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OBJECTIVES:

To provide practical strategies to enhance the quality of communication in the palliative and end-of-life medical care settings.

DATA SOURCES:

Published articles, textbooks, and reports.

CONCLUSION:

The components of effective and compassionate care at the end of life require successful communication with patients, families, and members of the health care team. Unfortunately, few health care professionals are formally trained in communication skills.

IMPLICATIONS FOR NURSING PRACTICE:

Nurses who possess self-awareness and are skilled in effective communication practices are integral to the provision of high-quality palliative care for patients and families coping with advanced malignancies.

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COMMUNICATION ISSUES AND ADVANCE CARE PLANNING

CRYSTAL DEA MOORE

HIGH-QUALITY care at the end of life can be promoted when health care providers: (1) ensure desired physical comfort and emotional support, (2) promote shared decision-making, (3) treat the dying person with respect, (4) provide information and emotional support to family members, and (5) coordinate care across settings.[1] To realize these components of effective and compassionate care at the end of life, health care professionals must be able to successfully communicate with patients, family members, and other health care team members. Unfortunately, few health care professionals are formally trained in communication skills. The professional literature is replete with examples of clinicians' communication difficulties, including studies that show how suboptimal communication practices can negatively affect patient care and patients' ability to cope with the demands of advanced illness.[2-5]

The challenges to effectual communication among health care professionals, families, and patients throughout the advanced illness disease trajectory are many, and can include medical professionals' fears about causing psychological harm[4] or diminishing patient and family hope when communicating bad news,[6,7] medicine's 'denial of death and dying, overuse of medical jargon by professionals,[8,9] and providers' own difficult personal and professional experiences with dying and death which impacts their willingness to confront such issues with patients and families.[3] Family members and patients also bring their own issues to clinical encounters that can negatively affect the quality of communication, including their previous experiences with and expectations about medicine, illness, death, and the patient or caregiver role. These and other factors provide a challenging context for nurses and other health care professionals who work with patients and families coping with advanced malignancies. This article seeks to provide practical strategies to enhance communication quality

in the palliative and end-of-life care settings. Topics include specific communication skills that can be incorporated into one's practice with patients and families who are confronted with end-of-life issues, the centrality of the professional–patient relationship in effective communication, the importance of provider introspection and self awareness as relationship-building tools, and tactics to initiate and sustain advance care planning discussions with patients and families.

Communication Skills in Palliative Care

Palliative care is a patient-centered approach to medical treatment, and its practitioners seek to holistically address patient concerns and needs, from biomedical issues to existential matters.[10] Although the literature on palliative care reflects an emphasis on pain and symptom control, a growing body of research that represents the voices of patients indicates that emotional and spiritual support are integral components of effective palliative care.[6,10-12] To meaningfully address the critical dimensions of palliative and end-of-life care, physical, emotional, practical, and spiritual domains,[13] health care professionals need to communicate clearly and supportively with patients, families, and other health care professionals. Communication can be considered the primary medium of care delivery.[14] It is a process between two or more people that is born out of a relationship. Relationship problems inherently impact the quality of communication.[3]

Basic interpersonal skills, such as good attending behavior, use of open-ended questions, and use of active listening skills, promote rapport that is the foundation of an effective working relationship. Health care professionals can provide an appropriate setting for optimal communication to support patients' sense that they are being listened to and cared about. This setting includes an appropriate environment (eg, private, comfortable), allocation of enough time to process information and emotions, and inclusion of the patient's identified support system.[15] This becomes even more important when patients and families must process bad, sad, or disappointing news. Providing one's undivided attention through nonverbal channels, such as directly facing the patient, being at eye level, and avoiding distractions sends the message that what the patient is conveying is important and that the nurse is truly listening.[16] Professionals must often multitask during patient visits to maximize efficiency because of the time constraints present in medical settings. One may review a medical chart at the beginning of the visit while the patient is talking or record information into a computerized record as the patient discusses symptoms. The nurse may indeed be listening, but the patient may not perceive it that way. Nurses can develop strategies to minimize the negative impact of such activities, such as reviewing the medical chart before sitting down with the patient, and explaining to the patient the necessity of recording information during the visit (eg, expressing to the patient, "As we talk, I will be entering information into your record so I am sure to accurately record your concerns"). There are times when it is necessary to focus one's full physical and mental attention on the patient and avoid such distractions (eg, when the patient is discussing difficult emotional reactions and/or processing difficult news). Avoiding interruption and giving patients undivided attention communicates that the health care professional is fully present and ready to listen.

