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Navigating Do-Not-Resuscitate Orders in the Emergency Department: a Case Report on Ethical Decision Making

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ABSTRACT

A patient with Chronic Kidney Disease Stage V presented to the Emergency Department (ED) with severe shortness of breath, caused by pulmonary edema resulting from non-compliance with fluid restriction. The patient and her husband consented to the use of a mechanical ventilator and dialysis; however, they declined to authorise cardiac and pulmonary resuscitation in the event of cardiac arrest or to establish a Do-Not-Resuscitate (DNR) order. This presents a dilemma, as patients with requiring ventilatory support typically necessitate ICU admission; nevertheless, patients with DNR orders are generally not admitted to ICU. The situation worsened when the extended family opposed the DNR Order established by the patient and her husband. This case report aimed to provide solutions for nurses addressing ethical dilemmas concerning the determination of DNR orders. This case report follows the CARE Case Report Guidelines. Following immediate and continuous care in the emergency department and intensive care unit, the patient demonstrated significant improvement. The nurse resolved ethical issues by organizing a family conference that included the patient's family and care team, discussing the treatment plan on the basis of the most recent assessment results. Nurses' proactive engagement of multiple stakeholders in patient care within the hospital effectively addresses Do-Not-Resuscitate order-associated ethical dilemmas. To effectively address ethical conflicts, nurses should improve their emphatic communication skills, prioritizing patient interests.

Keyword: Do-Not-Resuscitate, Ethical dilemmas, Decision making, Advance care planning, Case report

1. Introduction

Chronic kidney disease (CKD) represents a major global public health concern, with a reported prevalence of 359 million cases (Guo et al., 2024). CKD prevalence is markedly elevated in low- and middle-income countries (LMICs) owing to the increased incidence of communicable and noncommunicable diseases (Stanifer et al., 2016). In Indonesia, CKD prevalence is reported to be 0.5% according to the National Basic Health Survey conducted in 2018 (Hustrini et al., 2022). Patients with CKD extensively utilize health services, including regular emergency department (ED) visit (Chambers et al., 2018). One of the most common reasons

for ED visits among patients with CKD is pulmonary edema, occurring in approximately 18% of cases (Hani et al., 2025).

Chronic conditions experienced by patients with CKD may lead to demotivation and depression, prompting some patients to consider Do-Not-Resuscitate (DNR) orders for alleviating prolonged symptom burden. In Canada, 10% of patients with CKD holds DNR orders (Moorman et al., 2019). DNR consents obtained by patients are correlated with a decrease in life-prolonging treatments, indicating enhanced patient autonomy (Yang et al., 2021). However, patients with CKD may experience cognitive function decline due to severe uremic syndrome, compromising their capacity to make informed healthcare decisions (Iyasere et al., 2017). This condition requires the involvement of families in decision making processes. In Asian countries, family health decision making collectively occurs, and the extended family frequently struggles to accept the patient's condition and make the decision for DNR (Edmonds et al., 2024; Shaku & Tsutsumi, 2016).

This case report presents a challenging scenario involving a CKD patient who exhibited a diminished will to live and necessitated life-saving intervention. The patient's diminished will to live resulted in a refusal of emergency treatment provided by healthcare professionals. Furthermore, a distinctive element of this case is that nurses encountered a situation particular to Indonesia, specifically decision-making that involved the extended family. This case report aims to offer guidance for emergency room nurses in managing such situations.

According to the Indonesian Ministry of Health Regulation No. 37 of 2014, DNR orders should only be made when the patient already has a terminal illness or life support is futile. This decision presents a dilemma when a patient requests DNR and the physician assesses that the prognosis remains favorable. The frequent decline in motivation to live among CKD patients results in a high rate of DNR decisions, necessitating a specialized approach to ensure that such decisions are grounded in sound and appropriate reasoning. Furthermore, within the Indonesian context, a distinct approach is required to address DNR decision-making challenges in extended family environments. This case report comprehensively elaborates on the ethical dilemma in making decisions about DNR orders in patients with CKD. The complexity of the situation increases when the patient's extended family opposes the patient's decision to implement a DNR order. This case report aimed to provide solutions for nurses addressing ethical dilemmas in determining DNR orders within the decision-making framework in Indonesia, emphasizing the role of extended families in this process.

