

JOURNAL CLUB

Family Perspectives on Communication With Healthcare Providers During End-of-Life Cancer Care

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This article has been chosen as being particularly suitable for reading and discussion in a Journal Club format. The following questions are posed to stimulate thoughtful critique and exchange of opinions, possibly leading to changes on your unit. Formulate your answers as you read the article. Photocopying of this article for group discussion purposes is permitted.

1. This article presents the results of a qualitative research study. How can we assess the level of evidence that is presented?
2. How similar is our patient and family population to the participants in the study?
3. What are the four major themes identified by the participants in the study? How well do the themes represent the types of emotions that might be expressed by family members of the patients for whom we care?
4. How well or often do we offer families the types of interventions recommended in Figure 1? Where can we improve?
5. What strategies can we use to address the issues involved in family communication that were identified in the study?

At the end of the session, take time to recap the discussion and make plans to follow through with suggested strategies.

Purpose/Objectives: To assess healthcare provider communication about end-of-life (EOL) and hospice care with patients with terminal cancer and their families, from the perspective of the family members.

Design: Exploratory, qualitative study using focus group discussion.

Setting: University of Maryland Greenebaum Cancer Center.

Sample: 24 spouses and first-degree relatives of deceased patients with cancer who had been treated at the cancer center from 2000–2002.

Methods: Family members participated in one of two focus group discussions and completed a short questionnaire regarding their sociodemographic characteristics and the type of EOL care their deceased relatives had received. Quantitative data were analyzed using descriptive statistics. Qualitative data were audiotaped and analyzed by comparing, contrasting, and summarizing content themes from the focus groups using NUD*IST 5(N5) software.

Main Research Variables: Family perceptions of communication with the healthcare team in EOL cancer care.

Findings: Participants associated the information, content, style, language, and timing of communication about EOL and hospice care from healthcare professionals with patient age, attitudes, and compliance with medical decisions. Informed decisions about EOL care by patients and their family members, including the use of hospice services, appeared to be compromised by these types of communication biases.

Conclusions: Satisfaction with EOL care was associated with the perceived quality of communication among patients, family members, and the healthcare team.

Implications for Nursing: Study findings highlight the importance of training healthcare professionals in the content, timing, and potential biases associated with information delivery to facilitate informed decisions about EOL and hospice care to dying patients and their families.

Key Points . . .

- Communication about hospice and end-of-life (EOL) care can be less than optimal, leaving patients and their families struggling to get the information they need to make informed decisions.
- Families stress the importance of receiving timely and accurate information about EOL care options to assist in making informed decisions and obtaining the best quality of care for patients.
- The training of healthcare professionals in the content, timing, and potential biases associated with information delivery about EOL and hospice care can promote a peaceful transition for dying patients and their families.

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Chronically ill and dying patients often encounter difficulty in dealing with the healthcare system, compromising their physical, emotional, and spiritual integrity toward the end of life (EOL) (“A Controlled Trial,” 1995; Mills, Davies, & Macrae, 1994). When delivered effectively, EOL care honors patients’ wishes as much as possible; facilitates communication among patients, relatives, and caregivers; and addresses problems with financial coverage for medical services. It minimizes the stigma associated with pursuing or refusing treatment options, attends to the needs of patients and their families with sensitivity to cultural differences, and offers available supportive services, including hospice care. Communication about EOL care by healthcare professionals, including the guidelines they recommend to patients with cancer and their families for making informed decisions about hospice care, has received limited attention in the healthcare communications literature.

In this article, the described study addressed the gap in the literature and investigated communication at EOL from the perspectives of family members of patients who recently died from cancer. The study’s researchers assessed the experiences, attitudes, and beliefs of family members about the care their loved ones received. Specifically, the researchers inquired about the information and support the families received from healthcare professionals who cared for their family members; the language, timeliness, and sensitivity of communication regarding treatment decisions and terminal illness; and communication about EOL and hospice care to help them make informed decisions.