Other nonverbal strategies that promote rapport include maintaining an open posture and appropriate eye contact.[16] A closed posture (eg, arms folded across the chest or legs tightly crossed) can suggest defensiveness and the desire to be cut off from what is being said. It is helpful to slightly lean forward toward the patient to demonstrate interest, engagement, and presence. Nurses may be unaware of their nonverbal behavior during patient interactions. Paying attention to one's body language during patient encounters can help to cultivate self-awareness. If one notices that his or her nonverbal behavior does not convey openness or interest, it may be helpful to reflect on such questions as, "Am I feeling uncomfortable or defensive?," "What is preventing me from connecting with this patient or family?," or "Do I have specific fears about addressing this issue with the patient or family?" Paying attention to these issues can promote self-awareness about how nonverbal behavior can be influenced by contextual as well as personal factors.

Appropriate eye contact is another important component of nonverbal communication. Looking patients in the eyes while talking and listening signals emotional connection and psychological presence and the provider is truly listening to, connected with, and concerned about the patient. As previously discussed, multitasking can be distracting and

can also inhibit the health care professional's ability to make eye contact. The importance of direct eye contact is valued in the dominant Western culture, and may not be appropriate when interacting with patients and families from diverse backgrounds. Providers should assess the appropriateness of direct eye contact in cross-cultural encounters. For example, when discussing serious subjects, certain Native American tribes will avoid making eye contact.[17] Among other cultural groups, averting one's gaze when speaking with those in authority is a demonstration of respect.[18,19] In cross-cultural interactions in which providers are not sure of the cultural roles about various nonverbal behaviors, observing how the patient and family interact with one another and other members of the medical staff can provide direction regarding nonverbal nuances.[19]

Nonverbal communication skills set the stage for rapport building and empathic communication. Active listening strategies, such as the use of open-ended questions, paraphrasing, reflection of feelings, and summarizations[16] help the nurse to develop rapport, gain trust, and better understand patients and their unique perspectives. Given that conversations in advanced illness are stressful and fraught with strong emotion, what is communicated by health care team members can be misunderstood or misheard by the patient. To develop patient-centered care plans, health care professionals need to develop the skills to <u>really hear</u> what the patient and family are communicating. Although time constraints can be a systemic barrier to the use of active listening, when at all possible, patients should be allowed to share information at their own pace and in their own way. Although necessary for assessment, providers may over-rely on closed-ended questions. Open-ended questions, although more time-consuming, allow patients to express what is most important to them. By allowing patients to discuss their concerns uninterrupted and at their own pace, the clinician can gain valuable insight into the patients' unique experience of illness.

An effective question to ask patients to learn about how they perceive their illness and treatment options is to ask the open-ended question, "What is your understanding of where things stand now with your illness?"[20] This question, followed by silence, can be a powerful strategy to assess what the patient knows and understands, thereby providing an opportunity to correct any misinformation, answer any questions, and gain insight into what is important to the patient during this time in the disease trajectory.

During any patient encounter, the use of paraphrases can show empathy and promote rapport and trust. Paraphrasing involves repeating back to the patient the content of the communication, using some of the patient's own words.[16] One does not want to "parrot" what the patient expresses, but by repeating back the essence of the patient's communication, any misunderstandings can be clarified. When paraphrases are used, understanding is enhanced. It has been suggested that empathic listening in and of itself can be therapeutic to palliative care patients and their families.[20] Below is an example of paraphrasing:

> Nurse: "I'd like to hear about what you understand about your illness at this time (pauses)."
>
> Patient: "I'm really not sure. I know that the last test I had showed that the cancer is starting to spread and the doctors are worried about that. Dr Jones said something about the chemotherapy that I am on, that maybe it isn't working like it is supposed to. But I'm not sure about that either. When she told me and my wife about the spreading of the cancer, I was shocked. I really thought this treatment was going to work. I just don't know what to do next."
>
> Nurse: "It sounds like you have a lot of unanswered questions about your cancer and the treatment. You know that the cancer has spread and that Dr Jones has some concerns about the effectiveness of the chemotherapy. This was a shock and you had faith this treatment was going to work. What are some specific questions you have at this time about your illness or treatment?"

In this example, the nurse began with an open-ended question and let the patient discuss his perspective in his own way. Instead of trying to immediately answer the questions that the patient expressed, the nurse demonstrated empathy through the use of paraphrasing. The nurse ended with another open-ended question that invited the patient to discuss his most salient questions and concerns.

