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The Criminal Responsibility of the Doctor for the (DNR) Order in UAE Legislation

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Abstract

Numerous times, TV medical dramas show a patient in cardiac arrest getting cardiopulmonary resuscitation (CPR), coming back to life, and being back to their old self in no time. In fact, being resuscitated is not so simple and can be dangerous in its own right. Given that, in many cases, the risks of pain and harm from CPR outweigh the benefits, it comes as no surprise that a growing number of people issue a do-not-resuscitate (DNR) order as part of their advance care plan to prevent CPR attempts on them should their heart or breathing stop. This legal document illustrates their aversion to euthanasia. For many, the idea of being kept alive via artificial means, such as life support, is more appalling than death itself. This study focuses on the concept of dying and the legal repercussions of a medical doctor (MD)'s refusal to perform CPR without the patient's consent, thus, allowing, the patient's natural death to occur. What ought the MDs do and ask in a situation like this so as to avoid criminal responsibility? The result of this study is that deciding about DNR orders is a difficult process that can be affected by various factors. However, few legislations have codified the criminal responsibility of the doctor, as the UAE legislator did in Federal Decree-Law No. (4) of 2016 regarding Medical Liability.

Keywords: Doctor, DNR Order, CPR, Legal and Criminal Responsibility, euthanasia

Introduction

In the make-believe world of movies and television, CPR (cardiopulmonary resuscitation) is virtually a panacea. Thus, we tend to overestimate CPR's success rate. Admittedly, it can double or triple the chance of survival, but only 10% to 20% of people actually survive after cardiac arrest outside the hospital. This figure is even lower for people with several chronic health conditions and terminal illnesses, like advanced cancer. Even if a person is brought back to life after CPR, it is highly unlikely that they will escape unscathed. CPR may have severe long-term side effects such as brain or heart damage, lung injury, internal bleeding, and broken ribs. Numerous times, a patient in cardiac arrest is getting cardiopulmonary

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resuscitation (CPR), coming back to life, and being back to their old self in no time. In fact, being resuscitated is not so simple and can be dangerous in its own right (Angela M, 2023). When a person has a cardiac or respiratory arrest, CPR can be used in an attempt to restart their heart and breathing and restore their circulation. CPR is invasive, involving chest compressions, the delivery of electric shocks from a defibrillator, the injection of drugs, and ventilation of the lungs. In some circumstances, if delivered promptly, CPR has a reasonable success rate. Generally, however, CPR has a meager success rate, and the risks of CPR include damage to internal organs, rib fractures, and adverse clinical outcomes for the patient, such as hypoxic brain damage or increased physical disability. An incision in the throat or a relaxation of the throat muscles may cause noisy breathing, sometimes called a rattle. Moreover, if CPR is not successful in restarting the heart or breathing and restoring circulation, it may mean that the patient dies in an undignified and traumatic manner. At this point, it is worth highlighting that the final moments of a person's life can have a lasting impact on their family members and friends, so it is not only the patient who is impacted by the decision or not to attempt CPR on a dying patient.

Often, options for end-of-life care involve deciding whether to accept the possibility of dying sooner but in more comfortable conditions or try to prolong their life by receiving intensive treatment that may increase discomfort and dependency. For instance, a person dying of severe lung disease may live longer if they are placed on a mechanical ventilator. However, most people find being on a ventilator very unpleasant and often require intense sedation ((Ferrand, 2001). If a hospitalized patient has not been issued a DNR, then CPR and further resuscitation efforts are automatically performed when the patient suffers cardiopulmonary arrest. Not all patients desire CPR and intubation, however, and such measures might be medically inappropriate and might cause undue harm to the patients as well as their families and caregivers. Nevertheless, physicians are often unaware of their patients' resuscitation preferences due to patients' ignorance of the option of making provisions for their end-of-life care and making informed decisions about what they wish to happen if need be. Considering the absence of pertinent legislation in many countries, the importance of this study is evident. This loophole in criminal law creates a legal area. It also hinders public prosecution and courts from determining whether there is criminal responsibility on the part of the doctor in the event of a patient's death. Nevertheless, what if the doctor refuses to perform CPR on a dying patient in desperate need of drastic intervention? This paper examines all aspects of CPR and resuscitation. It focuses on an MD's legal responsibilities in case they refuse to perform CPR without the patient's consent, resulting in the patient's death. Finally, recommendations are

offered on what MDs should do and ask in a situation like this to avoid criminal responsibility. The research question reflects the changes in people's perceptions concerning death and the need for pertinent, comprehensive legislation that protects both patient's and doctors' rights.

