus was on lay people who are not healthcare providers.

What does this paper contribute to the wider global clinical community?

- This study contributes to clarifying the perspectives of the Palestinian community regarding do-not-resuscitate. This may aid in facilitating communication between the health staff and patients' families about end-of-life care decisions and add to the growing literature regarding do-not-resuscitate orders in developing countries.

2 | BACKGROUND

A DNR is "written order by an attending physician that precludes resuscitative efforts being undertaken in the event of cardiopulmonary arrest" (Fallat & Deshpande, 2004). DNR only refers to declining to undertake CPR when otherwise warranted. However, other symptom control or comfort measures should be offered or continued to enhance quality of dying (Chan, 2015).

This study focused on the DNR order for terminally ill patients. Terminally ill concept was defined differently in the literature (Hui et al., 2014). For the purpose of this study, it was defined as any patients that have advance, incurable illness that is expected to lead to death within reasonably short period of time, usually six months, regardless of the medical treatment that they receive (Hui et al., 2014), and this definition was explained to the participants.

The majority of DNR orders are authorised by surrogates, not patients themselves (Hanson, Danis, Mutran, & Keenan, 1994; Sulmasy, Dwyer, & Marx, 1996). Performing CPR for terminally ill patients would help family members to know that everything possible was done for their loved one (Bashayreh, Saifan, Batiha, Timmons, & Nairn, 2015). Nevertheless, some researcher viewed CPR as an aggressive intervention and harmful life-saving process in dealing with terminally ill patients (Ong, Chan, Srither, & Lim, 2004). Moreover, witnessing a failed CPR attempt of a loved one may be associated with displaying symptoms of post-traumatic stress disorder in the early bereavement period (Compton, Grace, Madgy, & Swor, 2009).

A study conducted in New York explored the experiences of surrogates who made a DNR order (Handy, Sulmasy, Merkel, & Ury, 2008). The DNR order signing process caused negative emotions for the surrogates, and that prior discussion with the patient or family aided in this decision. It was reported that past experiences with the DNR order decision-making processes further impacted their decisions and experiences.

Another study conducted by researchers at the Royal Hospital in Oman showed that religious, social and cultural issues played more vital role in the DNR decision-making process than economic considerations, including the cost of keeping patients in hospital and on life-supporting machines (Da Costa, Ghazal, & Al Khusaiby, 2002). This study is particularly important as it is one of few studies that highlighted the perceptions of the participants around DNR order in a Muslims community. This community has many similar characteristics with the Palestinian community.

The influence of religion and cultural issues on DNR decisions in Muslims countries occasionally appears in the literature (Ahmed et al., 2015). In the religion of Islam, there is a fundamental belief that "Whomever takes a human life, for other than murder or corruption in the earth, it is as if he has taken the life of all mankind" (Quran 5: 32). Al-Hassan and Hweidi (2004) explained that Muslims believe that illness and wellness is God's will, and their faith is in God only.

In making a DNR decision with a patient, there must be an adequate understanding of the patients' perceptions of the DNR order (Jellinek, Catlin, Todres, & Cassem, 1992). Until the 1960s, it was widely accepted that a fatal diagnosis should not be discussed with the patient; however, over time, this communication has progressed (Lucchiari, Masiero, Pravettoni, Vago, & Wears, 2010). Effective communication should include several meetings between physicians and family members (Handy et al., 2008). These meetings should consider the clinical and psychological concerns that family members may face (Yuen, Reid, & Fetters, 2011).

In Palestine, no study had previously covered the community perception around the concept of DNR among terminally ill patients, which is an important element in the communication about it in the hospitals. Therefore, this study aims to cover this gap.

3 | METHODS

3.1 | Design

A descriptive-qualitative design was adopted to illustrate the community's views, opinions and stances about the concept of DNR for terminally ill patients.

3.2 | Study sample and setting

This study was conducted in the district of Ramallah within the Palestinian territory. The sample was purposefully selected considering their demographical characteristics and socio-economic status. The eligible participants in this study were people residing in Ramallah district, aged over 25. Moreover, 50 invitation letters were randomly distributed in the district of Ramallah, and 30 responses were received immediately after distribution.

Finally, 24 participants were selected with respect to age, gender, education, economic status and place of residency. The number of participants was determined based on data saturation; this means that the enrolment stopped when no new themes were emerging.

3.3 | Data collection

Individual semistructured interviews were used to collect data. All the interviews were conducted in the participants' homes, and the participants were not compensated for their participation.

