

Acknowledging the 'Elephant': Communication in Palliative Care

Speaking the unspeakable when death is imminent.

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Mary Lamont, a 65-year-old retired businesswoman, was diagnosed with cancer in 2001, during what she characterized as the prime of life. Widowed at the age of 55, she'd remarried five years later, after having been reintroduced to a childhood friend, Ben Lamont, at a church social. Then, at the age of 63, she learned that she had stage 2 breast cancer and underwent lumpectomy, chemotherapy, and radiation therapy; follow-up at the recommended three-month intervals revealed no recurrence of the disease. The couple then began traveling and visiting their grown children, and during this time Ms. Lamont often declared that she felt that she'd been blessed.

One evening, almost two years after the diagnosis, Ms. Lamont

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Palliative Nursing



◀ *Fullness*, by Deidre Scherer, fabric and thread, 11" × 10", 1997; photo by Jeff Baird.

The image represents the bond between generations, Scherer says. "They're touching heads. They could be sharing a memory, an affirmation, a whimsy, or a moment of consolation."

For more on the artist and her work, go to www.dscherer.com.

arrived at the ED complaining of a new, sharp, and severe back pain that had begun that morning. She described it as intense, immobilizing, and unlike anything that she had experienced. The ED physician ordered magnetic resonance imaging (MRI), which showed metastasis with several vertebral lytic lesions; no involvement of major organs was noted. After discussing these findings with the Lamonts, the physician arranged for immediate consultations with a neurosurgeon, a radiation oncologist, and a medical oncologist.

"I can't believe this is happening," Ms. Lamont confided to the nurse. "When I first found out I had breast cancer, I really believed it could be cured. For a year I've lived thinking that the cancer was gone,

but now my world has turned upside down. Will I be able to walk again? How much time do I have left to live? What will happen to me now?"

Questions like Ms. Lamont's present an opportunity for conversation about death and dying, a topic that's often difficult for both nurses and patients. If the nurse doesn't respond in a way that encourages discussion, one will not take place, and death will become "the elephant in the room"—something unavoidable and yet taboo. The elephant metaphor has been used by hospice nurses in reference to dying and death; the elephant's presence is undeniable in hospital corridors, in waiting rooms, and at bedsides, but few acknowledge it. Yet addressing the issue of death and dying can relieve anxiety and

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allow all those affected by a patient's death to think more clearly, face fear, and make decisions; such discussion is essential to good nursing care at the end of life.

A FRAMEWORK OF COMMUNICATION

Understandably, Ms. Lamont was anxious about the metastasis. Such emotional discomfort often is noted in patients who've had a new diagnosis or an exacerbation or progression of a life-threatening or chronic illness. Immediate concerns often involve unfinished matters (a child's upcoming wedding, an imminent anniversary, or the reckoning of family finances, for example), and questions such as "Where will I be when I'm dying?" and "Who will take care of me?" arise. By discussing such worries, nurses can help a patient to concentrate on impending treatment and on his ideas of living well and dying well.¹

In the case of Ms. Lamont, chemotherapy and radiation were administered in the hope of stabilizing the disease and controlling pain. Opioid anal-

gesics were initiated. But when it became clear that cure was no longer possible, the focus of care shifted to palliation only. Such a change is difficult to convey to a patient and family, but nurses work so closely with patients, families, and other providers that they are the ones best positioned to lead such communication. The first step concerns the patient's understanding of palliative care.

THREE CRITICAL NURSING TASKS

In a study of bereaved family members, Pierce identified three critical tasks of the nurse providing end-of-life care: creating an environment conducive to communication, easing interaction between patient and physician, and facilitating interaction between patient and family members.²

Creating an environment conducive to communication entails consideration of the particular needs of the patient and each family member. Good patient-nurse communication is essential to this effort. One example of this would be a nurse who passes her pager to a colleague and draws a chair to the bedside. Giving the patient her full attention indicates that she values what he has to say.

Conversations about difficult issues may be started by asking the patient open-ended questions and listening attentively to his responses. In this instance, Ms. Lamont's cancer didn't go into remission as everyone had hoped it would, and so the nurse might say, "It must be frightening to have the news you've received today." By naming an emotion, the nurse lets her know that it's acceptable for her to talk about her feelings.

Prognosis. Ms. Lamont had directly asked her nurse, "How much time do I have left to live?" And although there is no precise answer to such a question, physicians and nurses should discuss the prognosis with the patient.