Research Questions of the Study

The study aims to identify MDs' legal responsibilities concerning patients' Do-Not-Resuscitate (DNR) Orders. The aims were realized by virtue of the following questions:

1. What is the definition of a Do-Not-Resuscitate (DNR) order?
2. What is the procedure according to the medical protocol?
3. What is the criterion of death in legal thought?
4. Is there criminal liability if the medical staff refuses to perform cardiopulmonary resuscitation on the patient?
5. What is the position of criminal legislation on the DNR order?

Study Problem

The research problem arose out of the reality of the academic job experience of the current study. It also originates from the latter genuine sense of the importance of "DNR "Order, Hence, the problem of the study arises from the criminal responsibility of the doctor, in the event that he refuses to save the patient's life by performing pulmonary resuscitation in the event of death and allowing him to die naturally.

Research Practical and Social Implications

Not all patients desire CPR and intubation, however, and such measures might be medically inappropriate and might cause undue harm to the patients, families, and caregivers. Yet physicians are often unaware of their patients' resuscitation preferences .The importance of this study comes in light of the absence of the text regulating this issue in most of the legislations which enlightens the path before the Public Prosecution and the Court in determining the criminal responsibility of the doctor in the event of a dying patient.

Theoretical Framework

We often see people survive after CPR on television and in movies. However, we tend to overestimate the success of CPR. It can double or triple the chance of survival, but only 10% to 20% of people survive after cardiac arrest outside the hospital. This number is even lower in people with several chronic health conditions and terminal illnesses, like advanced cancer. Even if a person is brought back to life after CPR, they are not likely to return to their normal state of health. Which causes side effects afterward. So, in many cases, the risk of pain and harm

from CPR is much higher than the benefits. Some people simply don't want to be on life support at the end of their days, so they choose a DNR order to prevent that.

Originality/Value

The value of this study is that it is the first study to be conducted in the UAE. Besides, the examination of the DNR order adds new knowledge to the academicians.

Research Methodology

Research Methodology, this should be properly described and explained. Describe your research approach, research design, source of data collection, data collection method, data analysis procedure, ethical sources, and limitations, etc.

Study Terminology

DNR (Do Not Resuscitate) Order: An order that instructs the medical team to not resuscitate the patient if either the heart stops beating or the individual stops breathing.

No Code: A note written in the patient record and signed by a qualified, usually senior or attending physician instructing the staff of the institution not to attempt to resuscitate a particular patient in the event of cardiac or respiratory failure.

CPR: An emergency procedure used to restart a person's heartbeat and breathing after one or both have stopped. It involves giving strong, rapid pushes to the chest to keep blood moving through the body. Usually, it also involves blowing air into the person's mouth to help with breathing and sending oxygen to the lungs. Also called cardiopulmonary resuscitation.

Code blue: When this is called, there's a patient who needs immediate emergency medical attention. It signals that the code blue team should drop everything and rush to the announced room number.

End-stage disease: A disease that cannot be cured or adequately treated and is expected to result in the death of the patient.

(DPOA) A durable power of attorney is a person you choose to make medical decisions for you if you cannot communicate your wishes. Your medical team will use your living will to guide your medical care, but your DPOA will make decisions about anything not covered in your living will. Note that a DPOA has many other names, including healthcare proxy, healthcare power of attorney, or surrogate (American Academy, 2021).