The interview questions were prepared based on critical literature review. The flexible characteristics of the qualitative approach helped in adding more questions to the interviews themselves. Initially, the interviews started with only six open-ended questions. Jacob and Furgerson (2012) argued that in keeping with the flexible nature of qualitative research design, interview guides can be modified over time to focus on areas of importance. During the data collection process, four more questions were added for a total of 10 questions (see Table 1).

All the participants were informed about all ethical issues and interview guidelines and gave written consent. The interviews each lasted 30–45 minutes. The data were recorded on audiotape, and notes were taken throughout the interview.

3.4 | Ethical considerations

Approval for the study was obtained from the Institutional Review Board (IRB) committee from Birzeit University. All participants signed an informed consent to understand the aim of the study and their ethical rights, and that their anonymity would be guaranteed. All the participants were informed that they had the right to withdraw from the study at any time.

3.5 | Data analysis

The data from all of the interviews were transcribed verbatim by the principle authors. The records were transcribed twice to ensure the accuracy of the transcription. The analysing, interpreting and evaluating processes were performed for each interview individually and simultaneously. Braun and Clarke's (2006) inductive technique of thematic analysis was utilised to analyse our data. The analysis started during the transcription as the initial thoughts and first impression about the data were noted down, which can be considered as the first order of analysis. Then, the derived data were further interpreted and put it in to code and potential themes. These themes were reviewed and double-coded by another researcher, and they were judged depending on the internal homogeneity and the external heterogeneity (Patton, 2002), which can be considered as the second order of analysis.

After these two orders of analysis, the code and themes were finally refined and named. Then, the derived themes were critically evaluated by addressing what they mean, and how they can be conceptualised in order to achieve the study objectives. Considerations were made not only of the story told within individual themes but how these related to the overall story that was evident within the derived data. Finally, the themes and subthemes were summarised and presented in table (2) to show the main perceptions of the participants.

Numerous strategies were used to maximise the rigour of the study. This includes the use of reflections and field notes that contain the whole interview context and clarify the data collection process (Black, Brazier, Fitzpayrick, & Reeves, 2000; Thorne, 2000). In addition, double coding has been used to overcome the subjectivity issue within the qualitative analysis, as it enabled another person with different perceptions and backgrounds to review the data (Barbour, 2001; Broussard, 2006; Thomas, 2006). Two researcher (each independently) coded the data. Nevertheless, the results of the double coding showed that there was a consensus on most of the themes and codes (Bazeley, 2009; Black, Brazier, Reeves, & Fitzpatrick, 1998; Murphy, Dingwall, Greatbatch, Parker, & Watson, 1998).

TABLE 1 The interview schedule

Interview schedule
1. What is your definition of the do-not-resuscitate (DNR) order?
2. Explain to me the difference between DNR and removal of life-sustaining treatments on terminally ill patients.
3. What is your perception about DNR order for terminally ill patients?
4. Do you believe that DNR for terminally ill patients is acceptable or unacceptable? Why?
5. What are the factors that may be involved in your point of view?
6. Who are the healthcare workers who in your point of view should be involved in the decision-making process? Why?
7. If the government was legislating about DNR orders for terminally ill patients, what factors do you believe should be considered in this decision?
8. Why do you believe that these factors should be considered?
9. Please explain these factors are involved in your perception. Does the age of the terminally ill patient play a role in your opinion?
10. Do you think that involvement of health team in decision-making process can affect your opinion?

3.6 | Reflexivity

The researchers should explain how their experiences and *a priori* assumptions have shaped the data analysis (Hammersley & Atkinson, 1995). Bonner and Tolhurst (2002) pointed out that familiarity with the research setting and participants makes the researcher sensitive to the researched. However, the researcher may be biased in understanding the respondents' accounts or may make assumptions in the research (Gerrish, 1997). To avoid bias, the authors used the Husserlian principle of "bracketing" (Parahoo, 2006). Considering the "bracketing technique" in our study, we acknowledged our previous understanding of implementing DNR for terminally ill patients and its influence on the treatment process, and we tried to put this knowledge and experience aside. We then kept our mind open to any new meanings or interpretations from the study participants (Todres & Holloway, 2010).

Nevertheless, the researchers that conduct this study were not completely with or against implementing DNR order, as they were aware of the complexity of the issue in the Palestinian community through their previous experience as nurses in intensive care units and their interactions with the patients and their families.