Commonly, patients with breast cancer that metastasizes only to the skeletal system respond to treatment,³ but metastasis outside that system is associated with a shorter survival.³ Imparting to Ms. Lamont all of that information, or repeating it if already given, is appropriate for her nurse to do.

When a patient learns that cure is no longer possible, prognosis is of primary concern. Median survival times have been determined in some advanced cancers,⁴ but it remains a matter of conjecture in many nonmalignant diseases. The course of congestive heart failure or of chronic obstructive pulmonary disease often is irregular,⁵ for instance, and exacerbation of either can lead to remission or death, complicating prediction of survival time. In such situations,

acknowledging the uncertainty can serve as a starting point for discussing it with a patient.⁵

Culture and ethnicity exert a strong influence on personal communication. The nurse should consider the patient's language; spiritual and religious beliefs; and views of illness, dying, and death—especially if her own cultural background is different. She must strive to understand the patient's attitudes and beliefs (and to be conscious of her own) regarding truthfulness, the significance of death, and concepts such as the afterlife and miracles. In some cases, it might be most appropriate *not* to discuss the patient's imminent death directly with him. A recent article in the *Journal of the American Medical Association (JAMA)* noted that in many cultures, including those predominant in Ethiopia, Greece, and mainland China, people tend to view truthfulness about diagnosis and prognosis as unnecessary, cruel, and possibly injurious to the patient.⁶ Kagawa-Singer and Blackhall suggest asking a patient whether he'd rather receive information on his condition from providers or from family members. Questions that can be useful in assessing a patient's cultural background include⁶:

- Where were you born and raised?
- When did you come to the United States, and what has your experience here been like? In which ways has coming to this country changed your life? (Matters of specific concern might include language, education, access to health care, and standard of living.)
- What have been some of the important experiences or events in your life that could help the hospital staff to better understand you?
- In which language do you feel most comfortable discussing your health? (If possible, people outside the family should translate when necessary; family members may relate medical information with bias.)
- Who is responsible for your health care decisions?

As you consider the patient's answers, determine the resources necessary to respond to them. Can someone in the patient's community, such as clergy and social workers, for example, assist you?^{6,7} (See "Cultural Considerations in End-of-Life Care," *AJN*, March 2003.)

Establishing priorities is vital. It's achieved by listening to and understanding the patient's desires about health care. A nurse might say, for example, "Now that we've discussed the uncertainty of your situation, what's most important to you?" or "What's the most important thing that I can do for you right now?" Patients' responses will vary consid-

Practical Guidelines for Communicating with Physicians

A nurse's guide.

1. Review your questions and their specificity before contacting the physician.
2. Consider how you can save the patient and the physician time in attaining a goal. For example, you might arrange for family members to be present when the physician makes rounds, and let her know beforehand what type of questions the patient has.
3. Keep the conversation focused on the concerns and desires of the patient and his family, not on yours. You might let the physician know that they have questions about nutritional support, for example, but aren't ready to discuss a decision about the performance of cardiopulmonary resuscitation.
4. Assess the patient beforehand and know the full details of the case, including any problems that may have arisen.
5. If you have a particular intervention or medication in mind, tell the physician about it and explain why you think it's appropriate.
6. If you've discussed an intervention with a patient and he is willing to try it, tell the physician. You are in close, daily contact with the patient, more so than the physician is. Don't oblige her to make guesses or assumptions about the patient's condition.
7. If the physician does not concur with your recommendation, ask her why in a manner that shows you want to understand and learn, not to challenge her judgment.—*Susan McInnes, MD, assistant professor of medicine, Division of General Internal Medicine and Medical Oncology, University of Colorado Health Sciences Center, Denver, and medical director of Hospice of Metro Denver, developed these guidelines as part of her work creating a model for nurse-physician communication, supported in part by a grant from the National Cancer Institute (CA83857).*

erably. For example, one patient might have questions about insurance coverage; another might want to know how to discuss end-of-life care with family members.

Facilitating patient-physician communication. In 1995 *JAMA* published findings of the Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT) that, among other matters, brought into sharp focus the

“shortcomings in communication” between physicians and patients.⁸ The study, which involved 9,105 patients hospitalized at five prominent medical institutions during a four-year period, demonstrated that many Americans were dying—in institutions, in intensive care units, on ventilators, and in pain and isolation—with their preferences in end-of-life care either unknown or unacknowledged. For example, during phase I of the study only 47% of physicians knew under which circumstances their patients wanted to forgo cardiopulmonary resuscitation (CPR). Yet despite phase II interventions that involved nurses trained in communicating outcome data and the patients’ preferences, communication between patient and physician showed no improvement.