2. Methods

This case report adheres to the CARE Case Report guidelines. The patient's husband has provided written informed consent for this case report. The study was conducted during the patients' hospital stay, which lasted 10 days. Researchers performed observations, direct treatments, evaluations of medical records, and interviews with patients and their families. During the treatment, the nurse prioritized optimal care to facilitate the patient's recovery. During the treatment process, the author concurrently documented the required information. The case report was composed following the patient's discharge from the hospital.

3. Case Presentation

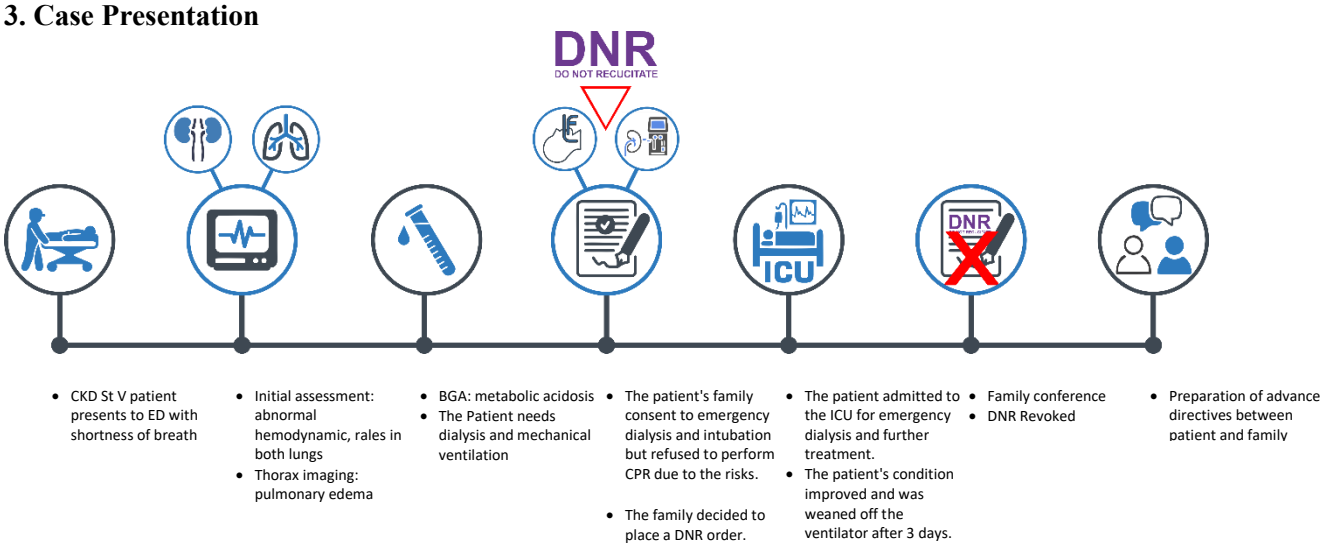

Figure 1 The patient's timeline

3.1 Patient Information and Clinical Findings

A 52-year-old female with CKD stage V on routine dialysis twice a week for the past 10 years presented to the ED with increasing respiratory distress and shortness of breath. Nursing assessment in the ED indicated that the patient consumed a significant amount of water before symptom onset. The following were the vital signs: heart rate, 128 beats/min (bpm); blood pressure, 238/116 mmHg; respiratory rate, 40 breaths/min; and oxygen saturation, 87% at room air. Physical examination revealed the presence of rales in both lungs. Owing to the high potential for deterioration, this patient was categorized as Emergency Severity Index Triage Level 2.