4 | FINDINGS

The data that emerged from the participants were organised and contextualised to explain the perceptions of the Palestinian population about DNR orders. This is described under five main themes, organised according to the respondents' views (see Table 2).

Twenty-four participants were finally interviewed in the current study. The characteristics of these participants can be seen in Table 3.

4.1 | The meaning of DNR orders

The interviewees identified different meanings for this concept. Significantly, the majority of the participants did not actually know the meaning of DNR and thought that removal of life-sustaining devices and DNR were the same concept.

> *"I believe that there is no difference between DNR and removal of life-sustaining treatments."* [P1]

Other participants completely misunderstood the concept of DNR. They assumed that the DNR order is what causes cardiac arrest and leads to immediate death.

> *"Maybe after a while, the person will live and wake up from the coma. DNR sends them to the death stage and the heart will stop."* [P3]

On the other side, a few participants understood the concepts of DNR and the removal of life-sustaining devices.

> *"In DNR, the patient is taking medications but in a certain moment the heart stops working and he/she needs to be resuscitated by chest compressions and shocks, and it's not given to him/her."* [P9]

The majority of the participants hesitated when they were asked this question, possibly because this topic is not well known or spoken about in Palestine.

TABLE 2 The main themes

No.	Main themes	Sub-themes
1.	Meaning of DNR order	a. Misunderstand the concept of DNR
		b. Understand the concept of DNR
2.	Perceptions of DNR order	a. Against the DNR order
		b. Conditional acceptance of DNR order
3.	Factors that affect the DNR decision-making	a. Islamic religion
		b. Age
		c. Emotions and relation to the patient
		d. Quality of life
		e. Economic status
		f. Health status
		g. Culture in Palestine
4.	Involvement of health team in decision-making process	a. Doctors have the biggest role
		b. Nurses have a role
		c. Lack of information among the Patient's family
5.	Legalising the DNR orders in Palestine	a. Religion consideration
		b. Flexible regulation
		c. Health professional protection

TABLE 3 The demographic characteristics of the participants

Demographic characteristics	Category	Number of participants
Gender	Male	11
	Female	13
Age	Range (Mean)	25–62 (40.6)
Marital status	Married	24
	Divorced	0
	Widowed	0
	Single	0
Place of resident	Urban	8
	Rural	8
	Refugee camps	8
Level of education	Primary school education	4
	High secondary school education	10
	Diploma	2
	Bachelor degree or higher	8
Number of children	1	4
	2	5
	3 or more	15

Total number: 24.

4.2 | Perceptions of the DNR order

After the participants were asked about their definition of DNR, the researcher did verbally explain the meaning of DNR to them. The same DNR definition of Fallat and Deshpande (2004) was introduced to all participants to eliminate any potential bias. Most of the interviewees adopted stances against the DNR order. The majority of the participants bluntly stated their opinions and explained the factors that played a role in their perceptions. Some of them explained that no one has the right to end any patient's life. They thought that patients' health could be improved at any time, and DNR may deprive patients of this opportunity.

> *"I am against the DNR and view it as unacceptable, because no matter what the case was, he/she should be resuscitated because there might be improvement in the patient's health status."* [P7]

It was noticed that all the interviewees expressed the difficulty of describing their perceptions of DNR. This was not surprising, as making a decision regarding DNR is a critical and sensitive step (Hayes, 2013). Although the majority of the interviewees were against DNR, a few of them stated that they would accept taking this decision. However, this acceptance was dependent on certain factors such as absence of any chance of patients living. One of the interviewees was more specific, saying that she would accept the DNR order if the patient received several life-saving procedures and all of these failed.

> *"In my opinion, if the patient needs resuscitation and his heart muscle is strong… in this situation I think that DNR is murder. If the patient was given medicine and CPR was done more than once and the heart stopped and was tired, that is something else."* [P9]

4.3 | Factors that affect DNR decision-making

The majority of the participants mentioned religion as a major factor in forming their viewpoints, specifically in orienting them against DNR. They explained that DNR is forbidden in Islam and was thought to be a failure to provide the best level of care for patients from a religious point of view.

> *"Our religion says to do all that can be done, even if the patient is hopeless."* [P3]

Other participants mentioned that the duration of life is in God's hands. These participants thought that the DNR decision is not one a healthcare provider should make.