Literature Review

Making Informed Decisions About End-of-Life Care

Communication among healthcare professionals, the patients in their care, and patients’ family members may serve to promote or impede the process of making informed decisions about EOL and hospice care. Von Gunten, Ferris, and Emanuel (2000) developed a seven-step approach to help physicians structure their communication about EOL care that emphasized assessing the medical knowledge and capacity of patients and family members, delivering information in a sensitive but straightforward manner, and establishing an overall plan of care, including goals for care and treatment priorities. Briss et al. (2004) assembled guidelines to assist healthcare professionals in promoting informed patient decisions about cancer screening. The guidelines are relevant for assisting patients with cancer and their families make informed decisions about EOL and hospice care. The key activities for supporting informed decisions are (a) promoting understanding of EOL and hospice care, (b) facilitating participation in decision making about EOL and hospice care at a level that is comfortable for patients and their families, and (c) encouraging patients and their families to make decisions that are consistent with their values and preferences. Translating the guidelines into clinical practice can be a difficult and time-consuming process. Currently, communication about hospice and EOL care appears less than optimal, leaving vulnerable patients with cancer and their families to struggle with the process of getting the information that they need to make informed decisions.

Barriers to Making Decisions About Hospice Care

Obstacles to discussions that support informed decisions about hospice care abound from patients as well as providers.

Physicians and nurses may be uncomfortable discussing EOL topics or believe that it is not their responsibility (Edwards, 2005; Schulman-Green, McCorkle, Cherlin, Johnson-Hurzel, & Bradley, 2005). They may want patients and their families to maintain hope as long as possible. Patients and their families may be unwilling to accept the prognosis and terminal status, actively avoiding referral to hospice care. Whatever the reason, one of the main outcomes of limiting discussions about patient prognosis and options for care may be to delay the access to and benefit from timely hospice services (Hofmann et al., 1997).

Timely hospice care enables individuals to experience the spectrum of life with all of its emotions, including facing the reality of death (Hines & Peura, 1995). The mission of hospice care is to relieve suffering, enhance psychosocial support, and help patients achieve closure near EOL (Lo, Quill, & Tulsky, 1999). It provides physical, psychological, social, and spiritual care to dying patients, their families, and other loved ones. Typically, a hospice team offers care in patients’ homes, nursing homes, hospitals, or hospice facilities, and a nurse coordinates patients’ care and works with a social worker, chaplain, nurse’s aide, hospice physician, and volunteers to support families in caring (National Center for Health Statistics, 2004). Nurses can play an important role in EOL care, including managing patient physical care and emotional needs and facilitating care services and systems (Volker, Kahn, & Penticuff, 2004).

Hospice care remains underused, even though the quality of care of dying patients is an important priority for healthcare professionals and the American public (Field & Cassel, 1997). According to a 1999 public opinion survey, 80% of respondents did not know what the word hospice meant (Friedman, Harwood, & Shields, 2002). Hospices care for only a small percentage of dying patients with cancer, with an average length of stay of fewer than 30 days (Emanuel, von Gunten, & Ferris, 2000). This suggests that many patients and their family members do not receive education about hospice care as an important option for life-threatening illness prior to making decisions about EOL care.

Methods

A qualitative study design was used to examine communication and decisions about EOL and hospice care from the perspective of spouses and first-degree relatives (i.e., mothers, fathers, sons and daughters, or brothers and sisters) of deceased patients with cancer who had been treated from 2000–2002 at the University of Maryland Greenebaum Cancer Center in Baltimore.

Participants

A list of potential participants was generated from the medical records of 300 patients with cancer who had died from October 2000–August 2002. In the records of the 300 deceased patients, 149 identified spouses or first-degree relatives. Letters describing the study were mailed to those individuals in January 2003. Follow-up telephone calls were made during a three-week period to confirm eligibility and enroll participants.

Procedures

Two, two-hour focus groups were conducted during March 2003 at the University of Maryland Medical Center. Upon arrival at the focus groups, the group leader asked the par-

ticipants to complete a brief, self-administered questionnaire. Subsequently, the leaders facilitated a discussion, following a moderator guide that was designed to allow for the standardization of questions and data collection methods for the two groups. In both groups, the same patient vignette (see Inset) was used to open group discussion.