3.2 Diagnostic Assessment and Therapeutic Intervention

The patient was diagnosed with acute pulmonary edema, which raises suspicion of respiratory failure in end-stage chronic kidney disease. Following the administration of 10 liters/min of oxygen via a nonrebreathing mask, the patient's oxygen saturation increased to 98%, respiratory rate decreased to 26 breaths/min, and heart rate decreased to 96 bpm. Nitroglycerine was intravenously administered at a rate of 50 mcg/h via an infusion pump, resulting in a gradual reduction of blood pressure to 163/105 mmHg. Owing to pulmonary edema, intravenous (IV) furosemide was continuously administered at 5 mg/h. Urine output was monitored using a Foley catheter; however, the patient was anuric, indicating the absence of urine. The patient persistently reported significant shortness of breath and severe thirst. The patient exhibited signs of restlessness and repeatedly requested to drink water despite prior fluid restrictions imposed by the nurse due to excessive fluid accumulation in her lung. To elicit a placebo effect, the nurse instructed the family to only moisten the patient's lips. The patient demonstrated noncompliance and expressed a feeling of impending death.

Blood test results showed the following abnormal findings: potassium, 5.2 (3.5–5.1) mmol/L; creatinine, 12.96 (0.5–1.1; critical value, >3) mg/dL; urea, 163.5 (10.7–42.8) mg/dL; hemoglobin, 7.7 (11.7–15.5) g/dL; and hematocrit, 24.9% (35%–47%). Additionally, blood gas analysis (BGA) results were as follows: pH, 7.28; pCO2, 20.2 mmHg; pO2, 82.1 mmHg; HCO3, 9 mmol/L; and BE, −16.2 mmol/L. Thoracic imaging results revealed cardiomegaly and acute pulmonary edema with mixed infection.

3.3 Ethical Conflicts

Despite the patient showed clinical improvement following treatment in the ED, a risk of respiratory failure still existed if immediate mechanical ventilation and dialysis were not performed. The patient expressed willingness to undergo both interventions but expressed a preference for DNR in the case of cardiac arrest. The patient's husband, as the guardian, provided informed consent for the DNR order. Circumstances shifted when the patient's relatives arrived and opposed the DNR decision established by the husband. The patient's extended family blamed the husband, believing that he will be responsible for her death by signing the DNR order. The environment became tense as the patient expressed a desire to die, citing exhaustion from pain, leading to the decision to implement the DNR order. The nurse attempted to facilitate the situation by allowing the family to engage in a discussion to reach a decision. To calm the patient, the nurse suggested the patient to pray. Following extensive discussion, the family decided to proceed with intubation in the ED despite the DNR order. The patient was transferred to the intensive care unit (ICU) for immediate dialysis.

4. Results

The mechanical ventilator of the patient was on a pressure support intermittent mandatory ventilation mode. The following were the ventilator parameters: tidal volume, 375 mL; pressure support, 12 cmH_2O; positive end-expiratory pressure, 10 cmH_2O; respiratory rate, 20 breaths/min with an inspiratory and expiratory ratio of 1:2; and fraction of inspired oxygen, 80%. For sedation, the patient received IV dexmedetomidine at a rate of 0.4–0.8 mcg/kg body weight/h, resulting in a total dose of 24–48 mcg/h, adjusted according to the patient's level of consciousness. The patient underwent immediate dialysis in the ICU for 4.5 h without heparin. During dialysis, the patient received two units of packed red blood cells to elevate hemoglobin levels.

Following improvement of the patient's condition, the dosage of drug support was reduced. Following mechanical ventilation initiation, the patient exhibited respiratory function and BGA improvements. Improvements in blood pressure and heart rate led to the reduction of IV nitroglycerine dosage to 25 mcg/h. The patient presented with anuria; therefore, IV furosemide dosage was decreased to 20 mg every 8 h. Improvement of the patient's condition resulted in ventilator weaning on the day following ICU admission and extubation on the third day of ICU care.