> *"In religion, it says 'Do not kill the soul'. I, personally, think that the patient should be left until the last minute, until God says he should die."* [P6]

However, a few participants did not indicate any role for religion to decide whether to accept or refuse the DNR order, stating that this is a human decision that should not depend on religion.

> *"It's not religion that has the biggest role in my opinion. I look more at the human aspect."* [P7]

Interestingly, most of the participants mentioned that age did not affect their opinions about DNR. Other factors had greater influence on their opinions such as health status and the relationship to patient. They explained that a soul remains a soul, regardless of age.

> *"I do not like that idea at all, because maybe a patient who is 80 years old can still live to be 100 years old. A soul is a soul, and death is death".* [P10]

Conversely, some participants mentioned that age plays a role in their opinion and that the age of the patient contributes to forming the DNR decision. One of these participants frankly stated that an older person's death might be handled better than that of a younger person.

> *"To me age plays a role for sure, if someone is old they may accept death faster, but if the patient is a child then no".* [P21]

The relationship to the patient was viewed by many as crucial to shaping their views regarding accepting or rejecting the DNR order. Five participants mentioned that their relationship to the patient is the main factor in accepting the DNR order.

> *"My decision depends on my emotional connection to the patient... another important factor is if the person is significant to me." [P1]*

Moreover, most of the participants said that the emotional issue encourages them to oppose the DNR order.

> *"If I have strong relationship with the patient, I refuse to leave him or her die if he or she has a chance to live." [P20]*

Some of the participants explained that quality of life and the economic situations of family members and patients may influence the DNR decision, while others said they would not be swayed by such considerations, and CPR should be done for each patient regardless of their quality of life or economic status. On the other hand, some participants said that poor quality of life and poverty might play a role in accepting the DNR order.

> *"The person should not deny resuscitation, even if the economic status was very bad." [P23]*

> *"The patient's family does not want to sit in the hospital for months and pay very high hospital fees and be in debt, and in the end the patient dies." [P18]*

Only four participants throughout all the interviews mentioned that culture influenced opinions regarding DNR, but they did not think that it was a crucial factor in making the DNR decision. One of them expressed that:

> *"Sometimes the culture is different from city to village. The culture usually affects people's decisions. However, in this matter, I do not think that culture plays any role." [P2]*

In summary, the participants suggested several factors influencing their perceptions of DNR. Religion and the relationship to the patient were the most important factors. Other factors may have less effect, such as patients' age, economic status and culture.

4.4 | Involvement of health team in decision-making process

The role of healthcare providers in making DNR decisions was considered important by the majority of the participants, but with different points of view regarding the responsibilities of these providers. The majority of the participants suggested that the physician plays the biggest role in decision-making. These participants believed that physicians have the medical experience to make this decision, usually knowing their patients and family members.

> *"I think only the physician is specialized for the patient. People in general do not take the opinion of nurses, they usually ask physicians." [P13]*

A few participants believed that the physician should give all information to patients' families and help them in the decision-making process. However, one of the participants said that the family should not have any role:

> *"The family has no right to choose yes or no... The one who can determine this issue is the specialist physician." [P5]*

A minority of participants believed that physicians and nurses are equal in their roles in the decision-making process, and both opinions are relevant because physicians and nurses have important roles in the treatment process. Physicians plan the treatment process, while nurses observe the patient's situation continuously and spend the most time with patients.

> *Yes, nurses could have a role and may affect decision making... nurses also follow the patient's situation." [P15]*

The roles of healthcare providers originated from the idea that family members could not decide whether to do CPR or to make the DNR decision. Some of the participants talked about the educational level of families in the decision-making process, saying that many family members are unable to decide on the best option.

> *"Does the family of the patient have enough knowledge and awareness to fully understand the concept and what's going on? I do not think that they have this knowledge. This plays a huge role." [P16]*

Significantly, the participants who adopted this view supposed that Palestinian families' levels of knowledge and education do not enable them to understand the nature of their patients' health condition. Therefore, physicians should not include family members in the decision-making process.

4.5 | Legalising DNR orders in Palestine

Whether the participants supported the DNR order or opposed it, they were asked about their preferences regarding legalising this order. The participants expressed different views regarding

legislating DNR orders in the Palestinian government. Some of the participants opposed this idea on religious grounds, saying that in Islam the end of life is in God's hands, all people die according to their destiny, and a law is therefore unnecessary.

