

Clinical Oncology Nurse Best Practices: Palliative Care and End-of-Life Conversations

Kellie Spine, MSN, RN, OCN®, Anne Skwira-Brown, APRN, AOCNP®, Deanna Schlifke, BSN, RN, OCN®, and Ellen Carr, PhD, RN, AOCN®



BACKGROUND: Clinical oncology nurses (CONs) support and guide patients and caregivers by encouraging open dialogue and using effective communication skills. Palliative care (PC) and preparing for the end of life require that CONs apply experienced communication skills that are focused, nuanced, and helpful.

OBJECTIVES: The aim of this article is to review communication methods and competencies, which can contribute to a best practices foundation for PC-focused conversations with patients and caregivers.

METHODS: Expert CONs provided case studies and responded to clinical scenarios, which illustrated and highlighted communication competencies as applied to PC-focused conversations.

FINDINGS: To establish communication competencies applied during PC-focused conversations with patients and caregivers, CONs can develop, enhance, and apply timely and effective communication skills in clinical oncology practice. To build a foundation for PC-focused communication competencies, nurses can access PC and communication skill resources, including mentoring by expert interprofessional practitioners from PC teams.

KEYWORDS

palliative care; end of life; palliative care conversations; communication skills

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DURING ALL PHASES OF THE ILLNESS TRAJECTORY of a patient with cancer, clinical oncology nurses support and guide patients and their caregivers by encouraging open dialogue and using effective communication skills. For nurse, patient, and caregiver conversations about palliative care and end-of-life decisions, nurses can apply advanced communication skills, addressing illness complexities, patients' and caregivers' stresses, and patients' life review with existential insights (Kwame & Petrucka, 2021; Moore et al., 2018; Wittenberg et al., 2018).

By example from the following case studies and accompanying scenarios and responses, three expert clinical oncology nurses applied their seasoned communication competencies to real-world palliative care-focused conversations (Brown et al., 2010). The case studies that follow include having conversations with patients about advance directives, relaying emotionally packed information to family members, and managing conflict among family members about treatment decisions.

In addition, in Figures 1–5, communication skills applied to palliative care-focused conversation scenarios include the following situations: how to provide clinical care when a patient's caregivers are anxious, how to handle patient questions about prognosis, what to do when a nurse disagrees with a physician-established plan of care, when and how to introduce the concept of palliative care to a patient and caregivers, and when and how to discuss hospice with a patient and caregivers.

As best practices supporting difficult and often intimate conversations, the case studies and accompanying brief scenario conversations in this article illustrate how a clinical oncology nurse can initiate and continue conversations with patients and their caregivers about palliative care and end-of-life transitions and decision-making (Berg et al., 2021; Wittenberg et al., 2018). It is worth noting that nurses may have different ways of initiating or continuing ongoing conversations; all of these have merit and can be effective.

Based on the communication skills highlighted in Figure 6 and palliative care conversation resources (see Figure 7), the content of this article contributes to a scholarly based clinical foundation about palliative care-focused conversations. In addition, these case studies and scenario responses can serve as an initial guide for clinical nurses new to clinical oncology practice, as well as for veteran clinical oncology nurses who seek to refine their communication skills in the context of palliative care (Berg et al., 2021; Moore et al., 2018).

Case Study 1: Discussion With the Patient About Advance Directives

Kellie Spine, MSN, RN, OCN®

Ms. J is a 45-year-old woman with a history of ovarian cancer. She completed treatment two years ago and was considered to be in complete remission. Since then, she has continued to follow up with her oncologist. She recently started experiencing headaches. She called and notified her oncologist of this new onset of symptoms, and she was scheduled to come in for a clinic visit.

During Ms. J's clinic visit, she was evaluated by her oncologist. No other neurologic abnormalities or signs of recurrence were noted during her assessment. The oncologist ordered MRI of the brain. The MRI revealed a mass, and Ms. J was scheduled back at the clinic to discuss the findings. The oncologist explained to Ms. J that the mass was indicative of an ovarian cancer recurrence with metastasis to the brain.

The oncology nurse, who knows Ms. J well through her initial treatment and follow-up visits, notes that Ms. J does not have

an advance directive in place and wants to discuss this with her during this follow-up visit.

The nurse knows that Ms. J is divorced and has three adult children. During her initial treatment, Ms. J's children were all involved in her care, but the nurse recalls disagreements among the children when it came to decisions about Ms. J's care. The nurse is concerned that with her recurrence, Ms. J could eventually experience mental status changes that would deem her unable to make decisions about her care.