The moderator asked the focus group participants to consider how their personal family experiences compared to the experience of the family portrayed in the vignette. The vignette illustrated how productive communication of treatment options leading to informed decision making about EOL and hospice care can be carried out among a physician, patient, and family member. The vignette was used as a springboard for discussions about the study participants' perceptions of communication issues with the patient described in the vignette, as well as their perceptions and experiences in relation to the EOL care of their loved one. The study protocol was approved by the institutional review board at the School of Medicine in the University of Maryland.

Measurements

At the beginning of the focus group, each participant completed a brief questionnaire that asked where his or her

Patient Vignette Used to Begin Group Discussions

Mrs. Williams is a 70-year-old [African American] woman who was diagnosed with breast cancer two years ago. She received surgery to remove her breast, followed by chemotherapy, but the cancer came back after the treatment and had spread to her liver and lymph nodes. Her oncologist, Dr. Samuels, is well known in his field and is someone Mrs. Williams trusts. After learning about the cancer's spread, Dr. Samuels met with Mrs. Williams and her daughter to discuss further treatment options. He explained that they had given Mrs. Williams very strong treatment and the fact that her cancer came back showed that it was very aggressive. He offered two choices. The first was that they could continue with more chemotherapy—this could give Mrs. Williams maybe another few months of life but would also cause her to feel very sick like she did from the previous chemotherapy (e.g., she would most likely experience nausea, vomiting, and weakness).

The second option was not to give her more chemotherapy but to focus on making her as comfortable as possible by relieving her pain and any other symptoms she might have. One way they could do this was by involving the palliative care team in the hospital. They, like hospice care, treat people who are not expected to survive their disease. A team approach is used to make the person as comfortable as possible, while dealing with his or her medical, emotional, and spiritual needs. Mrs. Williams' daughter asked about other treatment options such as further surgery, but Dr. Samuels explained that the cancer had spread too far to be able to remove surgically and that no treatment was available to cure the disease at this point.

Mrs. Williams asked how hospice worked, and Dr. Samuels explained that hospice care is usually provided in the patient's home with the support of the hospice team, although residential hospices are also available. The team consists of a nurse who coordinates the patient's care and works with a social worker, chaplain, nurse's aide, hospice physician, and volunteers to support the family in caring for Mrs. Williams. Dr. Samuels would continue to oversee Mrs. Williams' care with the help of the hospice team. The focus is on treating any symptoms Mrs. Williams might have by attending to her physical, emotional, and spiritual needs and those of her family members. Both the patient and family are considered the focus of care. The goal is to maximize the quality of Mrs. Williams' remaining life.

relative had received EOL care; the type and duration of any hospice care received; and participant demographic information, including age, gender, ethnicity, education, income, and relationship to the deceased. Questionnaire data were analyzed separately from the focus group data. In the focus groups, participants were asked a series of questions that probed their communication and decision-making experiences with physicians and nurses about the EOL and hospice care of their loved ones.

Data Analysis

Questionnaire data were summarized with descriptive statistics. The focus groups were recorded on audiotape to ensure collection of the entire contents of the discussions. A note taker also participated to provide a backup to the audiotapes. Data were transcribed from the audiotapes, and two types of thematic analyses were conducted to inductively identify emergent themes. First, basic categorical answers to specific inquiries were analyzed. Second, qualitative data analysis addressed the specific research questions and the themes that emerged from participants' perspectives and conclusions. A codebook was constructed, and data were coded by theme and area of inquiry using the NUD*IST 5(N5) data analysis software. At several points in the process, the data and codes were checked for consistency and to maintain objectivity. Data reduction was accomplished through a coding sort using NUD*IST 5(N5) to identify the key concepts in the thematic and inquiry categories. Key concepts were derived from the focus group participant responses to questions posed by the moderator, statements made by the participants about other topics that they introduced, and ongoing dialogue among the participants. Data were analyzed by comparing and contrasting themes within and across the two focus groups. The quotations that appear in this article were selected for their clarity and representation of the final and tested key concepts in the analytical categories.

Results

Questionnaire Data

Telephone recruitment identified that 56 out of 149 telephone numbers had been disconnected or changed to unlisted, 2 potential participants had died, and 14 did not return 8–10 recruitment calls. Of the 77 who were contacted successfully, 24 completed the study, resulting in a 31% response rate. The most common reasons people gave for declining to participate were that they were still in too much pain related to the death or that they lived too far away to attend the focus groups.