Is it proper for nurses to address clinical issues with patients and advise their inclusion in advance directives? Yes. Is it appropriate for them to provide information that may help patients to make treatment decisions? Certainly. Are nurses and physicians comfortable in doing so? Probably not. Some clinicians may not have been taught how to have such conversations. But the time has come for them to learn.

If you don’t have an answer for a patient or a family member, write down the questions and let the physician know what they are and arrange a time for the patient and physician to talk. You should be present to facilitate the discussion and to ensure the patient’s understanding of the conversation. Also, determine whether he wants family members present. If the patient prefers to meet initially without family, that should be honored. Family members can be spoken to separately or included in later discussions.

At times a nurse must act as a go-between for patients and physicians. Yet nurses and physicians sometimes have conflicting views of the goals of care (such as when life-prolonging treatment should cease and palliative care intensifies) and roles (such as whether it’s appropriate for a nurse to question a physician’s decision). Some nurses say that they lack sufficient support from their organizations that would allow discussion with physicians as colleagues. But it’s vital that nurses do so; such discussion should be made part of standard nursing practice.

Nurses must understand not only the patient’s and his family’s goals but also the physician’s—taking into account that physicians, too, may be loath to acknowledge the elephant in the room. As part of her ongoing work concerning nurse–physician communication, McInnes has formulated nurses’ guidelines for communicating with physicians (see

Practical Guidelines for Communicating with Physicians, page 51).

Facilitating patient–family communication is achieved by identifying which family members make decisions and how they’re made. Asking either the patient or a family member “How are things going, really?” can elicit a frank response. For example, a patient might express frustration with his family’s reluctance to talk about the fact that he’s dying by declaring, “No one tells me anything” or “They talk, but not about what’s important.” Exploring further to find out to whom the patient is referring and asking which topics appear to be taboo in the family can yield valuable information.

In Ms. Lamont’s case, the nurse asked Mr. Lamont, “Have you and your wife talked about what matters most to her right now?” When he replied that they hadn’t, the nurse decided to make sure that he was included in patient–physician consultations (with Ms. Lamont’s consent). Because people under stress tend to have difficulty absorbing information, having a family member accompany the patient to a consultation allows them to review information together. It’s also important to recognize that patients and family members may need different information at different times. Mr. Lamont may want to know his wife’s prognosis so he can discuss home care with her children, for example; but his wife may not want to know quite yet. In this instance, the nurse could help by encouraging Mr. Lamont to speak with the physician privately or by arranging the meeting for him.

ASSESSING FUNCTIONAL STATUS

Functional ability is the most significant predictive factor in prognosis in advanced cancers.^{4,9} (It may serve as a prognostic indicator in nonmalignant illnesses as well, but not necessarily as the most important one.¹⁰) The Eastern Cooperative Oncology Group (ECOG) Performance Status Scale was designed for the evaluation of functional ability in subjects participating in cancer clinical trials. This and other comparable tools such as the Karnofsky Performance Status Scale score functional status numerically.

In merely offering an observation such as “I noticed that you arrived in a wheelchair today; are things getting harder for you?” the nurse might elicit a patient’s worries about physical decline. Patients often verbalize what providers may be aware of but aren’t openly acknowledging: that circumstances are not improving or are deteriorating.

Ms. Lamont was scheduled for a course of radio-

therapy to the spine and also began weekly chemotherapy treatment, both at an outpatient oncology clinic. The clinic staff used the ECOG scale at each visit. The tool assigns a number ranging from 0 (normal) to 4 (bedridden) according to the patient's abilities to care for himself and the amount of time spent in bed daily (see www.ecog.org/general/perf_stat.html).

Ms. Lamont reported that her ability to take care of herself was limited and she spent more than half of each day in bed, thus rendering an ECOG score of 3. She was unable to receive chemotherapy treatment weekly as planned because of low white blood cell counts, indicative of bone marrow suppression, and although the chemotherapy dosages were adjusted and the course of radiotherapy completed, her status didn't improve. During a routine assessment, she said, simply: "Things aren't getting better. I need to make plans, perhaps put some things in writing."