The nurse has worked in oncology for many years and has unfortunately seen too often that discussions about advance directives with a patient do not happen at all or are brought up too late. Although the nurse knows that discussions about advance care planning can feel uncomfortable to initiate, she is aware of the negative impact a delayed or avoided discussion can have, which can be overwhelming for patients and their family members when decisions feel rushed. Therefore, the nurse decides she will initiate the conversation about advance directives at this visit. She knows that all the members of the

FIGURE 1. FAMILY CONFLICT

On an inpatient oncology unit, you are assigned to a patient transitioning to end of life. At the bedside, members of the patient's family are anxious, frequently calling for your assistance for seemingly minor requests (e.g., performing additional vital signs checks, refreshing the patient's water pitcher hourly). You are aware that family members are in conflict with each other—and the patient—about the patient's decision to stop treatment. In behavior and words, family members express anger, dissatisfaction with care, sadness, and despair. Providing primary palliative care to the patient and family, how will you respond—in your words or behavior—to these conflicted family members?

- **KS:** It is key to take the time to seek understanding of the family members' perspectives and feelings. Find out what their understanding is of what the patient's diagnosis and prognosis is. There may be a lack of understanding of how the patient is doing, and they may just need some questions answered. Taking the time to listen and fill in informational gaps can be helpful and increases their trust in you as the nurse. Lastly, try not to take anything personally. Often, the patient and family feel a loss of control, which may be the reason for their demanding behavior, and it is an attempt to maintain some control.
- **ASB:** It is clear that they care deeply about the patient and that they want the best care. I would try to align with them and start by acknowledging the emotion that likely underlies the family members' behaviors. NURSE statements may be a helpful starting place.
 - ☐ Naming: It seems that you are frustrated (or worried, sad, mad, etc.).
 - ☐ Understanding: After they explain the emotion(s), follow with, "This helps me understand . . ."

- ☐ Respecting: "I can see that you really take an active role in her care."
- ☐ Supporting: "I will do my best to make sure she has what she needs now."
- ☐ Exploring: I might try to understand the needs of the family members with a question like, "Can you tell me more about what kind of support you need right now?" I sometimes find that the family members soften when they realize that we care about them.

Also, it seems important to come together as a care team on an approach to caring for this patient and family. It would be helpful to come up with strategies for how to consistently approach daily care and communication. If time and setting allow, I would pursue a formal palliative care consultation because this situation involves complex dynamics.

- **DS:** I would ask to speak in private with the proxy/family in a calm, private area away from the patient. This would give the family member with opposing views the opportunity to speak in private and express their feelings without the patient hearing or feeling the conflict. I would speak to the family and explain that even if not conscious, the patient may still hear and caution them against having these conflicts in front of the patient. I would reiterate the plan of care and how it is being tailored to the patient's final wishes based on the patient's choices and advance directive. I would also describe, in more detail, what palliative/hospice care means to the family member. I would explain that taking vital signs or giving medications based on the vital signs results would be more uncomfortable for the patient at this time.

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healthcare team play a vital role in discussing goals of care but feels that she has the knowledge and a good rapport with the

FIGURE 2. WHEN WILL I KNOW?

On an inpatient oncology care unit, you are caring for a patient diagnosed with advanced pancreatic cancer who has completed 3 courses of an adjuvant gemcitabine-based chemotherapy protocol. You know this patient from previous admissions; for this admission, she is being treated for fever and dehydration. Compared to yesterday, today she appears more cachectic, fatigued, and in pain. When assisting her with her morning hygiene, the patient casually asks you, "How will I know when it is time for hospice?" "How long do I have to live?" or "What would you do?" How would you respond to any one (or more) of her questions?