Literature Review

Cherniack (2002) highlights how studied patient and family attitudes toward DNR orders. There is evidence to suggest that while many elderly favor resuscitation, they die with DNR orders in place. In limited data from other countries, most elderly in the United Kingdom and Israel desired CPR, while those in Ireland did not. The attitudes of patients in a large part of the world are, however, not known. The investigation should be extended to the rest of the world. There are some elderly individuals who are uninformed about the details of the procedure or overestimate its chances of success. Others might decline DNR orders because they have been asked about CPR while in good health without consideration of survival with functional loss or low life expectancy.

Most elderly patients die with an order in place that they not be given cardiopulmonary resuscitation (DNR order). Surveys have shown that many elderly in different parts of the world want to be resuscitated but may lack knowledge about the specifics of cardiopulmonary resuscitation (CPR). Data from countries other than the US is limited, but differences in physician and patient opinions by nationality regarding CPR do exist. Physicians' own preferences for CPR may predominate in the DNR decision-making process for their patients, and many physicians may not want the participation of the elderly or believe that it is necessary. More complete and earlier discussions of a wider range of options for care for patients at the end of life have been advocated. The process ought to include education for patients about the process and efficacy of CPR and for physicians on how to consider the values and levels of knowledge of their patients, whose preferences may differ from their own.

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A survey, Raoofi (2021) was conducted using a systematic review protocol. The statistical population included all the articles on DNR orders among nurses in Iran and around the world. The search strategy was also fulfilled based on a proper combination of Persian and English keywords (i.e, cardiopulmonary resuscitation, CPR, nurses, attitudes, do-not-resuscitate, do-not-resuscitate policy, do-not-resuscitate decision, do-not-resuscitate order, do not attempt resuscitation, do not

attempt resuscitation order, DNR) and the studies and scientific documents were searched according to the features of search engines or databases. To conduct the given search; the databases of ScienceDirect, Web of Science, Cochrane, ProQuest, Scopus, PubMed, SID, Irandoc, Magiran, and Iranmedex were explored with no time limits to find the related articles. Moreover, the search was carried out on Google Scholar and the website of the American Nurses Association (ANA). Furthermore, the references of the selected studies were reviewed to find articles missed in the search process. The search continued articles published without any time limits until September 2018. Using the notification systems of online databases and Google Scholar, the search for articles was updated until October 2018. The inclusion and exclusion criteria in this study were articles related to DNR orders, nurses, and the conclusion of this study, it should be noted that deciding about DNR orders is a difficult process that can be affected by various factors. The results of the studies in this domain indicated that making decisions regarding the implementation of DNR orders should not be based solely on wishes.

of a particular person. In the mentioned studies, most of the nurses stated that nurses, patients, and patients' families were required to play roles in deciding about DNR orders, and thus their willingness and desires needed to be considered. For example, the findings of the study by Goniewicz et al. In Poland, it was revealed that nurses had stated that they needed to play a role in DNR orders and also have the right to decide about them (DA, 1992), since they had no defense role in this (De Gendt CBJ, 2007). The results of the study by Manias (1998) on Australian nurses' experiences and attitudes toward decisions about DNR orders also revealed that nurses believed that patients' families, patients, and nurses needed to get involved in making decisions about DNR orders since physicians were only responsible for deciding about such orders in current (E, 1998). In addition, in the studies by Prevost et al. and Rye Park et al. In other investigations in this domain the involvement of patients' families, patients, and nurses in deciding about DNR orders was emphasized. The results of this study showed that nurses were willing to implement DNR orders in the last moments of patients' lives. It was also suggested to develop a DNR order policy in each hospital to avoid any confusion in this regard. Moreover, it was required to pay attention to nurses' roles and their encounters at the bedside in such conditions and take necessary measures in policy making in this domain.

Commenting on previous studies

All previous studies were keen on ID but did not mention the legal aspect of the DNR Order. It did not show us the criminal responsibility of the doctor in the event of refusing to perform pulmonary resuscitation for the patient and allowing him to die naturally.