CARE PLANNING

Under the Patient Self-Determination Act of 1990, all health care facilities that receive federal funds must recognize advance directives, the two basic types of which cover treatment (the living will) and the appointment of proxy authority (the durable powers of attorney for health care). All 50 states have enacted statutes that address both types of directive, although they vary by state. Advance directive instructions and forms can be obtained without charge at the Web site of the Partnership for Caring (www.partnershipforcaring.org).¹¹ (See "Ethical Concerns in End-of-Life Care," *AJN*, January 2003.) Subjects usually covered in advance directives include, but aren't limited to, the following.

Pain management at the end of life is of vital concern in preparing an advance directive. The nurse should explain to the patient that the advance directive could include a statement addressing pain control specifically that clarifies his spoken preferences. For example, a patient might write, "When I am close to death, comfort is most important to me. I wish to be treated with analgesics as aggressively as necessary to maintain my comfort. I am not concerned about sedation. If the level of analgesics necessary to control pain also causes sedation, I welcome it."

The ANA has issued a 2003 statement regarding the promotion of comfort and the relief of pain at the end of life (see www.ana.org/readroom/position/ethics/etpain.htm). Its 1995 statement cites Wanzer's definition of "the proper dose [as that] sufficient to

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reduce pain and suffering" and states that nurses "should not hesitate to use full and effective doses of pain medication for the proper management of pain in the dying patient."¹² Addressing the question of whether sedation or respiratory depression may occur as a consequence of that approach, the ANA's 1995 statement maintains that achieving "adequate symptom control, even at the expense of life," is an ethically justifiable goal.

Place of death. Ms. Lamont, for example, may be anxious about where she will be as she's dying—at home, in a hospital, in an inpatient hospice, or at a nursing home. This, too, can be addressed in the directive.

End points in curative or life-prolonging intervention. To guide the family, Ms. Lamont may wish to include instruction for stopping life-prolonging intervention, by writing "I no longer wish interventions to treat cancer to be pursued when the disease has affected major organ systems and return of their

Family Conference

Making the most of the meeting.

I. Why

- Clarify goals with your team members before meeting with the family.

II. Where

- In a comfortable and private setting, arrange seating in a circle.

III. Who

- Attendees include the patient, if he is able; the patient's legal decision maker or health care proxy if he is not; family members; other supportive people (whomever the patient identifies); and essential providers.

IV. How

a. Introduction

- Introduce yourself and have others introduce themselves.
- Review and state the goals of the meeting and the specific decisions at hand.
- Establish ground rules: each person has the opportunity to ask questions and express his views without interruption. Identify the legal decision maker, and explain the importance of collaborative decision making.

b. Review of medical status

- Review current medical status, plan, and prognosis.
- Ask each family member in turn if he has any questions about current status, plan, or prognosis.
- Defer decision making until the C or D.

c. Family conference with a patient capable of making decisions

- Ask the patient, "Which decisions are you considering?"
- Ask each family member, "Do you have questions about the treatment plan? How can you be supportive to the patient?"

d. Family conference when the patient is incapable of making decisions

- Ask each family member, "What do you believe the patient would choose if he could speak for himself?"
- Ask each family member, "What do you think should be done?"

- Leave the room and give the family time to confer in private.
- If there is consensus, go to V; if not, go to E.

e. When there is no consensus

- Restate the goals. Ask, "What would the patient say if he were able to communicate?"
- Schedule another conference to take place the following day.
- Try further discussion. Ask, "On which values is your decision based? How will it affect you and other family members?"
- Identify the legal decision maker.
- Identify resources: these may include clergy, other physicians, and the ethics committee.

V. Summation

- Summarize the consensus reached, the decisions made, and the follow-up plan.
- Remind participants that unexpected outcomes are still possible.
- Identify the family spokesperson for the purposes of ongoing communication.
- Document in the patient's chart who was present, which decisions were made, and the follow-up plan.
- Remember that decisions to discontinue treatment are the *joint* responsibility of the team, the patient or his proxy, and the family.
- Continuity is important. Maintain contact with the family and the team. Schedule follow-up meetings, as necessary.

VI. Family dynamics and decisions

- Respect the wishes of the family decision maker whenever possible.
- Recognize that established patterns of family interaction will continue.
- Note that unresolved conflicts between family members may come into play.
- Realize that problems in dealing with authority figures, physicians, or institutions will affect the process. Ask those present about them.

Adapted with permission: Weissman DE, et al. Improving end-of-life care. Milwaukee, WI: Medical College of Wisconsin. 2001.

function is not anticipated without further invasive or debilitating procedures."