- **KS:** First, I would ask the patient what she knows about hospice care, ensure that her understanding of it is accurate, and clarify any questions she has about it. Then, I would discuss with the patient how she feels most days. Obviously, the patient is in the hospital for disease or treatment complications, so at this point, she is not feeling her best. I would explain to the patient that her decision is ultimately the right decision, and I would encourage her to base her decision on how completing treatment versus opting for hospice care would affect her quality of life.
- **ASB:** "How will I know when it is time for hospice?" I would say something like, "That is such an important question. What have you understood from talking to the physicians and care team?" Based on the patient's response, I would probably ask more about her goals. I tend to use phrases like, "What are your hopes?" or "What is important to you right now?" If patients are not sure how to answer, I ask about where they want to be, who they want with them, and what their hopes are for managing symptoms. When I understand the patient's goals, I ask if I can offer a recommendation that seems to fit [their] framework and goals. The recommendation may be hospice, but it also may be an alternative to hospice, like palliative care with ongoing treatment.
- **DS:** A palliative care consultation could be a great resource to help with symptom management and provide better quality of life. The team can help guide you in decision-making surrounding your care and specific healthcare choices that you would like addressed. Hospice is linked to palliative care, and the need for consultation can be appropriately assessed and discussed with yourself, the team, and your family. Some symptoms you may experience during the transition to hospice care can be decreased desire to eat, increased amounts of sleeping, and not having the desire to get out of bed for daily living tasks. Hospice care can help to ease your way by making you more comfortable through symptom management, providing emotional support for you and your family during this time.

ASB—Anne Skwira-Brown, APRN, AOCNP®; DS—Deanna Schlifke, BSN, RN, OCN®; KS—Kellie Spine, MSN, RN, OCN®

patient to be able to effectively start the conversation (LeBlanc & Tulskey, 2022).

The nurse will use the PAUSE method to help her in discussing the topic of advance directives with Ms. J as follows (VitalTalk, n.d.):

- P: Pause
- A: Ask
- U: Understand
- S: Suggest
- E: Expect

The nurse asks Ms. J how she is feeling hearing about her cancer returning. The nurse offers to answer any questions she has right now and asks if Ms. J needs any support in sharing the news with her children; the nurse offers to talk with any of her children to explain what her treatment plan going forward will look like. Ms. J tells the nurse that she first will talk to her children but that they will likely have more questions; Ms. J would like to give them the nurse's contact information to better explain the plan of care. Ms. J states that because there are three children, she will have her oldest daughter, Susan, be the contact person so the nurse does not have to discuss the same information with each of them individually.

The nurse says to Ms. J, "Because you mentioned Susan as the point of contact and we are going to be coming up with a plan of care for your recurrence, I wanted to take some time during your visit today to ask if you have thought about who you would want to make medical decisions for you, if for some reason you were not able to. Discussing this topic is something we like to do with all of our patients with a new diagnosis, and with brain involvement, there is a possibility you could become confused. Would you want Susan to be that person?" The nurse knows that normalizing the discussion will make opening up this discussion easier.

Ms. J pauses for a few seconds and says she is not sure. The nurse continues, "Having an advance directive is a way to ensure that your wishes related to your care are carried out. Have you heard of an advance directive?" Ms. J says she is not familiar with advance directives. The nurse goes on to explain to her that when someone does not have an advance directive, healthcare decisions fall on the next of kin, which in Ms. J's situation would be her children. Because there are multiple children, ideally they can reach a consensus, but if they are not able to, decisions would be based on the majority of her children. The nurse explains to Ms. J that it can be very difficult for families to agree, which may cause delays in care and conflict among family members.

The nurse says to Ms. J, "There are different types of advance directives, but they commonly include a living will, which indicates your wishes regarding your medical care, such as whether you want to receive life-prolonging measures, artificial nutrition/hydration, or cardiopulmonary resuscitation, or donate organs. A power of attorney identifies the person you want to make medical decisions for you, should you be unable to."

Ms. J expresses she does not want the potential burden of her medical decisions to fall on her children and requests more information on how to initiate an advance directive. Ms. J says, “I am not ready to make any decisions today, but I appreciate you bringing up the conversation because it is not something I had thought about before.” The nurse responds, “I understand that there is a lot to think about and you will need more time and information.”

The nurse prints out a handout that her facility compiled with resources and information on advance directives for Ms. J. Included on the handout is contact information for a social worker who could help facilitate completing an advance directive as well as how to access advance care planning documents to complete, which are available online for each state (CaringInfo, 2022). The nurse also explains to Ms. J that the facility has a palliative care team that can be consulted to help clarify goals of care. The nurse provides a brochure about the palliative care team that outlines the members of the team, including a physician, nurse practitioner, chaplain, social worker, and psychiatrist.

Kellie Spine, MSN, RN, OCN®, is an inpatient oncology nurse educator at the University of Louisville Hospital in Kentucky. Spine can be reached at kellie.spine@uoflhealth.org, with copy to CJONEditor@ons.org. (Submitted June 2022. Accepted August 22, 2022.)