Theoretical Framework of the Study

a. The definition of DNR

A type of advance directive in which a person states that healthcare providers should not perform cardiopulmonary resuscitation (restarting the heart) if his or her heart or breathing stops. Also called DNR order. A DNR order allows you to choose whether you want CPR in an emergency. It is specific about CPR. It does not have instructions for other treatments, such as pain medicine, other medicines, or nutrition. The doctor writes the order only after talking about it with the patient (if possible), the proxy, or the patient's family. A do-not-resuscitate order (DNR) is a legally recognized order signed by a physician at a patient's request. Its purpose is to let medical professionals know you do not want to be resuscitated if you suddenly go into cardiac arrest or stop breathing (Morrow, 2023).

b. How is a DNR Order Created

If the Patient decides he wants a DNR order, he should tell the doctor and health care team what he wants. The doctor must follow the Patient's wishes (Dugdale, 2021), or:

- doctor may transfer patient care to a doctor who will carry out Patient wishes.
- if a patient is in a hospital or nursing home, the doctor must agree to settle any disputes so that the patient's wishes are followed.
- The doctor can fill out the form for the DNR order.
- The doctor writes the DNR order in the Patient's medical record if the patient is in the hospital.
- The doctor can tell the patient how to get a wallet card, bracelet, or other DNR documents to have at home or in non-hospital settings.
- the patient should include wishes in an advance care directive (living will)
- the patient should inform a healthcare agent (also called health care proxy) and family of the decision

if the patient does change his mind, he should talk with his doctor or healthcare team right away. Also, the Patient should tell his family and caregivers about his decision (RM, 2022).

c. When You Are Unable to Make the Decision

If cardiac or respiratory arrest is an expected part of the dying process and CPR will not be successful in restarting breathing and circulation, discussing, making and recording a decision in advance not to attempt CPR can help to ensure that the patient dies in a dignified and peaceful manner. It may also help the patient achieve their wish of spending their last hours or days at their preferred place of death. These management plans are called Do Not Attempt CPR (DNACPR decisions and are best made in the wider context of advance care planning. A recorded DNACPR decision is not, in itself, legally binding and should be regarded as a clinical

assessment and decision, made and recorded in advance, to guide immediate clinical decision-making in the event of a patient's cardiorespiratory arrest (Councl, 2022)Due to illness or injury, the Patient may not be able to state his wishes about CPR. In this case,

- if your doctor has already written a DNR order at the Patient's request, his family may not override it.
- The patient may have named someone to speak for him, such as a healthcare agent. If so, this person or a legal guardian can agree to a DNR order for the Patient.
- if the Patient has not named someone to speak for him, under some circumstances, a family member can agree to a DNR order for the Patient, but only when he is not able to make his own medical decisions (MK, 2018)

Refuse a DNR order

If a person has already completed a DNR order, their family cannot refuse the order. If the Patient has a DNR order and his family members disagree, medical personnel will still honor the Patient's wishes. However, the medical staff will communicate with the Patient family to try to get everyone on the same page with the Patient's decision (Anaebere, 2022)

However, there are many legislations that refuse to give the patient or his family the right to refuse a DNR order by law. This is in the case of Resuscitate Orders and allowing doctors Do Not Resuscitate Orders (Hiestand, 2019 Mar).

Cases

Case 1

Mrs. W is an 81-year-old woman with recurrent colon cancer with liver metastases admitted to the hospital for chemotherapy. Because of her poor prognosis, you approach her about a DNR order, but she requests to be "a full code." (GE, 2019).

Case Discussion

As a competent adult, this patient has the right to make decisions about her medical care. You must respect her wish not to be treated until she gives you permission to do so. However, it is especially important under these circumstances to clarify with Mrs. W her understanding of what CPR means and what her likely outcomes will be. To ensure that there is a clear understanding, addressing Mrs. W's hopes and goals is essential. Perhaps she wants to live to see her granddaughter graduate from high school in two months, knowing that she will die soon thereafter, however, she does not want heroic measures to prolong her life forever. Additionally, she may not want to live on machines for a prolonged period, and

hence, if she survives cardiopulmonary arrest yet is dependent on a ventilator to breathe, her decision may change. Understanding Mrs. W's goals may help you partner with her to make meaningful medical decisions that address her concerns and wishes throughout the duration of her illness (GE, 2019).