Specific procedures also can be addressed. For example, CPR was initially developed to treat sudden cardiac arrest in otherwise healthy people, but

it's now generally assumed that patients in cardiac arrest want it performed. In fact, it's one of the few interventions for which a written medical order *prohibiting* it is required. This should be explained to patients, as should the fact that CPR is seldom suc-

cessful in patients with metastatic disease. Research has shown that the most significant factor predictive of successful CPR is the patient's condition before the arrest.¹³ Although patients should indicate their views regarding CPR (and other interventions) in an advance directive, such a statement would serve only as a guide; it is not a medical order, in itself.

Because patients may be apprehensive about formalizing decisions that might limit the time remaining to them, it can be helpful to focus on their goals as they approach death.¹⁴ In an article published recently in the *Journal of Palliative Medicine*, Griffie and colleagues suggest that the nurse ask the following open-ended questions.¹⁵

- What do you consider important for you to accomplish at this time?
- How can we help you to live well in the time ahead?
- What do you perceive as keeping you from attaining your goals?

If the patient has designated a health care proxy, consider asking that party to be present at the foregoing discussion; it will help him to make decisions later if it becomes necessary.

The frank discussion of a patient's condition need not wither hope, as some believe. For instance, as Ms. Lamont's illness progressed, her focus shifted from cure to remission; now, in the acceptance of impending death, she hopes for a painless, dignified one, setting short-term goals such as "being comfortable and awake when the children visit next weekend."

Encourage patients to write advance directives as soon as possible if they haven't already done so and to be as specific as they can. Both you and the patient should ask for help when needed. For example, in Ms. Lamont's case, the nurse said to her physician, "Ms. Lamont will be completing her advance directive today, and I think it should include her preferences about aggressive pain management and CPR. Which other issues should be addressed?" Talk with the physician after she has assessed the patient, when the patient's case normally would be discussed, as during rounds. This can help to ensure that goals are addressed and that other team members also gain a clearer understanding of the case. Document in writing what you do and say to the physician, and share relevant information with *any* team member who helps the patient complete an advance directive.

THE FAMILY CONFERENCE

Two months after metastasis was discovered, Ms. Lamont was hospitalized. She was jaundiced and had elevated liver enzyme counts. A computed

tomographic scan of the organ showed several areas of metastasis. She slept much of the time, reported pain when awake, and received opioid pain medication intravenously. The clinicians and her husband were reluctant to begin an opioid drip because of the poor liver function and the desire to have Ms. Lamont alert enough to converse. As her children began arriving from out of state, the results of a liver biopsy confirmed the metastasis. The family requested a conference with the physician, which Ms. Lamont was too sedated to attend. The family then met with the health care team and returned to the bedside to review the discussion with her.

When cure is no longer possible, that fact must be conveyed clearly and, if possible, in person. The sentence, "There's nothing more that we can do for you," must be stricken from health care parlance. There is *always* more that can be done for dying patients and their families. Symptoms can be managed aggressively, and the patient and family can be helped in setting realistic goals—a far cry from nothing.

Calling a family conference. Because conferences can be called for many reasons, it's important to establish the purposes beforehand. Typical goals include addressing specific ethical issues, discussing treatment decisions or symptom management, resolving conflicts, and planning for disposition. A conference should be held whenever there's a need for discussion among the team, the patient, and the family. All team members may benefit from reviewing the guidelines for family conferences created by Weissman and colleagues (see *Family Conference*, page 54). Before the conference, consider the following questions.

What are the purposes of the meeting? Which decisions must be made? In Ms. Lamont's case, the health care team had to address, in advance of the conference, the question of whether to continue cancer treatment. Her current regimen had failed, and the risks, including that of toxicity, associated with other possible treatments had to be weighed against benefits. Ms. Lamont's weight had declined steadily in recent months, and her nutritional status was poor; she found it difficult to swallow and ate at most a couple of bites daily. Further, her liver could not metabolize medication. In view of all this, further chemotherapy wasn't recommended, and it was expected that Ms. Lamont would die within days. This information would be imparted to Ms. Lamont and her family, who needed to decide where she would die.

Is the health care team aware of the patient's

wishes? If he is cognitively impaired or unable to communicate, is there an advance directive in place? Ms. Lamont had written a durable power of attorney for health care that clearly stated her preferences and that named her husband the health care proxy. Although she could awaken and recognize individuals in her room, assessment now showed that she could no longer process information, understand the consequences of her decisions, or communicate her preferences—important criteria in determining decision-making ability.¹⁶ The team decided to activate the durable power of attorney for health care so that her husband could begin making decisions for her.