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Case Study 2: How Am I Going to Tell My Kids That I Am Dying?

Anne Skwira-Brown, APRN, AOCNP®

Mary is a 63-year-old bookkeeper who underwent surgery and chemotherapy for colon cancer. Treatment-related neuropathy and fatigue complicated her ability to continue working. She was in the midst of filing for disability when she developed pain, nausea, and weight loss. A computed tomography scan showed ascites and liver metastases. After recovering from a paracentesis and inpatient management of nausea and vomiting, she returns to see the medical oncology team with her three adult children to discuss a return to chemotherapy. “She’s a fighter,” they agree as they consider her past cancer treatments and her life as a single mother. After her family members leave the room, the RN, Ella, returns with printed information about the new chemotherapy regimen. Mary looks sadly at the RN and asks, “How am I going to tell my kids that I am dying?”

Although this question sounds cognitive, it is filled with underlying emotion. Ella is alarmed by the question. She sets the patient education materials aside, pulls up a chair, and

makes visual contact with Mary. An important starting point for serious illness conversations is to align with the patient by

FIGURE 3. ON THE SAME PAGE

Your patient with advanced breast cancer (hormone receptor–positive, human epidermal growth factor receptor 2–negative) is now enrolled in a stage II clinical trial (chemotherapy/targeted therapy). At this stage of her disease, with her not responding to treatment, you believe she would benefit from a palliative care consultation. However, her oncologist disagrees and does not want her to have a palliative care consultation yet. As the patient’s longtime oncology nurse who sees the patient in the outpatient clinic, what can you do to move palliative care and end-of-life conversations forward and be on the same page as the oncologist managing the patient’s care?

- **KS:** As the nurse, you can advocate for your patient by having open conversations with the patient, family, and oncologist. Discuss goals of care with all. If the patient’s goals do not align with the treatment plan, then the nurse should attempt to facilitate a goals-of-care discussion among the oncologist, patient, and family, and continue to advocate for a palliative consultation if that is more in line with the patient’s wants. As a nurse, you can discuss the role of palliative care and encourage the patient to open a discussion about it with the provider.
- **ASB:** One potential strategy could be to work with the oncologist to identify the needs of this particular patient. The nurse can add to the list of the needs that the oncologist compiles by including the other care needs that they see. For example, the oncology nurse may identify symptoms that are not well managed or social and emotional issues. If the nurse and oncologist can come to agreement on a list of issues and how they affect the care of this patient, it may provide insight as to where palliative care can provide assistance to fill the gaps. There are palliative care program marketing and program-building resources on the Center to Advance Palliative Care website (www.capc.org) that may help, too. However, attempts to ease resistance to referrals may benefit from building consensus on what care issues exist for patients and then working on how best to address them.
- **DS:** Nurses are often the first to hear about a patient’s true conflicting feelings surrounding their plan of care; therefore, it is imperative that nurses advocate and communicate these concerns with the providers. It is important to have these difficult conversations to ensure that patients, families, and caregivers are aligned with supporting that individual’s end-of-life healthcare needs and wishes. Our facility’s healthcare ministries provide advanced communication educational training events, classes, and literature in our multimedia libraries through the Institute for Human Caring. This provides a great resource for providers, nurses, patients, families, and caregivers regarding end-of-life discussions to support whole-person care.

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FIGURE 4. DELAYED PALLIATIVE CARE REFERRAL

A patient with advanced glioblastoma has been admitted to your inpatient unit for end-of-life care. Because the patient's disease has progressed so rapidly, there was no time to schedule a palliative care or hospice consultation. Of course, you will provide excellent end-of-life care for the patient and family. However, it frustrates you that—yet again—a patient and family were not immediately referred to palliative care when the patient was diagnosed. Moving forward with your clinical practice, how can you work collaboratively to initiate palliative care so it is not too late to benefit the patient and family?