Case Number: 2

Mr. H is a 24-year-old man who resides in a skilled nursing facility, where he is undergoing rehabilitation from a cervical spine injury. The injury left him quadriplegic. He has normal cognitive function and no problems with respiration. He is admitted to your service for treatment of pneumonia. The resident suggests antibiotics, chest physiotherapy, and hydration. One day while signing out Mr. H to the cross-covering intern, the intern says, "Hadre should be a DNR, based on medical futility." Do you agree? Is his case medically futile, and if so, why?

Case Discussion:

Medical futility means that an intervention, in this case CPR, offers no chance of meaningful medical benefit to the patient. Interventions can be considered futile if the probability of success (discharged alive from the hospital) is <1%, and/or if the CPR is successful, the quality of life is below the minimum acceptable to the patient. In this case, Mr. H would have a somewhat lower-than-normal chance of survival from CPR, based on his quadriplegia. Furthermore, his quality of life, while not enviable, is not without value. Since he is fully awake and coherent, you could talk with Mr. H about his view of the quality of his life, particularly focusing on his goals and hopes for the future. You could share with him the likely scenarios should he have an arrest and the likely outcomes following CPR. After this discussion and clearly understanding Mr. H's goals, you can partner with Mr. H to determine whether or not CPR is indicated in the event of an arrest. In this case, CPR is not necessarily futile. A decision about resuscitation should occur only after talking with the patient about his situation, goals, and hopes in his life in order to make a shared and mutual decision.

Circumstances where medical personnel will resuscitate a person even with a DNR order.

medical personnel may resuscitate a person with a DNR order if:

There is no written documentation of the DNR order.

They cannot find or confirm the DNR order.

There is a question whether the DNR is valid.

The cause of the heart or breathing stopping is something unnatural, like trauma or a sudden blockage in the airway.

Most states have options for people to wear jewelry, which ow indicates that there is a DNR order. However, it is important to check with your state laws to know what type of identification is valid. It is also important to know if the jewelry can work in place of a physical DNR order and which jewelry makers are approved by your state.

If there is any doubt, medical professionals will err on the side of resuscitation. So, if you sign a DNR order, be sure your family knows your wishes (staff, 2023). When we ask how an advance healthcare directive is different from a DNR or POLST order the answer is that all three advance Care Planning Documents guide some aspect of your medical care. The chart below highlights some differences between them.

Differences in advance care planning documents (Anaebere, 2022)

	Advance healthcare directive	**POLST**	**DNR order**
Is it a legal document?	Yes	Yes	Yes
Who typically fills one out?	Any adult	Terminally ill persons, older adults, those with advanced chronic disease	Terminally ill persons, older adults, those with advanced chronic disease
Who is it completed and signed by?	An attorney	A physician	A physician
How long is the document?	Several pages	Usually one to two pages	Usually one to two pages
Can you name a healthcare POA?	Yes	No	No
Is it used by first responders (i.e., paramedics)?	No	Yes	Yes
Is it in your medical record?	No	Yes	Yes

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The procedure is according to the medical Protoprotocol.-not-resuscitate (DNR) order placed in a person's medical record by a doctor informs the medical staff that cardiopulmonary resuscitation (CPR) should not be attempted. Because CPR is not attempted, other resuscitative measures that follow it (such as electric shocks to the heart and artificial respirations by insertion of a breathing tube) will also be avoided.

This order has been useful in preventing unnecessary and unwanted invasive treatment at the end of life. The success rate of CPR near the end of life is extremely low (Charles Sabatino, 2022).

As part of care planning for seriously ill patients, doctors should discuss with seriously ill patients the possibility of cardiopulmonary arrest (when the heart stops and breathing ceases) considering their immediate medical condition, describe CPR procedures and likely outcomes, and ask patients about treatment preferences. If a person is incapable of deciding about CPR, an authorized surrogate may make the decision (Charles Sabatino, 2022).