Table 1 Patient's BGA Results

Normal value	Arrival in ED	After Mechanical Ventilation and Emergency Dialysis	3rd day in ICU
pH (7.35-7.45)	7.28	7.36	7.37
pCO_2 (35-45 mmHg)	20.2 mmHg	32.5 mmHg	32.7 mmHg
PaO_2 (80-100 mmHg)	82.1 mmHg	103.5 mmHg	259.2
HCO_3 (22-28 mmol/L)	9 mmol/L	18 mmol/L	19 mmol/L
BE ((-2) – 2)	-16.2 mmol/L	-6.8 mmol/L	-5.1 mmol/L
$AaDO_2$	462 mmHg	211 mmHg	154 mmHg

The nurse assessed the patient's psychosocial status using empathic communication when the patient was stable. The assessment results indicated that the patient experience exhaustion due to the lifelong requirements of medication and hemodialysis. The patient perceived herself as burdens to their families and express a belief that death would be preferable. The patient expressed feelings of deemed it necessary to inform the family about the patient's condition, prompting the organization of a family conference that included the healthcare team and family members. The conference aimed to address previous ineffective circumstances surrounding the DNR order in the ED, aiming to prevent similar conflicts in the future.

The family conference comprised the patient's family, nurses, the attending physician, and the anesthesiologist. The physicians reported that the patient's condition improved, and the critical phase was resolved. The nurse communicated that the patient demonstrated diminished motivation to live, which could impact the DNR decision made in the ED. Subsequently, the nurse recommended psychological assistance for the patient, providing insights on the preparation of advance directive when the patient achieves a stable physical and psychological condition. During the meeting, the family reached a consensus to withdraw the DNR order. Furthermore, it was agreed that the patient would receive psychological assistance following her stay in the inpatient ward, with the nurse coordinating with psychologists and the palliative team.

5. Discussion

5.1 Balancing Ethical Principles

Patients with CKD frequently experience depression, likely leading to declining psychological drive to maintain life caused by the treatment burden (Cogley et al., 2023). Depression has been demonstrated to influence medication noncompliance and fluid indiscretion, which are associated with adverse medical outcomes (Shirazian et al., 2017). Additional research indicated the association between health-related hope and adherence of patients with CKD to fluid and dietary intake restrictions (Kurita et al., 2024).

This finding aligns with our patient who persistently expressed feelings of impending death, leading her to repeatedly request a drink in the ED and disregard the imposed fluid restriction. Before symptom onset, the patient reported excessive water intake, contrary to the prescribed fluid restriction. This finding agrees with prior research, indicating that noncompliance with prescribed fluid and salt intake among patients with CKD contributes to ED readmission owing to pulmonary edema (Plantinga et al., 2018).

The situation presented a dilemma as the patient expressed her desire for a DNR order, accompanied by her feelings of hopelessness regarding her condition. The physician and nurses met with the patient and her husband at the bedside to discuss the favorable prognosis, indicating a high likelihood of recovery; however, the patient persisted in requesting a DNR order. The husband's statement reinforced that the patient expressed a desire to have a DNR order over the past 3 months. Subsequently, the healthcare team experienced ethical dilemmas regarding beneficence of resuscitation actions for the patient; nonetheless, they respected the patient's autonomy in decision making.

Healthcare providers responsible for the patient's care strive to balance the ethical principles of beneficence and autonomy involved in managing this case. From a beneficence standpoint, healthcare providers believe that performing cardiopulmonary resuscitation (CPR) will be advantageous for this patient considering her favorable prognosis. Furthermore, healthcare providers should consider the principle of nonmaleficence, particularly in cases where a patient achieves return of spontaneous circulation following CPR; implications on the patient's quality of life must also be considered (Fritz & Fuld, 2010). DNR orders must consider the ethical implication of patient autonomy, as the individual holds the primary right to decide the manner of their death (Dignam et al., 2021). To facilitate shared decision making following the physician explanation of the patient's condition, prognosis, treatment plan, and goals of treatment, the healthcare provider, the patient, and the patient's husband conducted a joint discussion. This result aligns with patient-

centered care, defined as a healthcare approach that highlights respect for patient preferences, needs, and values, which guide all clinical decisions (Langford et al., 2021). Patient decision making capacity is defined by the ability to demonstrate understanding, reasoning, and effective communication of their wishes (Barstow Craig et al., 2018).