- **KS:** Building relationships with the oncologists and providers you work with is so important, and having continued conversations with them regarding their perspectives on palliative care can be helpful. If your oncologist knows and trusts you, they will be more willing to hear you out when you think palliative care would benefit the patient. Work with your leadership and peers on how to normalize discussions about palliative care with patients and families. Also, remember that you can advocate for palliative care without having a formal palliative consultation. You can advocate for better symptom management and medication changes, as well as discuss goals of care and educate the patient about advance directives.
- **ASB:** It may help to work with nursing and physician leadership to review some of the Center to Advance Palliative Care resources available (www.capc.org). In particular, the Center to Advance Palliative Care has resources for identifying triggers for referral to palliative care. In the meantime, I would also work to equip staff with knowledge about how to talk about palliative care. Again, the Center to Advance Palliative Care provides resources on messaging about palliative care and the research that has shown that the public wants “an extra layer of support that improves their quality of life while they are receiving all other treatments for their disease. They also want a specialized team that works together with their other doctors” (<https://bit.ly/3TH4BGX>). As the team grows in its awareness about how to talk about palliative care, the team creates momentum and builds stories of success that can be shared.
- **DS:** I would start my conversation with asking the patient and family about their perception of their diagnosis and if they understand that their condition is not curable. I would ask the patient and family what their hopes for the future are. I would ask about their goals of care and how we can provide an additional layer of support for them during this time. I would let them know we will continue to do everything we can to make them comfortable. I would explain that there are numerous members of the hospice care team (e.g., RN, physician, chaplain, social worker, home health aides, bereavement counselors, complementary therapy). The families are also provided with emotional support and resources during this time.

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acknowledging the emotions first (Center to Advance Palliative Care [CAPC], 2019a). Not certain what to say next, Ella pauses. Although silence can seem awkward, it can provide a moment for the nurse and the patient to gather their thoughts.

In this situation, Ella remembers the following NURSE acronym (VitalTalk, 2019) and starts with naming and exploring:

- **N:** Naming
- **U:** Understanding
- **R:** Respecting
- **S:** Supporting
- **E:** Exploring

The patient's question is intimidating; however, a desire to be empathetic yields the following simple statement: “That sounds like a really hard thing to be thinking about.” Instead of telling a patient how she feels, Ella floats a hypothesis (VitalTalk, 2019) as follows: “You seem sad.” Pause. “And maybe scared?”

Ella does not have to be correct about the emotion but can remain open when asking questions or making statements. For example, dismissive statements such as, “You do not have to worry about that now,” or opinions such as, “Your children do not seem ready to hear negative information right now,” are not helpful. Just as importantly, after making an empathetic statement, it is important to pause, wait, and listen. A pause may be the most important way to follow an empathetic statement so that the patient has time to hear it, respond to it, and benefit from the conversation (Sheehan, 2018).

Mary cries and describes fear and anger about cancer recurrence. She feels weak, tired, and sick so that she cannot possibly “fight.” The question, “How will I tell my children?” is an emotional cue that belies her underlying worries. A gentle inquiry such as, “Tell me your concerns about talking to them,” can help the patient explore her feelings and can help the nurse to understand the patient's perception of family coping before offering advice (CAPC, 2019b). Through her tears, Mary admits that she feels guilty that she will no longer be able to protect and provide for them. In addition, she is heartbroken that she will not be able to see her grandchildren as they grow.

At that point, the initial conversation ended. The patient felt heard and supported. Ella and her team worked to become a trusted source of information and support. At a subsequent visit, the nurse practitioner asks the patient for permission, as follows: “So that we are all on the same page, would it be OK to ask some more questions about your children's understanding of your illness?” Mary admits that she has sheltered them from bad news because they seem to get mad, stop listening, and say that she is giving up. She explains that she is not afraid of dying because of her strong faith.

Mary does not want to have a formal meeting with her children because it seems too stressful. The nurse practitioner encourages her to consider other ways that she can talk to each of them on an individual basis. Helpful phrasing may include the following: “Getting prepared will help you to talk with them. Would you like to talk about how to do that?” (CAPC, 2019a). Initially, Mary does

not want to talk about death directly, but she is willing to talk to her children about working out ways to prepare for the worst-case scenario of getting sicker.

Over time, Mary shifts the notion of fighting not to mean battling the cancer but instead to mean fighting for her kids. The family discusses a plan for where she will move when she gets sicker and how they will manage some of the financial issues. Although her children do not share similar views about faith and prayer, Mary talks about the confidence and peace that her faith provides her. They begin to acknowledge how it gives her strength and courage as she faces the worst-case scenario.

Nurses can expect to be caught off guard by surprising or hard questions from patients and caregivers. Instead of an immediate attempt to find a right answer, this case study emphasizes the power of pausing and finding a way to make empathic statements.