A DNR order does not mean "do not treat." Rather, it means only that CPR will not be attempted. Other treatments (for example, antibiotic therapy, transfusions, dialysis, or the use of a ventilator) that may prolong life can still be provided. Depending on the person's condition, these other treatments are usually more likely to be successful than CPR. Treatment that keeps the person free of pain and comfortable (called palliative care) should always be given (Charles Sabatino, 2022)Physicians should discuss with critically ill patients the possibility of cardiopulmonary arrest, in light of their immediate medical condition, explain CPR procedures and possible outcomes, and ask patients about their treatment preferences. If the patient is unable to make a decision regarding CPR, the healthcare agent may make the appropriate decision in this regard.

A "do not perform resuscitation" order does not mean "do not treat," it just means that CPR should not be attempted. Other treatments (such as antibiotic treatment, blood transfusion, dialysis, or use of a machine) may be possible. artificial respiration), which can prolong life. Depending on the patient's condition, these other treatments can be more successful than cardiopulmonary resuscitation. Treatment that relieves pain and provides relief is called palliative care and should be provided on an ongoing basis (Marcia, 2018). In the USA for example, every state allows DNR orders, but there are differences in state laws. For example,

- Some states use different terms, such as a do not attempt resuscitation (DNAR) order; a no-code order; or an allow natural death (AND) order.
- In some states, only a physician can sign the order, while in others, a nurse practitioner (NP) or physician associate (PA) can sign it.
- Some states require a notary signature or two witnesses to be present at the signing.
- Unfortunately, most DNR orders are not honored from one state to another. So if you move from California to Texas, for example, a new DNR order would need to be signed (Anaebere, 2022)

Resuscitation Side Effects

It's important to realize that even if you are successfully resuscitated, you may end up with significant physical injuries as a result. For example, because the chest must be compressed hard and deep enough to pump the blood out of the heart, it can lead to broken ribs, punctured lungs, and possibly a damaged heart (Angela, 2022) Those who are resuscitated may also suffer brain damage. This can occur due to a lack of blood flow to the brain, followed by abnormal cell activity when blood flow to the brain is restored. Generally, the risk increases the longer the duration of CPR (Angela M, 2023)

The legal framework of the study

a. position of the legislator

If a patient is admitted to the hospital acutely unwell or becomes clinically unstable in their home or other place of care, and they are at foreseeable risk of cardiac or respiratory arrest, a judgement about the likely success of CPR in restarting breathing and circulation and its benefits, burdens and risks should be made as early as possible. You should also check whether any form of advance care planning is already in place and, if the patient lacks capacity, whether they have a legally binding advance refusal) Councl(2022 ،a DNR order states that no attempts should be made to restart breathing or restart the heart if it stops, an AND order ensures that only comfort measures are taken.8 This would include withholding or discontinuing resuscitation, artificial feedings, fluids, and other measures that would prolong a natural death. These orders are typically used in hospice settings or elsewhere for terminally ill patients. Most legislation does not provide for medical liability for do-not-resuscitate (DNR) orders and allows natural death to occur.

However, there are legislations that have settled the matter in the text of the law, as did the UAE legislator in the text of Article 11, considering the work of a doctor as a reason for permissibility (Federal Decree-Law). Natural death is permitted to happen by non-application of CPR in the event that the patient is dying, in the following cases: 1. if the patient is suffering from an incurable disease; 2. All medication methods have already been applied; 3. It is proven that medication is useless in the respective case; 4. The attending physician advises not to apply cardiopulmonary resuscitation; 5. Three consultant physicians at least decide that the patient's interest requires permitting natural death and non-application of cardiopulmonary resuscitation. In such a case, approval of the patient, his/ her guardian, or custodian is not required; 6. However, upon request of the patient, refraining from doing CPR is not permitted even if it is useless (Federal Decree-Law)The legislation did not agree on a specific and clear meaning for the moment of dying, but reference is made in this matter to the medical definition of dying, and

no legislative or explicit textual indications provide for defining that moment, which is called the state of dying, which has many legal implications for this person. however, those legislations have surrounded that situation with a number of premises and indications through which it can be said that that person is in a dying state .