Nurses who work with patients with advanced malignancies routinely deal with patients' and families' strong emotions. Displays of despondency, anger, fear, or other negative emotions can be hard to manage. If a patient's intense emotions go unacknowledged, the patient may experience health care professionals as distanced or uncaring. Like paraphrasing, reflecting on one's feelings can foster empathy and rapport through acknowledging and validating a patient's emotion. Reflecting feelings does not "fix" the underlying problem, nor does it offer solutions for coping.[20] However, it is a way that the provider can communicate compas-

sion and understanding in a nonjudgmental fashion. Strong displays of emotion are often tempered when a provider validates patients' or family members' feelings:

> Family member: (Angrily) "You people said this surgery would get the cancer! He was supposed to go home next week. He can't stay here any longer and he hates it here! You're telling me he has more treatment, more torture to go through?! I can't believe this."
>
> Nurse: "This is difficult news for you to. . ." (patient interrupts)
>
> Family member: "Difficult?! You have no idea. I can't bear the thought of him in this hospital anymore. This is too much to deal with. I have to take care of my kids, too. My sister is going to be devastated when she hears this. What am I going to do?"
>
> Nurse: "I can see you are overwhelmed with this right now. You have so much on your plate to deal with. What can I do right now to assist you with some of your immediate concerns?"

In this example, the nurse could have become defensive, which may have further angered the family member. Instead, the daughter's feelings were validated and the opportunity for the nurse to connect with her became a real possibility.

Finally, the technique of summarization can be helpful to ensure that the health care professional has picked up on the important themes of a meeting. Larson[16] refers to summarizations as "big paraphrases." This technique involves recounting the broader themes that were covered during an appointment and can be used throughout a discussion to make sure that central ideas are remembered and understood. In the following example, a nurse uses summarization to capture the content of an interaction with a patient regarding a discharge plan:

> Patient: "At this point, that is what is on my mind."
>
> Nurse: "Let me take a minute to make sure I understand your concerns and current situation. You are worried about meal preparation and being able to get into the bathtub so that you can bathe at least every other day. Your son is available for some help, but he cannot come to your home every day to help you because of his work and family obligations. You really want to stay in your home as long as possible, so a home health aide seems like a good idea to you. I will check into the available options and let you know what I find out. Is there anything that I missed?"
>
> Patient: "No, that sounds good. Thank you."

The nurse reiterated the main points covered during the appointment and developed a plan that addressed the patient's identified issues. When summarization is used, patients are reassured that the provider truly understands the most important concerns or issues expressed during the encounter.

When using active listening techniques and providing information to patients and families, nurses should be cognizant of the language they use. Use of medical jargon and technical language can result in ambiguities in communication.[5,8,9] Medical professionals routinely use such language, disregarding that patients and families may not easily grasp what they are saying. Jargon can impede patients' and families' abilities to grasp medical realities, used as a tool to obfuscate difficult truths, and can distance the health care professional from the patient.[8,9]

Reisfield and Wilson[9] point out that health care professionals may use terms intended to mean one thing but may mean the opposite to a layperson. For example, a clinician may inform a patient that a biopsy is "positive," indicating that a disease state is present, but a layperson may think the word "positive" is indicative of a favorable outcome (ie, an absence of disease). Table 1 provides a list of common clinical terms that may have antonymous meanings.[9] In addition to language that can be misconstrued, clinicians may also use euphemisms that can function to soften the truth but ultimately confuse patients. In cancer treatment, euphemisms include the terms "growth," "spot," or "mass." Common jargon that patients may misunderstand include "malignancy," "carcinoma," and "metastases."[9] It is vital that nurses become aware of the words they use and speak in language that patients can understand.

Effective communication is tailored to the needs of the individual patient. Assessment of patients' and families' communication preferences is important.[15] What are the patient and family's cultural and educational backgrounds? How much detail about the disease and treatment options does the patient want? Does the patient need time to absorb news before he or she is ready to ask questions and discuss options? Does it help to have loved ones present when discussions occur or does the patient prefer to have discussions with health care professionals alone? Continued assessment of the patient's communication preferences can provide a context for meaningful exchanges among health care professionals, patients, and family members.