Demographic data on the final sample of participants are presented in Table 1. The participants' ages ranged from 26–77 years ($\bar{X} = 57.3$); most were female (79%), Caucasian (71%), and spouses (75%) of a deceased patient; all had graduated from high school; more than half were college graduates; and most earned less than \$35,000 a year.

Table 2 describes the hospice care that participants reported their deceased loved ones had received. Sixteen participants (67%) reported that their relatives received hospice care delivered by a hospice team at EOL, eight in their homes, five in an inpatient hospice, and three in a hospital setting. African American participants more

Table 1. Demographic Characteristics of Family Member Participants

Characteristic	n
Age (years)	
X = 57.3	–
Range = 26–77	–
Gender	
Male	5
Female	19
Race	
African American	7
Caucasian	17
Relationship to patient	
Spouse	18
Other (first-degree relative)	6
Education	
High school diploma	10
Undergraduate degree	3
Graduate degree	11
Income (\$)	
15,000–25,000	6
26,000–35,000	9
≥ 36,000	9

N = 24

frequently reported using inpatient hospice care than did Caucasians (75% versus 24%), who reported more frequent use of in-home hospice care than African Americans (78% versus 22%).

Focus Group Themes

Participants shared their experiences—positive and negative—in the group discussions. Both focus groups reached consensus on the importance of obtaining accurate and timely information about the status of their loved ones and having information conveyed effectively and empathically by medical personnel. The two central factors associated with perceptions of care as positive or negative were access to healthcare professionals and the quality of communication between healthcare professionals and the family.

Communication issues that emerged from the focus group discussion are summarized in Figure 1. Subthemes that emerged within the broad category included difficulties related to (a) access to healthcare professionals; (b) quality of provider communication regarding stage of disease and treatment decisions, as well as language, timeliness, and sensitivity of communication; and (c) communication about hospice care. Additional subthemes were sources of bias in patient-provider communication about EOL care and recommendations for improving communication.

Access to the Healthcare Team and Quality of Provider Communication

Participants believed that having better access to the healthcare professionals involved in their loved one's care contributed to positive experiences, whereas participants who perceived the healthcare team to be less accessible had negative comments. Some participants believed that the staff was too busy to adequately explain their loved one's status or too busy to provide quality care. As a result, some participants questioned the competency of the healthcare team.

I had to be the manager of her care, and you do because you don't have an advocate in the hospital. Doctors are too busy, the nurses are too busy to be an advocate for a particular person, so the caregiver is the advocate and you've got to watch every single thing.

You start feeling like you have to be a nurse of your own to get through the situation. We never saw the doctor, but I guess we saw the resident who had been working 36 hours straight . . . that may be part of the hospital life, but sometimes it's hard, it rubs you a little. You just feel like, "God, am I getting the right care?"

The data suggest that participants who were pleased with their experiences with the EOL care of their family members had better access to the healthcare team. They consistently identified the quality of communication they received as crucial. Accurate information that was communicated clearly to patients and family members was much appreciated. According to one participant, "The staff was excellent. . . . They communicated with me, and if there was something I didn't know, I could call them and they would direct me in the way that I should go, and I thought that was real nice."

Communication About Disease Progression and Available Care Options

Focus group participants repeatedly commented about the need for more information from the healthcare team regarding the stage of disease and treatment decisions. When available, sufficient and accurate information helped them make informed decisions and feel comfortable with their loved one's care, even when the final outcome was death. When information was freely available and compassionately shared, perceptions were more positive.

Everyone that we had to deal with was kind and considerate, and they answered our questions and they helped us to understand what was going on, what his options were.