FIGURE 5. THE HOSPICE CONVERSATION

As an experienced clinical oncology nurse, you have no problem discussing the concept of hospice care with your patients. However, you sense that some of your patients are reluctant to have that conversation. For those patients (and family members), do you wait for the patient or family member to ask you about hospice care, or do you initiate the conversation? If you start the conversation, how do you approach the subject with patients and family members?

- **KS:** I do not think there is a right way to bring up the conversation. It is dependent on your comfort level, your relationship with the patient, and where they are in their cancer journey. The more you talk with your patient about their treatment plan and goals of care, the more likely an opportunity to open up the discussion in a more organic way will occur. In addition, look for ways to incorporate this discussion into your regular tasks. For example, often admission histories will ask if the patient has an advance directive or living will. This may be a good way to start a conversation or at least mention or provide education about advance care planning.
- **ASB:** Over time, I have shifted in how often I initiate the conversation about hospice and how I talk about it. I used to start by talking about the range of treatments that are available for cancer, on a continuum that includes hospice. Talking about hospice as a form of treatment and introducing the term early can be helpful. I still sometimes ask patients if they are familiar with hospice; it seems important to clarify misperceptions and describe it calmly and encouragingly. Now, as I see clinical status change over time, I tend to start the conversation by talking about what patients see as their hopes and worries. In that way, I can better understand how to sort out what they see as priorities and how to use language that seems to fit their framework. Patients often say that they want to feel better and live longer, but it is valuable to help start and continue a conversation about what they mean by feeling better and living longer.

ASB—Anne Skwira-Brown, APRN, AOCNP®; KS—Kellie Spine, MSN, RN, OCN®

IMPLICATIONS FOR PRACTICE

- Build effective communication competencies over time.
- Apply well-honed listening and communication skills to palliative care-focused conversations.
- Establish your own approach to initiate or continue palliative care conversations with patients and caregivers.

Patients often need a chance to reflect on how they are feeling or how they may resolve difficult health issues. Using tools, such as the NURSE acronym, can provide reminders to nurses (those new to practice or those with many years of experience) of the types of statements that can help respond to emotions (VitalTalk, 2019).

Anne Skwira-Brown, APRN, AOCNP®, is a nurse practitioner at Essentia Health Duluth Clinic in Minnesota. Skwira-Brown can be reached at anne.skwira-brown@essentiahealth.org, with copy to CJONEditor@ons.org. (Submitted June 2022. Accepted August 22, 2022.)

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Case Study 3: Patient and Family in Conflict to Continue Treatment

Deanna Schlifke, BSN, RN, OCN®

J.M. is a 91-year-old man with a history of benign prostatic hyperplasia, renal insufficiency, gross hematuria, and recurrent urinary tract infections. J.M. has a past medical history of congestive heart failure, coronary artery disease, and cardiac catheterizations. J.M. is a retired real estate agent and lives at his beach home with his wife and grown daughter.

Secondary to his multiple episodes of gross hematuria and urinary tract infections, J.M. had a cystoscopy, which revealed a bladder tumor; in 2020, he underwent a transurethral resection of the bladder tumor. From pathology evaluation of the tumor, J.M. was diagnosed with muscle-invasive squamous cell carcinoma of the bladder. Many complications arose after this diagnosis. He experienced a cerebrovascular accident on holding his anticoagulation medication for his upcoming bladder procedure, which required hospitalization. J.M. was treated with radiation therapy in combination with IV 5-fluorouracil/mitomycin C and pembrolizumab. Despite completion of treatment, in May 2021, J.M.'s chest computed tomography scan revealed large amounts of pulmonary metastasis. J.M. started on an IV antibody-drug conjugate, enfortumab vedotin, and completed four cycles with a significant decrease in his pulmonary metastasis. J.M. was recently hospitalized for recurrent hematuria and gastrointestinal bleed and had a Watchman left atrial appendage closure device placement and transcatheter aortic valve replacement. During this admission, J.M. was given multiple blood transfusions.

J.M. continues to follow through with his appointments and treatments, but he expresses to the nurses that he is extremely

fatigued and that he just wants to relax and spend as much time with his family as he can. He explains to the nurse that he feels that all these nonstop appointments, tests, and treatments are not the way he would like to spend the last chapter of his life. However, he feels that he will be letting down his wife and daughter if he does not continue with the chemotherapy treatments.