> *"I'm not with the legalizing this decision because when the human life ends, it ends with devices or without devices... it is according to their destiny."* [P4]

In contrast, around one-third of the participants agreed that a law should be made about DNR, and said that religion must take priority within the legislation of DNR processes. Also, these participants added that many factors must be included before the legislation, such as the age of patients and their social context.

> *"There should be a law about DNR in Palestine. They should consider the case specifically and the age. Religion plays a role because Muslims may view it as murder."* [P22]

Some participants believed that the DNR orders law should be considered for each case separately. This means that they suggest developing a law that can be modified to be applicable to all potential patients' scenarios, whereby in some cases religion might not be an important factor.

Do-not-resuscitate orders are a sensitive issue whose outcome should be considered in advance. Therefore, some of the participants stressed protecting physicians and healthcare providers in issuing such laws. In case of not legalising this practice, physicians and nurses may be blamed for the patient's death. With a law, the healthcare professionals' rights will be protected and the family will have full responsibility.

> *"Of course, families should take the responsibility of this decision. If the health team decide something, and then something bad happens, they will blame physicians and nurses. So, there should be an official agreement that makes the family responsible about these things."* [P24]

5 | DISCUSSION

This is the first study conducted in Palestine examining the community's perceptions regarding DNR orders for terminally ill patients. The present study is one of the rare studies that adopt a qualitative design in this field. No Middle Eastern countries have a policy regarding DNR orders for terminally ill patients (Santonocito et al., 2013). Therefore, this study sheds some light on the possibility of implementing this practice outside the Western countries. More importantly, our study explores the importance of considering cultural and religious differences when implementing DNR orders in a new arena.

Most of the participants did not understand the meaning of DNR and the difference between DNR and removal of life-sustaining devices. This finding was expected because there is no Palestinian policy regarding DNR orders (Bolstad & Viken, 2012). The rare participants who understood the meaning of DNR knew about it from their personal life experiences.

All participants were Muslims, and they mentioned religion as a key factor in their perceptions about DNR. This finding contradicts a study conducted in Haifa by Hileli et al. (2014), which aimed to determine the influence of religious and socio-economic backgrounds on parental DNR decisions. This study suggested that religion does not affect the DNR decision-making process. There are some religious similarities between the monotheistic faiths of Muslims, Christians and Jews. In all three religions, God is the origin of life, and all of them believe in the hereafter. Muslims and Christians alike believe that illness and wellness is God's will, and their faith is within God's hands only (Ismail, Hatthakit, & Chinawong, 2015; Opoku & Addai-Mensah, 2014). In Islam, it is not allowed to end life (Sachedina, 2005). Death will be acceptable after making every effort to save a patient's life. This makes DNR problematic for most Muslims.

Interestingly, the findings of the current study were consistent with those of a study conducted in Oman, which examined the need for a DNR decision-making process in a tertiary referral centre for terminally ill neonatal patients (Da Costa et al., 2002). It suggested that religious and cultural issues often play a more vital role in decision-making than economic considerations, especially in Arab nations (Da Costa et al., 2002). In this study, more participants mentioned social and cultural factors than economic and financial factors. This could be related to the fact the majority of the families (approximately 80%) in the Palestinian community rely of governmental health insurance (Giacaman et al., 2009). Therefore, they were less worried about the cost of CPR and hospital stay. This is not the case in many other countries such as United States (Ridic, Gleason, & Ridic, 2012).

The consistency between the findings of the current study and the results of the Oman study may be due to the shared major religion, although the predominant Ibadi sect of Oman and the mainstream Sunni sect in Palestine differ in many ways. Additionally, it is important to notice that there might be a difference between the parents' perceptions towards conducting DNR order to their terminally ill children, and conducting it to other adult or elderly family members (Balboni et al., 2013).

The majority of the participants who were against the DNR order refused this practice because they have faith and hope that the patient's status might improve. This was also consistent with the findings in the Oman study (Da Costa et al., 2002). The participants in the current study and the participants in Oman believed that no one could decide when a life ended and that the existence of God renders no case hopeless (Da Costa et al., 2002). This finding further emphasised our finding that religion plays a big role in the majority of healthcare workers being against DNR.

Another interesting factor that influenced many participants' views was the relationship to the patient. Most of the participants

indicated that the strength of the relationship between family members and their patients would have an effect on their decision regarding the DNR order. This means that the very close relationships with patients would disincline them from accepting a DNR decision or signing DNR order. These findings are in agreement with the findings of another US study (Blackhall et al., 1999) and another with women in Saudi Arabia with their children (Jan, 2011); both found that women who cared for sick relatives firsthand were more likely to be against the DNR order. These women strongly rejected the DNR order in favour of aggressive life-sustaining treatments.