Patients who perceive health care professionals as compassionate, emotionally supportive, empathetic, and caring are more likely to trust and be comfortable with such providers,[11] facilitating open and genuine dialogue. A nurse who behaviorally demonstrates these qualities develops rap-

TABLE 1.
Antonymous Meanings

Term	Clinical Meaning	Lay Meaning
Disease progression	Deterioration	Improvement
Disease regression	Improvement	Deterioration
Advanced	Unfavorable prognosis	Favorable prognosis
Positive (eg, biopsy)	Presence of disease	Absence of disease
Negative (eg, biopsy)	Absence of disease	Presence of disease

From Reisfield GM, Wilson GR. Ambiguity in end-of-life communications. J Terminal Oncol 2003,2:61-66. Reprinted with permission.[9]

port with patients, and they feel cared about and comfortable sharing thoughts and feelings. In developing rapport, the nurse conveys warmth and listens to patients in such a way that they feel heard and understood. Patients are respected as complete human beings, with unique histories, full lives, and distinctive value systems. To effectively convey empathy and compassion, nurses need to be genuine; such qualities can be difficult to "fake." A nurse who is genuine is authentic in his or her interactions with patients and families. Authenticity requires self-awareness and self-understanding as to what the nurse brings to the encounter with patient. Continued assessment of a patient's understanding of the illness and treatment options, communication preferences, and physical, emotional, practical, and existential concerns can assist nurses in delivering patient-centered care. Self-assessment of one's own emotional and behavioral reactions to patients and families is also crucial in cultivating effective communication in palliative care and avoiding burnout.

Introspection and Self-Awareness

Conversations in advanced illness can be emotionally charged and difficult for providers and patients alike. A cancer diagnosis and the medical decisions that must be made can evoke a psychological crisis for patients and families.[3] Depending on such variables as personality composition, coping style, previous experiences, and future expectancies, patients may react to bad news and the resulting stress with anger, anxiety, fear, acceptance, hopefulness, denial, shock, or any combination of the above. These emotional reactions influence one's ability to process information and effectively communicate. Providers also react to their patients' emotional states and displays depending on their personality, preferred methods of coping, and previous life experiences. Social and contextual features, such as behavioral expectations for "good patients," may impact the communication quality among nurses, patients, and families. Self-awareness of one's emotional reactions is imperative. Patients and families can provoke a wide range of reactions from providers, and if one is not aware of how a certain patient impacts professional behaviors, patient care may be compromised. For example, an uncomfortable provider may engage in distracting nonverbal behaviors that are manifestations of his or her emotional state and inability to make eye contact, eg, wringing the hands, fidgeting, etc. Patients can easily detect these nonverbal cues, and may choose to avoid difficult topics to be a "good patient" and to shield the nurse's feelings. This can impact what the patient is willing to reveal and compromise open dialogue.

Another important factor for nurses to consider is their experiences of grief and loss. Nurses often develop close bonds with their patients over the course of treatment, and are routinely faced with the deaths of their patients. How they cope with such losses can impact their level of engagement with living patients.[21,22] Grief experienced as a result of a patient's death can be described as disenfranchised, not publicly acknowledged, or supported. Nurses are often expected to go on "as usual" after the death of the patient, regardless of the closeness of the nurse-patient bond.[22] Grief is indeed a normal response among nurses, and needs to be acknowledged and processed to move through.[23] Research suggests that grief responses among palliative care nurses are repressed because of "intrapsychic disenfranchisement" (ie, detachment from one's feelings) and societal norms about grief reactions among professionals ("business as usual"). This disconnect, personally and socially, can lead to burnout.[22]

Nurses who work with patients who suffer from advanced malignancies do feel grief and other strong emotions that result from dedication to and care for their patients. This is normal and expected. It is emotions that are denied or unexamined that become problematic. Under these circumstances, such feelings can "leak" into encounters one has with

patients, and behavior is influenced by factors that are unknown to the professional.[21] This is countertransference, "the conscious or unconscious phenomenon that occurs when the clinician reacts to a (patient) based on the clinician's own past experiences, preferences, preconceptions, fantasies, and fears."[24] Countertransference can increase empathy and compassion and does not necessarily have to negatively impact patient care.[24] The key is self-awareness, the acknowledgement and exploration of one's emotional reactions that result from various patient encounters.

Novack et al[21] define self-awareness as, "insight into how one's life experiences and emotional make-up affect one's interactions with patients, families, and other professionals." Self-awareness begins with paying attention to one's inner life, emotional reactions, and concomitant behaviors. Novack et al[21] suggest that professionals reflect on the following issues to promote self-awareness: core beliefs/personal philosophy, family of origin influences, gender and sociocultural influences, feelings about boundary setting in medical care, attitudes toward conflict and anger, dealing with "difficult" patients, and attitudes toward death and dying.[21] Questions for reflection are presented in Table 2.