Who constitutes the patient's family? Who should attend the conference? The patient's family might include people who are not biologically related to him. Everyone the patient regards as family should be considered when convening a family conference. Ms. Lamont's adult children were present, as was, of course, her husband. Mr. Lamont's children were not informed of the meeting, but Ms. Lamont's closest friend, whom she had known since her college days, was.

Which staff members should attend the meeting? All members of the team, including physicians, nurses, social workers, discharge planners, case managers, and clergy, should be considered, but only those needed to assist in making decisions should be included. Too many attendees can overwhelm the family. Nursing representation is especially important at family conferences, as the nurse is charged with implementing plans, communicating information among agencies, and supporting the patient and family afterward. Nurse managers should be advised of impending family conferences, to allow schedules to be adjusted so that primary care nurses can participate.

How much longer is the patient likely to need care in this setting? Often, at the end of his life, the patient must be moved to a different setting because of issues concerning reimbursement. If he's in an acute care setting, one must ask whether the care provided continues to justify the need for him to be there. It's very distressing to everyone involved when a patient is moved to another setting and dies within 24 hours. Every effort should be made to avoid this.

FINAL DAYS

Ms. Lamont's family decided to take her home for the last days of her life.

Ideally, at family conferences the patient and family members begin to accept the imminence of

the patient's death. During the final days, views of what constitutes a good death can vary among the patient and family members. Steinhauer and colleagues conducted a random survey of 340 seriously ill patients, 332 recently bereaved families, 361 physicians, and 429 other providers in order to identify areas deemed important at the end of life.¹⁷ While most agreed on the importance of four areas ("pain and symptom management, communication with one's physician, preparation for death, and the opportunity to achieve a sense of completion"), there was wide variety in the ranking of others (including "decisions about life-sustaining treatments, dying at home, and talking about the meaning of death"). It's important that nurses consider the patient's status, psychologically and spiritually. If clinicians afford patients more time to come to terms with death—for saying to those who matter to them, "I forgive you," "Please forgive me," "Thank you," and "Goodbye,"¹⁸ perhaps more of them can die peacefully. (See "Grief and Bereavement Care," *AJN*, September 2003.)

Symptom management is of paramount importance. Family members providing care to a patient dying at home must understand which symptoms and behaviors should be reported. And in hospitals, nurses should review all procedures to ensure that those performed are absolutely necessary. For example, continuing to check a dying patient's vital signs doesn't increase his comfort, and the time it takes to do so may be better spent in comfort measures, such as a back rub. In any setting, a schedule for the nurse's contact with patient and family should be followed. For example, if the patient is receiving care at home, the nurse might say, "I'll visit or call you daily," and if the patient is in an acute care setting, she might say, "I'll be checking on you hourly. I won't disturb you if you're sleeping, but feel free to call me at any time." Focus your efforts on providing physical and emotional comfort to both patient and family, such as in arranging for cots to be brought in to accommodate family members spending the night.¹⁸

It's important to bear in mind that what occurs at the dying patient's bedside determines the family's memory of his death. If nurses treat the patient and family with empathy, and excellent communication takes place, this exceedingly trying time can be deeply meaningful to all involved.¹⁹

Ms. Lamont returned home, where hospice nurses assisted in her care. She died without apparent pain, surrounded by her family and in a place that she loved. Afterward, her husband and children

expressed their gratitude to the providers. “Even when treatment no longer could defeat the cancer,” Mr. Lamont said, “we still could do important things—we managed Mary’s pain and we shared our love for one another.” ▼



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CE 1.5 HOURS

Continuing Education

GENERAL PURPOSE: To present registered professional nurses with communication strategies for addressing death and dying with patients and families.

LEARNING OBJECTIVES: After reading this article and taking the test on the next page, you will be able to

- discuss basic concepts and concerns essential for understanding the importance of communication during end-of-life care.
- outline several communication techniques appropriate during end-of-life care.
- plan appropriate strategies for addressing death and dying with terminally ill patients and their families.

To earn continuing education (CE) credit, follow these instructions:

1. After reading this article, darken the appropriate boxes (numbers 1–15) on the answer card between pages 56 and 57 (or a photocopy). Each question has only one correct answer.

2. Complete the registration information (Box A) and help us evaluate this offering (Box C).*

3. Send the card with your registration fee to: Continuing Education Department, Lippincott Williams & Wilkins, 345 Hudson Street, New York, NY 10014.

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