These indications or signs are divided into the following:

First: Brain death: Brain death means the complete and irreversible cessation of all its functions because of injury or acute disease. Which can directly affect these functions and stop them, such as cancerous tumors, or infections such as meningitis, which lead to complete damage to the tissues and cells of the brain, and the brain stops completely from all its functions. Doctors unanimously agree that the person who dies goes through three stages: the first stage is the complete cessation of the heart and lungs from functioning, even though devices, and the second stage is the death of the brain or brain cells after the entry of oxygen-laden blood into them, and the third stage is called cellular death, which is subsequent to all stages, and differs from one patient to another (Alyaseen, 2022).

The jurists differed regarding a brain-dead person, is he considered dead or not? Some of them concluded that the death of the brain requires a complete cessation of the functions of the heart and breathing, and thus the soul leaves the body because the two most important organs in the body that provide it with life stop. Their argument for that is that if we were certain that a brain-dead person died, that would be a reason for trading in human organs.

It also opens the door to doctors who do not take precautions and do not consider the principle of caution and caution in medical responsibility and the ease of ruling the death of the patient, and we enter the vicious circle of doubt. Also, this ruling on such cases requires a specialized medical team, which is not available in many hospitals, so it is preferable to close this door to block the pretext. The death of the brainstem has sparked an escalating controversy. It is difficult to agree on a unified definition of brain death in all contemporary medical schools. There are three different definitions of brainstem death: the first is considered the death of the brain stem, the second is considered the death of the whole brain, and the third is the death of the main functions of the brain.

The second trend: is that brain death is considered real death. The proponents of this approach argued that the soul controls the body through the brain, so it works with its work, and stops when it stops, whether it stops completely or partially, such as the inability of some organs to perform their natural function. Accordingly, the brain is the one that controls the rest of the body, and if it dies or is damaged, the rest of the organs are unable to carry out their tasks, and the person is irretrievably dead and there is no hope of bringing him back to life again because

the soul has left the body (Sidhu, Dunkley, & Egan, 2007).This is what doctors call today "brain death". And they inferred that if any organ in the human body malfunctions, it is possible for the person to live with this malfunction, or to replace it with artificial organs, cure it or soothe it with some drugs, but the person remains alive, the brain is the decisive factor in determining the moment of death.

b. The criterion of death in legal thought

Sometimes a “natural death” is the best option for everyone. Is this logical and legal? Legal thought developed criteria for determining the state of dying or the moment of death, which are as follows:

1. traditional standard: The opinion of this criterion is that the soul leaves the body when all the vital organs of the body stop working, which means that the main organs such as the lungs, heart and brain must stop.

However, the cessation of some of these devices does not necessarily mean that death has occurred. The cessation of the heart from performing its functions does not mean death. It can be activated with electric defibrillators or artificial respiration; The criterion is that the brain cells remain alive so that they can register for that activation and be able to supply them with oxygen. If he returns to work using medical means, the aspects of life return to the body again.

2- The modern criterion for brain stem death

This criterion believes that a person is considered dead once the brain cells die or stop functioning irreversibly, including the brain stem, even if the brain cells are still alive and from them it is impossible for a person to return to his consciousness and normal life. But the question that imposes itself remains, if the patient's condition reached that condition while the patient was on resuscitation and assistance devices for a long time while he was in a deep continuous coma? Can the doctor remove the medical equipment from him? We cite in this regard the UAE legislation.

c. Brain stem death does not mean death.

In people with brain stem failure who are not dead Lazarus syndrome refers to your blood circulation returning spontaneously after your heart stops beating, and fails to restart despite cardiopulmonary resuscitation (CPR).In short, it’s returning to life after it appears that you’ve died. In people with brain stem failure who are not dead, in this case, the patient's body maintains its normal temperature, which means that the metabolism and pulse continue normally.