[My father] didn't complain or ask questions, and it was important for me to get this information or to have the doctors explain everything to him very clearly because he was able to make a decision on his own and I didn't want to have to make a decision for him. When he was informed, and the family members were informed, and

Table 2. Family Member Reports of End-of-Life Care Provided to a Deceased Relative

Characteristics of Care	n
Care received at the end of life (N = 24)	
Hospice	16
Medical care	6
Nursing home care	2
Location where hospice care was received (N = 16)	
At home	8
In a hospice care facility	5
In a hospital	3
Length of hospice care (N = 16)	
Weeks	6
Months	4
Other	2
Missing cases	4

1. Ways to facilitate effective communication practices between the healthcare team and patient or family
 - Patients and families have reasonable access to the healthcare team.
 - Providers give accurate, timely information.
 - Patients and family members feel empowered in making informed decisions.
 - Good communication exists among members of the healthcare team.
2. Barriers to effective communication between the healthcare team and patient or family
 - Disease progression, treatment plan, and medication side effects are explained minimally.
 - Information is provided too late.
 - Information is not accurate.
 - Information about available resources for end-of-life and hospice care is deficient.
3. Patient characteristics that may influence provider communication about end-of-life care
 - Patient's age
 - Patient's attitude
 - Noncompliance with recommended treatment options
4. Recommendations to enhance communication between the healthcare team and patient or family
 - Identify two contact people, one from the hospital staff and one from the family, who will always know the patient's medical status.
 - Develop a question-and-answer sheet for family members to ask questions to which physicians and nurses can respond.
 - Acquaint family members with frequently used medical terminology.

Figure 1. Themes Identified by Family Members in Communication About End-of-Life and Hospice Care

he made the choice, we felt more comfortable as to whatever happens. We were thoroughly informed, and my father chose not to go with the chemotherapy. He decided that he wanted to live his life out the way he wanted to and be in control, so I thought that was very, very good.

Participants who were unhappy with the quality of information they received expressed frustration with healthcare professionals who failed to explain disease progression. The professionals also misinformed the family or failed to provide information about available care options, including hospice care, for their dying loved ones. Often, reactions about EOL care were caused by information that was not known or withheld by healthcare staff.

You don't expect the doctors to play God, but I really think . . . if they don't want to be up-front with the patients, they should at least be up-front with the family members so that the family members can at least be prepared.

The word death was never said. Hospice was never said. Terminal was never said. The only way that I found out that I had days and weeks instead of months was by going on the Internet myself.

I have to say that [the hospital staff] were all very caring, but I felt that we got a lot of conflicting information and they didn't always do what they said they were going to do.

Language, Timeliness, and Sensitivity of Communication

Many participants reported difficulty understanding the information that healthcare professionals provided. In addition, they indicated that such difficulty affected the ability of patients, when possible, or relatives (on behalf of patients) to make EOL decisions. Unfortunately, the language and medical terminology used by healthcare providers sometimes impeded understanding.

I think the medical people assume that we know a lot about these diseases and things, but we don't. . . . And thank God for the Internet, because I went home and I became, not an expert, but knowledgeable of cancer and stage IV. . . . I had all the printouts and everything, but something like that, why do they assume that I know what stage IV cancer is?

Participants reported that time was an important obstacle to effective communication.

I had a complaint, too, about, in fact, one of my very few complaints was getting information results of [computed axial tomography] scans to see whether the treatment was working or wasn't working. I found it very difficult to get a timely output from the oncologists. . . . The difficulty was getting the information in a timely fashion.

Although some focus group participants preferred healthcare professionals to openly communicate information about the stage of disease and treatment decisions, the data indicated that others preferred just the opposite—especially when the information was shared in the presence of the patient. Some participants described experiences in which they felt that healthcare providers used language or shared information that was inappropriate because of its potential impact on the patient.

After it was mentioned that he may have two weeks to live, that's when my husband started saying, "Leave me alone. Let me die in peace." That's when he gave up, and I think those situations should be discussed away from the patient so they can have some hope.

Communication About Hospice Care

The questionnaire data indicated that 16 out of 24 focus group participants reported that their family members received hospice care. The focus group discussions revealed that the option of hospice was not discussed with some participants, who expressed a high level of frustration regarding the oversight. Several participants believed that hospice was a service provided only as a last resort for patients near death or for those with no hope of recovery. Some resisted considering hospice care when information was offered because they associated hospice with death and relinquishing hope.