5.2 Role of Family and Cultural Factors

The involvement of the extended family in end-of-life decision making poses a considerable challenge for healthcare providers, particularly regarding potential conflicts arising from different interpretations of the patient's best interest (Trees et al., 2017). Conflicts within extended families frequently arise at the end of a patient's life, mainly owing to a lack of readiness of the impending death of a family member (Waldrop & McGinley, 2022). The situation becomes more serious when the family's desires regarding end-of-life decisions vary from those of the patient.

By promoting culturally competent care and facilitating effective communication, transcultural nursing significantly mediates decision making conflicts in extended families. Transcultural nursing underscores the significance of family involvement in the care process, acknowledging their substantial role in decision making, particularly in critical care setting (Quinn et al., 2012). This finding agrees with the context in Indonesia, where the extended family significantly influence medical decision making (Pradanie et al., 2024).

5.3 Nurse's Role in Ethical Conflict Mediation

Patients with a DNR order may still be intubated, provided they do not have a separate and clearly documented Do-Not-Intubate order (Rubins, 2020). Intubation may be performed if it was not associated with cardiac arrest. Patients with DNR orders may still benefit from intubation in a pre-arrest condition, particularly for a potentially reversible illness, such as respiratory failure (Shearer et al., 2024). This approach was similarly applied to the patient in this case report, specifically intubation despite the DNR order.

As the patient was intubated and necessitated mechanical ventilation, she was subsequently transferred to the ICU despite the DNR order owing to the lack of a palliative unit in the hospital. This finding aligns with prior research, indicating that patients in the ICU, despite the DNR order, may still receive central lines, ventilatory support, and dialysis (Driggers et al., 2024). A previous study reported that 50% of patients with a prior DNR order upon ICU admission survived to discharge, suggesting that aggressive care could not be categorically futile (Wang et al., 2019).

As anticipated by the healthcare provider, the patient demonstrated notable improvement following dialysis and mechanical ventilation in the ICU. A decline in the patient's optimism was observed during the provision of nursing care, prompting the nurse to initiate a family conference. The family conference enables clear communication regarding the patient's condition, prognosis, values, and preferences, which are crucial for shared decision making (Scheunemann et al., 2019).

Following the family conference, it was determined that the patient required psychological assistance, and the DNR decision making process will be communicated to the patient once the patient becomes physically and mentally stable. The family opted to withdraw the DNR and allowed the patient to create an advance directive once stable. The decision regarding DNR withdrawal was documented in the medical record. Making DNR order decisions while the patient is in a stable condition facilitates thoughtful decision making that aligns with the patient's preferences (Al Sheef et al., 2017; Robinson et al., 2012).

The patient opted to seek psychological assistance in the general ward. Psychosocial intervention, particularly cognitive behavioral therapy, is an effective alternative to pharmacological treatments, which may have adverse effects in patients with CKD who develop depression (Gregg & Hedayati, 2020). Psychological intervention can enhance the quality of life by addressing both depressive symptoms and associated psychosocial stressor (Zahra et al., 2023).

Palliative care serves to align health care with patients' values, preferences, and wishes, particularly at the end-of-life, thereby fulfilling the principle of patient-centered care (Martina et al., 2023). Palliative care implementation in Indonesia faces challenges, particularly agreements among extended family members that significantly influence medical decision making for patients (Wilson et al., 2024). This case report also underscores a conflict among families caused by conflicting opinions regarding the patient's end-of-life wishes and those of the family. To prevent this situation, an effective solution is an advance directive signed by the patient, serving as documentation of the patient's end-of-life treatment preference (Shatri et al., 2020).

In Indonesia, a standardized mechanism to develop advance directive documentation that reflects patients' wishes or preferences regarding healthcare decisions at the end-of-life is yet to be developed (Alias et al., 2024). Research has indicated that a limited number of patients possess advance directives owing to insufficient knowledge (Fong et al., 2022). The lack of advance directives can be attributed to the involvement

of extended families in the care of patients with terminal illness, as not all families engage in open discussion regarding the dying process of their relatives (Waldrop & McGinley, 2022). Advance directives are essential in mitigating ethical dilemmas and family conflicts in emergency settings, while also ensuring that patient preferences are respected (Baker & Marco, 2020). To our knowledge, this is among the first reports describing ethical dilemma resolution managed by nurses in the Indonesian ED context.