J.M.'s daughter, Karen, is a nurse practitioner, and she would like to continue her father's chemotherapy treatment despite the decline in health status. Karen has arranged for a caregiver to come to the home for 24-hour care for her older adult mother and father. The caregiver takes J.M. to and from his appointments, tests, and treatments, because often Karen is working or home with her mother. Karen is single and does not have any children. Because of J.M.'s current plan of care, many nurses caring for him were feeling a sense of moral distress and had reservations about initiating difficult conversations with the family. Because of these clinical staff reservations, the RN and oncologist have a conversation and discuss the need to set up a meeting with J.M. and his family. In preparing for this meeting, the oncologist refers to the Institute for Human Caring (2017) and follows the Serious Illness Conversation Guide.

A meeting is set up for the following afternoon with the oncologist, RN, social worker, patient, wife, and daughter. The Serious Illness Conversation Guide is used as a tool to assist in starting the crucial conversation with the patient and family.

When the physician asks J.M. about his understanding of his illness, the patient explains that he is "tired and approaching the finish line." J.M. states that his most important goals in his plan

“Being comfortable with initiating crucial conversations comes with skills, patience, practice, and experience.”

of care are to spend time at home with his wife and daughter, rather than continuing with his chemotherapy appointments that are only, in his view, “wasting valuable time.”

Karen and J.M.'s wife are engaged in the conversation. Karen expresses that she is apologetic for failing to consider her father's true feelings. She states that she is surprised with herself for not beginning these important conversations with her father at the time of his diagnosis, particularly because she is a healthcare professional.

Avoiding these emotionally intense conversations in the beginning may appear to help one cope, but this could lead to moral dilemmas if palliative and end-of-life discussions have not begun, particularly when urgent decisions are necessary. Moral or ethical dilemmas can result in an unpleasant problem or situation for one in not knowing what to do or if they made a right choice. J.M. was placed on palliative care, discontinued his chemotherapy treatments, and is relieved to be spending time at home with his family.

FIGURE 6.

COMMUNICATION SKILLS AND SKILL SETS APPLIED TO PALLIATIVE CARE-FOCUSED CONVERSATIONS

- Invite, negotiate, and establish an agenda with specific agenda items and, when appropriate, next steps.
- Check in about the patient's understanding, medical knowledge, and preferences for information.
- Establish an open environment for the patient and caregivers to ask questions and process responses; clarify and restate questions and responses.
- Ensure empathy and willingness to help.
- Acknowledge, normalize, and validate responses.
- Encourage expression of feelings and emotions.
- Praise patient efforts to talk, process, clarify, and cope.
- Organize and summarize information.
- Support shared decision-making and patient preferences.

Note. Based on information from Brown et al., 2010; Kwame & Petrucka, 2021; Moore et al., 2018.

Deanna Schlifke, BSN, RN, OCN®, is a nurse manager in the Cancer Center, Breast Center, and Infusion Center at Providence Saint John's Health Center in Santa Monica, CA. Schlifke can be reached at deanna.schlifke@providence.org, with copy to CJONEditor@ons.org. (Submitted June 2022. Accepted August 22, 2022.)

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Implications for Nursing

Toward providing patient- and family-centered care and improving the patient experience, oncology nursing care includes addressing the patient's physical needs, providing psychosocial support, and connecting with patients and caregivers on a relationship-based, emotional level. In addition, based on an evolving or established relationship with a patient and their caregivers, the oncology nurse can serve as a trusted source of information and a guide to problem-solving and decision-making.

Integrated into all stages of the patient's treatment and care, oncology nurses have opportunities to interact in ways that help promote understanding of treatment or no-treatment options and decisions about care. Issues related to goals of care may be particularly difficult to work through as patients near the end of life.

By building and refining communication skills, nurses can interact with and support patients and caregivers, clarifying the plan of care and encouraging a productive decision-making process. As members of interprofessional care teams, nurses can be mindful of previous patient-provider conversations,

being congruent with the patient's care plan. For example, in conversation with the patient, nurses can provide consistent prognostic information to the patient and caregivers, complementing previous conversations they had with members of the interprofessional care team, particularly physicians and advanced practice providers.

