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Letters to the Editor

To the Editor:

Dr Joseph Breault's explanation of the rationale for changing the language of do not resuscitate (DNR) terminology was illuminating and welcome ("DNR, DNAR, or AND? Is Language Important?" *The Ochsner Journal*, Volume 11, Number 4). Clinicians have struggled for decades to communicate the medical reasons for withholding life support when patients near the end of life. We make efforts to assure patients and family members that they will be given the best chance available to recover. In this context, the suggestion that resuscitation is not advised runs counter to the message. As Dr Breault points out, families assume that cardiopulmonary resuscitation will allow their loved one to continue living in the condition experienced before the event, a perception reinforced by popular entertainment and culture. Available data clearly show that the prognosis for many patients is dismal. The terms do not attempt resuscitation (DNAR) or allow natural death (AND) allow the physician to focus on ongoing active treatment or comfort care while providing realistic prognostic information. They facilitate the physician's attempt to reassure the critically ill patient that he or she is not being abandoned, even if therapeutic options have a low likelihood of success.

The *American College of Physicians Ethics Manual,* Sixth Edition, advises physicians "to encourage patients who face serious illness or who are of advanced age to discuss resuscitation."[1] The terms DNAR and AND will facilitate the discussion and lead to a more realistic identification of the patient's goals and priorities, avoiding the implication of withholding or rationing effective care.

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1. Snyder L; American College of Physicians Ethics, Professionalism, and Human Rights Committee. American College of Physicians Ethics Manual: 6th ed. *Ann Intern Med*. 2012 Jan 3;156(1 Pt 2): 73-104.

To the Editor:

The special issue on the end of life in *The Ochsner Journal* (Volume 11, Number 4) is another example of how the Ochsner Health System is committed to the fulfillment of its mission to serve, heal, lead, educate, and innovate. This issue expresses, in a concrete fashion, how the healthcare professionals at Ochsner are always reflecting on the way they provide holistic healthcare for body, mind, and spirit. This is especially true when it comes to critical end-of-life decisions. Holistic treatment always attempts to integrate the care of the body, the mind, and the spirit. These three life-giving components work in concert to foster well-being and personal satisfaction in a person. When all measures of treatment of the body have been exhausted, the focus of care turns to the mind and the spirit, which hopefully develop along with the maturation of the body. If acknowledged and fostered, these human healing realities are called on to sustain the person throughout life. The mind and the spirit are the core ingredients for well-being and life satisfaction. This is especially true in the face of physical death for they direct the way end-of-life decisions are made and accepted. Optimal end-of-life decisions are not made in isolation but are the result of competent reciprocal consultation with the patient, family members, and healthcare providers. This reciprocal support is evident, especially when the healthcare providers are aware of the terrible impact the reality of death has on their patients because of their own reflection on the interaction of body, mind, and spirit.

Because critical end-of-life decisions are really ethical and spiritual decisions in nature, they therefore demand a clear reciprocal communication between healthcare providers and the patient. As a good example of this reciprocal communication, Lisa Tompkins, in her article "We Need to Talk,"[1] offers suggestions on how healthcare professionals can prepare themselves to improve end-of-life communication. She suggests that they could regularly assess their own beliefs about death and quality of life: that is, consider the role of the mind and the spirit in the healing process. Her suggestion is positive, not only for the healthcare professional but also for the patient and family; it presents an opportunity both to reflect on the positive approaches used over a lifetime to solve crises and to translate these skills, attitudes, and beliefs so as to face the reality of physical death. Such assessment will help healthcare professionals reflect on the deep-seated beliefs examined throughout life—aided by the practice of religious adherence to tradition, practices, and reflection—as well as to examine the spirituality assets that directed these professionals' thinking and behaving throughout life when seeking insight and comfort. Assessing one's beliefs aids in accepting death as the ultimate

transformational experience whereby death is no longer feared or repressed but accepted with openness.

Compassionate care and support come in many forms during a patient's interactions with healthcare providers. But in end-of-life situations, such care and support are manifest in the form of palliative care programs offered that treat the individual in a holistic way, always respecting the dignity of the person. These programs acknowledge the spiritual life, this vital experience of mind and spirit, as a major part in the healing process, especially at the end of life.

In the end, it is the spirit of each person and his or her reliance on what he or she perceives as the ultimate value that bring about the transformation from self-concern to self-transcendence. In this way, end-of-life decisions become opportunities to make spiritually transformational decisions.

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1. Tompkins L. We need to talk. *Ochsner J*. 2011 Winter; 11(4): 298-301.

From the Editor-in-Chief:

I would like to thank Dr Davis and Rev De Conciliis for their letters. The editorial staff strongly encourages discussion of the *Journal*'s contents, and these letters have highlighted several important aspects of the critical discussions that need to occur among our patients and colleagues. The end-of-life theme issue of *The Ochsner Journal* (Volume 11, Number 4) had many unique contributions. The editorial staff has received many complimentary comments and numerous requests for reprints from students, social workers, and even the members of a bioethics committee at a hospital in Mississippi.

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