As nurses develop insight into how their emotional reactions impact their behavior in patient care situations, steps can be taken toward behavioral change, and resisting the tendency to become overinvolved or underinvolved with evocative patients and families. It is not the health care professional's responsibility to "fix" challenging patients and difficult family dynamics, but it is important to monitor one's own inner reactions and manifest behavior, such that patient-centered care is optimized. As a strategy to regulating one's behavior and making positive changes as part of cultivating self-awareness, Meier et al[25] suggest these steps: (1) name the experienced feeling; (2) accept the normalcy of the feeling; (3) reflect on the emotion(s) and its possible consequences; and (4) consult a trusted colleague for support and guidance. Through taking the time to reflect on and process one's emotions, emotional states can be identified and the process toward positive behavioral changes begun. Objectifying feelings can promote conscious control over emotional states, allowing professionals to make rational behavioral choices. Accepting that strong emotional reactions are normal when providing palliative care helps to reduce guilt about one's feelings and give health care professionals permission to explore how the emotional reaction influences patient care. Finally, processing difficult emotions and their resulting behaviors with trusted colleagues can help to provide needed emotional support and the avoidance of burnout.

TABLE 2.
Questions for Reflection to Promote Self-Awareness[21]

Family of origin issues
What roles did I have in my family?
How might I be replicating these roles in my work?
What lessons did I learn from my family about the nature of relationships, caregiving, and acceptable responses to illness?
What kind of patients might I associate with family members or loved ones?
Gender/sociocultural issues
What messages have I integrated about sex roles?
How might my attitudes contribute to instances of communication with the opposite sex?
Do I respond to and communicate differently with male and female patients and colleagues?
With what culture do I identify?
How does my cultural background influence my values?
How do I emotionally, cognitively, and behaviorally respond during cross-cultural encounters?
How has the medical culture influenced how I respond to patients and families?
Feelings and emotional responses in patient care
How do I maintain professional boundaries yet be empathetic with patients and families?
If I experience a strong emotional reaction to a patient or family, what is that emotion?
Where does it come from? How does it impact my professional behavior?
What sort of patients elicit an angry response in me?
What sort of work situations make me angry and why?
How do I generally handle anger and conflict? What might I do differently that is more productive?
"Difficult" patients
What type of patients and families do I consider difficult?
What sorts of biases may underlie my tendency to label certain patients as difficult?
What emotions do I experience when I work with "difficult" patients?
Caring for dying patients
How have my personal experiences with loss and grief impacted my abilities to work with patients who are dying?
How do my own attitudes and fears of death and vulnerability affect my patient care?
If I were dying, what type of medical care would I want?

Advance Care Planning

Nurses skilled in interpersonal communication and who are comfortable discussing end-of-life issues with patients and families can be integral to the advance-care planning process. Too often, issues related to end-of-life care are not discussed until a crisis occurs, and the opportunity for meaningful discussions regarding values, preferences, and life goals has been forfeited. Advance care planning is a process in which the completion of an advance directive is only one aspect. It is important to include the patient's family and loved ones in advance care planning discussions so that there is shared understanding of the patient's preferences and values salient to end-of-life decision-making. Advance care planning completed before an emergency and in collaboration with family and loved one has the potential to reduce family conflict and burden when decisions must be made on behalf of a loved one.[26] Such discussions should occur throughout the illness trajectory, especially when there has been a change in the patient's condition and/or circumstances.

Areas important for advance care planning include patient understanding of the illness, goals, values, personal experiences with illness and death, family/social system support of patient goals and values, and advance directives.[27-29] It is important for providers to understand how patients' view their illness. How patients perceive their disease and how families and medical teams understand it may be quite different.[27] Developing a shared understanding of the patient's medical issues can make discussions about treatment preferences more meaningful and relevant to the patient's specific situation, and decrease the likelihood of disagreement about options.

