

Viewpoint: 'Allow Natural Death' vs. 'Do Not Resuscitate'

A kinder, gentler approach would benefit everyone.

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I did it twice in March 2007, once in a hospital and again in a nursing home: I signed my mother's do-not-resuscitate (DNR) form. Although I've been a nurse for more than 30 years, I'd never signed a DNR form before, and it hurt. "Do not resuscitate." I wondered, what else will not be done? Will she not be nursed in a caring manner? Will her pain not be managed? What measures will be withheld? The language of the DNR order offers no answers: it's an order *not to do* something. Its harsh tone implies that no interventions will be performed-or worse, that care will be withdrawn. The DNR order often confuses family members, magnifies feelings of guilt they might have, and adds to their sadness.

During the late 1990s the Reverend Chuck Meyer started a campaign to change the DNR policy to the gentler allow-natural-death (AND) policy, sparking discussions in hospitals and nursing homes that continue today. Although both policies have similar clinical implications-care focuses on managing pain and maintaining comfort, while aggressive interventions meant to prolong life are abandoned-they convey very different messages.

Compared with DNR, which, as Meyer has said, means "that resuscitation attempts [horizontal ellipsis] will not be started if the patient dies," AND has a kinder tone. Its more positive language describes what *will* be done. But the difference goes beyond semantics. AND reflects an end-of-life philosophy of providing comfort rather than cure, whereas DNR reflects a model of care in which death is seen as a failure of treatment. The DNR policy is framed in terms of crisis; often, it's offered only when death is imminent and the patient is too ill to participate in making decisions. The AND approach emphasizes palliation and encourages families to talk earlier about end-of-life choices, perhaps while the patient can still make decisions. In this context, AND can be seen as a positive choice, not a last resort.

These differences were illustrated in Richard W. Cohen's profile of two families struggling to make decisions about end-of-life care for loved ones, published in the May-June 2004 issue of the *Hastings Center Report*. One family, offered the option of signing a DNR form, "grew ever more upset about the thought that no one would do anything" if their loved one had a cardiac arrest. The other family was given the option of signing an AND form. Reassured that the team would "do everything possible" to keep their loved one comfortable, and that if he went into cardiac arrest he'd be allowed to die "naturally and peacefully," the family agreed.

Clinicians, too, suffer confusion and uncertainty about end-of-life care: what's the right thing to do? Are we sure? When should we stop trying to prevent death? Nurses and physicians alike have problems initiating conversations about death. Clinicians find it difficult to correct the common misconception that a DNR order means that nothing will be done, according to an article in the December 2005 issue of the *Journal of Emergency Nursing*. And a study by Oberle and Hughes, published in the *Journal of Advanced Nursing* in 2001, found that nurses and physicians felt great

distress when witnessing the suffering of dying patients, especially when treatment merely prolonged suffering. This suggests that the AND approach might also reduce clinicians' distress.

How can we facilitate a policy change? We can start with communication. If you've used an AND form, speak at public and professional forums. Get this issue on the agenda of an ethics committee meeting and share information, data, and anecdotal evidence. No policy can eliminate the anguish of dying. Nothing could have eliminated mine: my mother was transferred to hospice, where she died on April 12, 2007. But if I'd been offered an AND form instead of a DNR form, it would have helped to bring calm. That's an option every family deserves.

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