Nurses, responsible with addressing patients' holistic needs during hospitalization, must employ empathetic communication in family conference to effectively resolve conflicts. Conflicts between family members and the patient may lead to delays and inconsistencies in clinical decision-making, thereby impacting patient care planning and coordination (Higginson et al., 2016). Empathetic communication leads by nurses fosters a sense of being heard and valued among family members (Abdallah et al., 2025). Empathetic communication facilitates the open sharing of perspectives and concerns among family member, which is crucial for collaborative decision-making (Olszeweski et al., 2024). Empathetic communication in shared decision-making facilitates the alignment of family goals and expectations with the recommendations of the medical team (Christensen et al., 2025).

Empathy is a crucial concept within the Social and Emotional Learning (SEL) Framework, a significant theory in conflict resolution (Juang et al., 2025). Integrating SEL principles enhances nurses' capacity to manage emotionally charged situation, thereby improving their professional competence and personal well-being (Issenova et al., 2025). Nurses possessing advanced SEL competencies are more effective at delivering patient-centered care, navigating complex emotional interaction and enhancing patient outcomes, particularly in ICU and palliative care settings (Wakefield & Rogers, 2024). This align with the empathy demonstrated by nurses in addressing decision-making conflicts associated with palliative care in the case presented in this report.

5.4 Implication for Emergency Nursing

Emergency nurses frequently resolve ethical dilemmas by integrating ethical principles, clinical guidelines, and collaborative discussion with other healthcare professionals (Afenigus & Sinshaw, 2025). Emergency nurses should be aware of the legal and ethical considerations surrounding patient care, including consent and confidentiality-related issues (ICN, 2022). To effectively address ethical dilemmas and mitigate burnout, emergency nurses need accessible resources and support systems (Afenigus & Sinshaw, 2025). Consultation with the hospital ethics committee to address complex ethical dilemmas represents a form of support and resources (Baker et al., 2020). The establishment of an end-of-life care protocol in the ED can assist nurses in providing comfort and preserving patient dignity by mitigating unforeseen suffering (Boque Oliva et al., 2022). We recommend developing standard operating procedures for the establishment and revocation of DNR orders in emergency and critical care settings.

In this case, effective communication by nurses was the foundation for addressing ethical dilemmas, facilitating conflict resolution between families, and ensuring consideration of patients' desires. Nurses mediate conflicts in the ED by encouraging discussions among healthcare providers, patients, and families at the bedside. Clear and empathic communication demonstrated by nurses facilitates the understanding of patients' needs and preferences, which is crucial for ethical decision-making (Tuohy & Wallace, 2024). For nurses, empathic communication training is essential for addressing ethical dilemmas regarding the determination of DNR orders and the engagement of the patient's extended family.

This case report indicates a necessity for collaboration between nurses and psychologists in the ER to develop a targeted approach for patients exhibiting depressive symptoms associated with end-of-life decision-making. In Indonesia, the decision-making process regarding end-of-life discussion already includes nurses and psychologists within palliative care. These discussions typically occur in the ward rather than in the ER. Discussion regarding end-of-life decisions for patients exhibiting signs of depression is essential from the moment of their arrival in the ER.

Psychological intervention is necessary prior to making end-of-life decisions for patients exhibiting signs of depression. Behavioral activation is an intervention that promotes patient engagement in meaningful activities to enhance mood and overall mental health (Solomonov, 2023). Improved social interaction and activities can offer emotional support, positively affecting end-of-life decisions. The implementation of this behavioral therapy process necessitates the engagement of a psychologist and the inclusion of family members to ensure the patient's psychological well-being.

6. Conclusion

The patient underwent emergency dialysis, supportive medication, and mechanical ventilation in the ICU and was considered stable enough to return to the ward for discharge preparation and psychological assistance.