As illustrated by the case studies and scenarios in this article, nurses are advised that it takes time to build communication skills to apply to palliative care-focused conversations. Many situations involving palliative care conversations can occur on a

FIGURE 7.
RESOURCES FOR PALLIATIVE CARE AND END-OF-LIFE CONVERSATIONS, ADVANCE DIRECTIVES, AND LIVING WILLS

AMERICAN HOSPITAL ASSOCIATION

Put It in Writing

■ <https://bit.ly/3eYpYEQ>

AMERICAN MEDICAL ASSOCIATION

Tool Helps Patients Discuss End-of-Life Decisions With Physician

■ <https://bit.ly/3DeDnI7>

AMERICAN NURSES ASSOCIATION

Nurses' Roles and Responsibilities in Providing Care and Support at the End of Life

■ <https://bit.ly/3THgs7M>

ANNALS OF INTERNAL MEDICINE

Decision Aids for Advance Care Planning: An Overview of the State of the Science

■ <https://bit.ly/3N6C0s1>

CENTER TO ADVANCE PALLIATIVE CARE

■ www.capc.org

CLINICAL JOURNAL OF ONCOLOGY NURSING

Mobilizing Advanced Practice Providers to Enhance Patient Care

■ <https://bit.ly/3f6eS0q>

FORMSBUILD.R

■ www.formsbuidr.com

INSTITUTE FOR HEALTHCARE IMPROVEMENT

The Conversation Project

■ <https://theconversationproject.org>

JAMA INTERNAL MEDICINE

Communication About Serious Illness Care Goals

■ <https://bit.ly/3Sz0awD>

JOURNAL FOR NURSE PRACTITIONERS

Medicare Payment: Advanced Care Planning

■ <https://bit.ly/3N3L7tw>

JOURNAL OF ONCOLOGY PRACTICE

Implementation of Advance Care Planning in Oncology: A Review of the Literature

■ <https://bit.ly/3N1WUc0>

NATIONAL INSTITUTE OF NURSING RESEARCH

Palliative Care: Conversations Matter

■ <https://bit.ly/3DeNvKM>

NATIONAL INSTITUTE ON AGING

Advance Care Planning: Health Care Directives

■ <https://bit.ly/3z9rVor>

NATIONAL POLST

Advance Directives

■ <https://bit.ly/3DvmPWf>

NURSING OUTLOOK

Policy Brief: The Institute of Medicine Report Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life

■ <https://bit.ly/3D3FPtD>

PALLIATIVE MEDICINE

Advance Care Planning, Palliative Care, and End-of-Life Care Interventions for Homeless People: A Systematic Review

■ <https://bit.ly/3gGOxWZ>

VITALTALK

■ www.vitaltalk.org

regular basis, but not every issue needs to be addressed directly or immediately.

Toward building and refining communication skills to call on during intimate, difficult conversations, nurses can model their own approach to conversations by incorporating behavior and language used by clinical nurse experts and members of palliative care teams. Nurses can also further their competencies by accessing pertinent resources (e.g., communication skills, advance directives, POLST, living wills).

Conclusion

This compilation of case studies and scenarios provides examples of how expert clinical oncology nurses approach palliative care and end-of-life conversations focused on transitions and decision-making. As evident by the breadth of approaches, clinical oncology nurses individualize and differentiate their methods of conversation, depending on the patient's situation, the topic of conversation, and the patient's and caregiver's responses. There are different ways to initiate and continue these crucial conversations.

Over time as a competency of providing palliative care, clinical oncology nurses can build and advance these communication skills so they are timely and effective, supporting patients and their goals of care. Being comfortable and confident with initiating crucial conversations comes with skills, patience, practice, and experience. Supporting a foundation of communication competency, nurses can access palliative care resources, including mentoring by expert interprofessional practitioners from palliative care teams.

Ellen Carr, PhD, RN, AOCN®, is the editor of the *Clinical Journal of Oncology Nursing* at the Oncology Nursing Society in Pittsburgh, PA. Carr can be reached at CJONEditor@ons.org. (Submitted March 2022. Accepted May 17, 2022.)

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Journal club programs can help to increase your ability to evaluate the literature and translate those research findings to clinical practice, education, administration, and research. Use the following questions to start the discussion at your next journal club meeting.

- Respecting patient confidentiality, what was a palliative care (PC)/end-of-life (EOL) transition scenario from your own clinical practice, when you initiated or continued a conversation? What was effective—or not effective—about your conversation with the patient and/or caregivers? From that experience, what have you incorporated in your approach to PC/EOL transition conversations?
- From your nurse colleagues in clinical practice, who do you try to emulate, mirroring their approach to initiate conversations with patients and caregivers about PC/EOL transitions? What is their approach? Visit <http://bit.ly/1vUqbVj> for details on creating and participating in a journal club. Photocopying of this article for discussion purposes is permitted.