Patients have personal life goals that are connected to their value systems. These life goals and values are central to the advance care planning process. What does the patient want to accomplish in life? Is there any unfinished business that needs to be addressed? Patient aspirations should be central to the treatment plans developed for patients. For example, a patient may choose an aggressive mode of curative care for a period of time to attend an important family event. Medical decisions made by patients and families are influenced by their values and life experiences. What is important to this patient and family? What are their previous experiences with the medical system, illness, death, and dying? What is the role of religion or spirituality in this patient and family's life? Through exploration and understanding of these issues, providers can treat patients holistically, as individuals with a past, present, and future. Based on what has been and is now important to a patient, what decisions would be consistant with his or her life narrative? Values assessment can help providers and family members develop an understanding of patient preferences that can direct decision making in circumstances that might not have been anticipated. Numerous tools exist to structure such conversations among patients and surrogates including "Making Medical Decisions,"[30] "Five Wishes,"[31] and "Your Life, Your Choices."[32]

As previously indicated, inclusion of the patient and family in advance care planning discussions can reduce the potential for later conflict and regret, and ideally will enlist the family's support of the patient's preferences and treatment predilections that stem from values and life experiences. The patient's support systems, family members, and loved ones are integral to successful patient care. Family and social support for the patient's treatment plan should be assessed throughout the disease trajectory.

The documentation of advance care planning discussions takes the form of advance directives, which are legal documents that list specific treatment preferences (living will or health care directive) and specify who should make decisions on behalf of a decisionally incapacitated patient (durable power of attorney for health care or health care proxy). Advance directives completed without meaningful advance care planning discussions involving the identified decision-making surrogate, other family and social supports, and health care providers may not be very helpful in guiding care. For example, without provider input, patients may draft advance directives that are so unclear or ambiguous that their content cannot be substantively integrated into a patient care plan.[33] Patients who appoint surrogate decision-makers should be encouraged to thoroughly discuss their preferences and values with these individuals. Patients often appoint decision-making surrogates without directly addressing with them the issues that must be understood such that informed decisions can be made that are congruent with patient values and preferences.

Patients should be encouraged to keep their

advance directives in an accessible place and to give copies of the documents to their physicians, specialists, decision-making surrogates, and key loved ones and family members. Once an advance directive is completed, the process of advance care planning does not stop. It should be made clear to patients that they can change the content of their advance directives at any time. Nurses can help to ensure patients' current treatment preferences are appropriately represented in their advance directives by having ongoing discussion about values, goals, and medical treatment choices, particularly when there is a change in patient condition or circumstance.

In Table 3, questions that can help nurses begin and maintain advance care planning discussions are presented. The questions address the domains of advance care planning previously discussed: patient understanding of the illness, goals, values, personal experiences with illness and death, family/social system support of patient goals and values, and spirituality.[20,27-29] In addition, Quill[29] suggests that most end-of-life discussions also include advance directives, do not resuscitate orders, life-sustaining therapies such as mechanical ventilation, feeding tube, antibiotics and hemodialysis, management of pain and other symptoms, relief of suffering, and creating an opportunity to address unfinished business.

TABLE 3.
Suggested Questions for Advance Care Planning Discussions

Patient understanding of illness
What do you understand about where things stand right now with your illness?[20]
What do you know about your treatment options?
Patient goals
What is important for you to accomplish at this point in your life?
As you think about the future, what is most important to you (what matters the most to you)?[20]
What are your hopes/fears for the future?
If you were to die sooner rather than later, what would be left undone?[29]
What type of legacy do you want to leave your family/loved ones?[20]
Patient values
What makes life worth living?[29]
What would have to happen for your life to be not worth living?
What nourishes your spirit?
How do you feel about quality versus quantity of life?
To what extent do you want your family/loved ones to have input in decisions that are made about your health care?
What are your thoughts about pain control? Would you want your pain controlled even if it meant that you might not be as alert?
Personal experiences with illness, death, and dying
Has anyone close to you died of an illness? What happened? What was it like for you?
What other significant losses have you experienced?
What would you consider a "good death"?
Spirituality/existential issues
What thoughts have you had about why you got this illness at this time?[20]
Is faith (religion, spirituality) important to you in this illness and has it been important to you at other times in your life?[20]
Would you like to explore religious/spiritual matters with someone? Do you have someone to talk to about these things?[20]
Do you have any spiritual/religious beliefs that should be taken into consideration by your health care providers?

CONCLUSION

Palliative care is a holistic and respectful approach to meeting the physical, emotional, practical, and spiritual needs of patients and families coping with advanced illness. To provide the highest quality care possible, nurses who work with patients with advanced malignancies are called upon to communicate with them, their families, and other health care providers clearly, compassionately, and effectively. To do so, personal awareness about one's emotional reactions provoked by interactions with others is necessary so that positive behavioral choices can be made and burnout avoided. Nurses who are able to examine their own inner lives and develop successful communication practices are integral in promoting effective advance care planning among patients with advanced illness and their families.

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