The nurse facilitated discharge planning by engaging the family in discussions regarding the patient's ongoing care at home. Subsequently, the patient was discharged from the hospital in a stable condition and opted to continue writing a diary as a coping mechanism to express her feelings to her family. The patient stated that she would first consult with her family regarding the advance directive. This case underscores the significance of structured communication, early psychological support, and ethical clarity in DNR decision making in the ED. The author encourages for the establishment of standard operating procedure (SOP) in hospitals to guide clinical decision-making for patients regarding end-of-life choices, emphasising the importance of empathetic communication. This standard serves as a reference for nurses in managing conflict situations similar to those outlined in this case report.

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Appendix. CARE Checklist of Information to Include When Writing a Case Report

Topic	Item	Checklist Item Description	Reported on Line	Desc
Title	1	The diagnosis or intervention of primary focus followed by the words "case report"	2	"Navigating DNR order..: a case report"
Key Words	2	2 to 5 key words that identify diagnoses or interventions in this case report, including "case report"	25	Do not resuscitate, ethical dilemmas, decision making, advance care planning, case report
Abstract	3a	Introduction: What is unique about this case and what does it add to the scientific literature?	7-13	Patient consent to dialysis and intubated, but take DNR since DNR order can not admit to ICU. Family opposed the DNR order
	3b	Main symptoms and/or important clinical findings	5-7	Symptoms: shortness of breath because pulmonary edema
	3c	Main diagnoses, therapeutic interventions, and outcomes	6	Pulmonary edema
	3d	Conclusion—What is the main "take-away" lesson(s) from this case?	21-24	Nurse proactive coordinate stakeholders using emphatic communication
Introduction	4	One or two paragraphs summarizing why this case is unique (may include references)	38-39, 50-56	This patient takes DNR order present sign of depression. Extended family opposes DNR order.
Patient Information	5a	De-identified patient specific information	67	'A 52 year old woman…"
	5b	Primary concerns and symptoms of the patient	68	Shortness of breath due to pulmonary edema. Patient not adherence with fluid restriction.
	5c	Medical, family, and psycho-social history including relevant genetic information	N/A	
	5d	Relevant past interventions with outcomes	N/A	
Clinical Findings	6	Describe significant physical examination (PE) and important clinical findings	68-72	Increasing WOB, rales in both lungs, and elevated in BP, HR, RR, and decrease SpO2
Timeline	7	Historical and current information from this episode of care organized as a timeline	61-65	Figure 1
Diagnostic Assessment	8a	Diagnostic testing (e.g., PE, labs, imaging, surveys)	90-95	Blood test and thorax imaging
	8b	Diagnostic challenges (e.g., access, financial, cultural)	N/A	
	8c	Diagnosis (including other diagnoses considered)	76	Pulmonary edema
	8d	Prognosis (e.g., staging in oncology) where applicable	N/A	

Therapeutic Intervention	9a	Types of intervention (pharmacologic, surgical, preventive, self-care)	79-81; 111-119	Intervention in ED and in ICU
	9b	Administration details (e.g., dosage, strength, duration)	72-77; 115-124	Every pharmacological intervention described with dosage and route
	9c	Changes in intervention (with rationale)	115-124	Already described reduction of dosage of some drugs
Follow-up and Outcomes	10a	Clinician and patient-assessed outcomes (if available)	115-128	Already stated that there is improvement in patient condition
	10b	Follow-up diagnostic and other test results	115-126	
	10c	Intervention adherence and tolerability (how assessed)	N/A	
	10d	Adverse and unanticipated events	N/A	
Discussion	11a	Scientific discussion of strengths and limitations of this case report	246-248	
	11b	Discussion of relevant medical literature with references	148-248	
	11c	Scientific rationale for conclusions (including possible causes)	271-279	
	11d	Primary “take-away” lessons in a one-paragraph conclusion (no references)	250-269	
Patient Perspective	12	Patient's perspective on the treatment(s) received in 1–2 paragraphs	276-279	
Informed Consent	13	Did the patient give informed consent? (Please provide if requested)	Yes / No	Yes