The majority of the participants believed that the healthcare staff should have a positive role in the decision-making process. This prevailing belief among participants is consistent with multiple studies. In a study conducted to analyse the use of certain questions in communication with grieving parents about DNR for their child, it was discovered that these communication techniques from the health staff influenced parents' decisions and well-being during this process (Jellinek et al., 1992). An additional study conducted in New York also discovered that communication with healthcare personnel had a positive impact on the surrogates' experience (Handy et al., 2008). These studies support our findings.

Therefore, this study suggests the need to train the health professionals on communicating with the terminally ill patients and their family members around DNR decision, and encourage the heath team to conduct this professional communication regularly with them.

There were some participants who suggested that most Palestinian people have no knowledge about DNR issues, and they explained the difficulty of discussing DNR issues with lay people. They said that if the family is not aware of this concept, they will react poorly and things will become more difficult. Braham (1997) and Jan (2011) stated that medical professionals are much more paternalistic and powerful in developing countries. Davidson et al. (2007) explained that the paternalistic model gives more authority to healthcare professionals to decide what is better for patients; clearly, this high power distance approach is entrenched in Arab countries (Bashayreh et al., 2015); therefore, Palestinians may think that healthcare professionals know what is best for them. This might explain the attitudes of some participants in the current study, who suggested that family members are not competent to take part in DNR decisions.

There is no policy for DNR in the Palestinian hospitals. Nevertheless, the DNR requests are sometimes made for some patients. Although these requests are not formal or written, they are arranged between healthcare professionals and family members. Such practice places the health professionals under stress as they are not legally protected. Lack of clear polices about DNR in the Palestinian legislation and the rationale behind this should be investigated by other studies that target the policymakers and the health professionals' managers.

Our study found that one prevailing factor that should be considered whilst making this law was religion. Some researchers admitted the role of culture and religion in shaping individuals' attitudes during critical situations (Badir & Sepit, 2007; Demir, 2008; Fulbrook, Albarran, & Latour, 2005). This may explain the importance of considering religion in any law about DNR. However, some participants underestimated the role of religion in legalising the DNR order. Luna (2002) showed that Muslims, like people from other religions, vary in their degree of commitment. This may explain the difference in views between Palestinian people regarding the effect of religion on legalising DNR orders.

It is important to note that his study investigated the general public opinion regarding implementing DNR order. Usually individuals might have different views about complex and emotionally healthcare issues when presented with a hypothetical situation, compared to a real situation about either themselves or one of their family members. This can be one of the limitations of this study.

6 | CONCLUSION

The findings suggest that most lay people in this study did not know the meaning of the DNR concept. The results also showed that the perceptions of DNR were affected by a number of factors, mainly religion, relation to patients and culture. Differing ideas and opinions emerged regarding whom among the health staff and patient families should participate in the decision-making process, and about passing legislation regarding DNR in Palestine.

7 | RELEVANCE TO PRACTICE

This study contributes to clarifying the perspectives, feelings and opinions of the Palestinian community regarding DNR orders. This may facilitate communication between health staff and patients' families about DNR decisions and add to the growing literature regarding DNR orders in developing countries. Also, it illuminates the understanding of the DNR concept in the Palestinian community.

Major endeavours should be made in hospitals and healthcare settings to improve community awareness about DNR order, as the majority of the participants did not understand the meaning of this concept. Doctors and nurses caring for terminally ill patients should be obliged to discuss end-of-life decisions such as DNR order with the patients and their family clearly and early in the disease process.

Moreover, health professionals should have effective education regarding the topic of DNR order and the international policies around it. Additionally, this study suggests the need to train health professionals in Palestine around the best strategies to communicate with the patient and their family about the DNR order.This study could participate as a foundation for further quantitative studies around the DNR practices in the Palestinian hospitals. We recommend that the application of DNR order is researched more thoroughly from different aspects. A more diverse sample, wider population area and investigating other relevant factors could perhaps be thought to further improve our understanding around this topic.

In Palestine, as in many countries, hospital policy should be legally supported. This suggests the need for developing a central governmental policy for DNR order that addresses the religious and cultural concerns of the community.

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CONTRIBUTIONS

Study design: IA; data collection and analysis: RA, AB and manuscript preparation: AS.

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