- Excretion processes occur in a person naturally, which take place through the contraction and extension of the muscles of the rectum and anus to excrete waste through the rectum, so how can all this be done if the body is dead?

- There were cases of brain death in which pituitary hormone levels were found to be high, which indicates that parts of the brain are still working and giving orders to secrete those hormones and controlling their secretion.
- In some pregnant women with brainstem death, the pregnancy continues until the fetus is fully formed; how can the dead body provide all the requirements for the growth of the fetus and the continuation of its life so that the stages of its development continue, completed, and come to life?

d. The position of UAE law

According to UAE Federal Decree-Law No. (4) of 2016 regarding Medical we find that Article No. (10) was clearer in regulating the federal legislator for the process of ending the life of a terminally ill patient (Federal Decree-Law).

1. Ending a patient's life is not permitted for any reason whatsoever, even upon the request of the patient or his/ her guardian or custodian;
2. Cardiopulmonary Resuscitation (CPR) equipment may not be removed except in cases of cardiopulmonary arrest or if all brain functions completely stop as per the accurate medical criteria stipulated by virtue of a decision issued by the Minister and the physicians decide that such arrest is irreversible.

And then the legislator permitted Natural death is permitted to happen by non-application of CPR if the patient is dying, in the following cases:

1. if the patient is suffering from an incurable disease.
2. All medication methods have already applied.
3. It is proven that medication is useless in the respective case.
4. The attending physician advice not to apply cardiopulmonary resuscitation.
5. Three consultant physicians at least decide that the patient's interest requires permitting natural death and non-application of cardiopulmonary resuscitation. In such a case, approval of the patient, his/ her guardian or custodian is not required.
6. However, upon request of the patient, refraining from doing CPR is not permitted even if it is useless (Federal Decree-Law)At the end of this study we found, A do-not-resuscitate order instructs healthcare providers to refrain from cardiopulmonary resuscitation (CPR) if a patient's breathing stops or if the patient's heart stops beating. It can also pose a dilemma, but one worth considering, especially in the context of health.

Here's why: CPR requires the heart to be compressed hard and deep enough to pump the blood out of the heart. As such, it can lead to broken ribs, punctured lungs, and possibly a damaged heart. Those who are resuscitated may also suffer brain damage (Angela M, 2023).

Conclusion

At the end of this study, we found that deciding about DNR orders is a difficult process that can be affected by various factors. however, few legislations have codified the criminal responsibility of the doctor, as the UAE legislator did in Federal Decree-Law No. (4) of 2016 regarding Medical Liability. countless amounts of time and money is wasted treating terminally ill patients. In many cases, a prior DNR may have resolved the problem. a DNR order does not mean "do not treat." Rather, it means only that CPR will not be attempted. Other treatments (for example, antibiotic therapy, transfusions, dialysis, or use of a ventilator) that may prolong life can still be provided. Depending on the person's condition, these other treatments are usually more likely to be successful than CPR. Treatment that keeps the person free of pain and comfortable (called palliative care) should always be given (Charles, 2022).

Recommendations

- The Due Process Clause provides that no state shall deprive any “person” of “life, liberty, or property” without due process of law. All legislation must legalize the DNR Oder and the criminal responsibility of the doctor, as the UAE legislator did in Federal Decree-Law No. (4) of 2016 regarding Medical Liability.
- All healthcare workers have a responsibility to discuss DNR and advanced directive status with their patients.
- The goal is to educate the family and the patient that a DNR does not mean that the patient will have a poor quality of life- just the opposite.
- It is vital to assure the family that the patient will be made comfortable and any pain issues will be addressed
- Family members should be encouraged to maintain physical contact with the dying person, such as holding hands If the dying person so desires.
- family, friends and clergy should be present at this stressful moment.
- develop a DNR order policy in each hospital to avoid any confusion in this regard
- The difference must be determined medically and legally, between clinical death and biological death.

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