

'Do not resuscitate' vs. 'allow natural death'

By Jennifer Booth Reed, USA TODAY

Could three words change the way severely ill patients and their loved ones think about death?

Spiritual leaders and some medical staff at hospitals across the USA believe so, and they are reconsidering how they pose one of life's toughest questions:

Do you want to sign a "Do Not Resuscitate" form?

When they ask, family members often balk. They believe they are giving up, condemning a loved one to death.

Some are now asking the question a different way:

Do you want to allow natural death?

Do not resuscitate. Allow natural death. Both phrases are uttered at the same time — the moment when doctors believe they have exhausted treatment options and death is inevitable.

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But Lee Memorial Health System specialists in Fort Myers, Fla., are finding semantics do matter.

"More often than not, the body language of the family will soften" when the phrase "allow natural death" is used, says the Rev. Cynthia Brasher, spiritual services director. "It shifts the burden."

Specific meaning for 'do not resuscitate'

A study published last year in the *Journal of Medical Ethics* measured how often nurses, student nurses and people with no health care backgrounds would endorse allowing death to progress when they were approached with the phrase "do not resuscitate" vs. "allow natural death." The nurses were likely to support the dying process regardless, but all three groups reported a greater likeliness to forgo resuscitation if "allow natural death" was used.

Some intensive care doctors say the words "do not resuscitate" can't yet disappear. That phrase carries a specific command to the attending medical team.

Razak Dosani, head of Lee Memorial Hospital's intensive care unit, says "do not resuscitate" means doctors will not perform cardiac resuscitation. But they will do everything up to that point. That might not be what the family or patient really wants. "Allow natural death" suggests doctors will offer only comfort measures, because any other aggressive treatment, such as intubation, may only prolong death.

Intensive-care doctors believe adding new terminology will help families with their decision.

Only about 20% of Americans have advanced directives leaving their loved ones to make the call if they are too sick to do so. Brasher says she knows of only one other hospital in Florida — the Miami Children's Hospital — that uses similar terminology.

It is not clear, she says, how many other health organizations across the country use it, but enough are doing so to pique the interest of scholars who are studying how words affect end-of-life decisions.

"Our argument is it's more humane and more compassionate," Brasher says.

Debate drives discussions about death

The semantic shift is a sliver of a broader question: how to talk about death, disease and the limitations of medicine.

The conversations are more crucial than ever as doctors amass an arsenal of technologies to keep people alive — and a growing list of ethical dilemmas about the nature of life artificially supported.

"Allow natural death" isn't a new concept.

Samira Beckwith, CEO of Hope Hospice in Fort Myers, says a statewide task force a decade ago looked at adopting the language on its Do Not Resuscitate forms. That didn't happen, Beckwith says, but it got health care providers talking. Hope Hospice providers use "allow natural death," along with other terminology, to make sure patients and family understand their options.

"Our greatest responsibility is to listen to the person and find the language that is best understood by them," Beckwith says.

St. David's Health Care in Texas adopted the "allow natural death" terminology eight years ago, championed by the manager of spiritual care, the late Rev. Chuck Meyer, and his successor, the Rev. Amy Donohue-Adams.

"I think people are much more comfortable with that," says Donohue-Adams, who first introduced the switch at the system's Round Rock Medical Center in Texas. "They hear 'allow natural death' and say, 'Well, that's exactly what we want. We want a death that is as natural as possible.' "

Frank Chessa, director of clinical ethics at Maine Medical Center, understands the rationale but questions its usefulness. He argues the phrase isn't specific enough.

" 'Allow natural death' to my ears is ambiguous between 'do not resuscitate' and 'comfort measures only,' " Chessa says.

He suggests using no such terminology but rather explaining patients' options with specific examples of potential life-prolonging therapies.

Many hospitals, Chessa says, are using lengthy, specific end-of-life order sets to decide on everything from CPR to dialysis to intubation to blood transfusions.

Dosani and Marilyn Kole, the Lee Memorial medical director for intensive care, say explaining terminology, options and implications of their choices will allow family members to make the best decisions for their loved ones.

"That's one of the things lacking in our medical community," Dosani says. "We need to take time and educate."

Reed reports for the News-Press in Fort Myers, Fla.

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