Although some participants had positive experiences with hospice discussions, others were disappointed. Many believed that the healthcare team should have explained the options more clearly. Several participants faulted healthcare professionals for assuming that they already had adequate information or would be uncomfortable with the topic.

I think there is an assumption made that everybody knows what hospice is. It's not true. [Physicians] assume too

much sometimes. They assume that we don't want to know [about hospice], but some people would rather know because they can prepare far in advance and set things up, just in case.

My only problem with the communication from the physician to us is that they did not give a realistic picture as to what hospice was going to be like.

Sources of Bias in Patient- and Family-Provider Communication

Participants were asked whether they believed that healthcare providers demonstrated any biases or beliefs that affected patient EOL communication. No one reported racial or gender discrimination, although several mentioned possible age biases by healthcare professionals. One man explained that because his dying brother was young and had a close relationship with his healthcare providers, they had difficulty telling the patient that he was close to death. Another participant believed that information to promote informed decision making about hospice care was given only to older patients.

Several other potential biases were identified that did not adhere to any particular pattern. One woman reported that because her husband looked healthy, physicians had difficulty telling him he was close to death. Another participant believed that because her brother decided to forgo life support, his physician communicated differently with him than if he had decided otherwise.

He didn't want to go on life support. Near the end, one of his doctors made a statement, "You don't need to try to do anything else, because he's gonna die anyway," and I thought that was very harsh to say, so I requested another doctor. I didn't want to deal with him anymore.

For two participants, the attitudes or behaviors of their dying family member were believed to influence the communication and quality of care received from healthcare professionals.

There definitely was a bias toward my husband when he was so nasty on that medication. I mean, he was ugly and the nurses weren't very nice to him, but I didn't want to be nice to him either. I mean, he was ugly, but it was the medication.

I know my mom tended to get pretty good care cause she was always very positive, even when she was sick.

Recommendations for Improving Communication

Participants suggested ways to improve communication between family members and the healthcare team. They recommended developing strategies to facilitate the sharing of critical information about the patient's condition such as identifying a family contact person who would be available at all times to receive and communicate to others information from the hospital staff. They emphasized the importance of receiving timely and accurate information about EOL care options to facilitate obtaining the best quality of care for patients and making informed decisions during terminal illness.

Discussion

Optimal use of hospice care was perceived to be compromised by a broad range of communication difficulties in this study.

Satisfaction with EOL care was associated with the judgments that family members made about the quality of communication among patients, themselves, and the healthcare team. This finding is in agreement with several studies in which effective communication among patients, families, and healthcare professionals was presented as the main criterion used by family members for assessing the quality of EOL care (Hanson, Danis, & Garrett, 1997; Wenrich et al., 2001, 2003). In the current study, participants reported concerns about limited access to healthcare professionals who had information about their family members, difficulty with the content of what was communicated to them, and concerns about the style, language, and timing of communication.

Billings and Kolton (1999) found that communication issues, including difficulty in reaching a physician and the quality of received information, were among the most important criticisms given by deceased patients' families that affected their hospital experience. In the present study, some participants preferred healthcare professionals to openly communicate information about the stage of disease and treatment options, whereas others preferred just the opposite, especially when the information was shared in the presence of the patient. Clayton, Butow, and Tattersall (2005) also found that patients and caregivers emphasized the importance of openness and consistency of information given to them but preferred that separate discussions take place with patients and caregivers. The perceived ability of physicians to balance sensitivity and honesty when discussing the prognosis of patients with a terminal illness also was mentioned as a patient concern in a study by Wenrich et al. (2001). In general, the quality of EOL care was viewed as closely related to the perceived quality of communication that patients and family members had with their healthcare professionals.

Efforts to target the special needs of patients with cancer and cultural beliefs of patient groups are important, because communication by physicians, nurses, and other healthcare providers may not be uniform among diverse patient populations. Participants in the current study reported that patients' ages, attitudes, compliance behaviors, and medical decisions appeared to influence healthcare providers' communication with patients and families in making decisions about EOL and hospice care. None of the participants mentioned any racial or gender bias. Perhaps the gender and racial composition of the participants in the focus groups accounted for this finding, because other studies have identified the influence that patient age, gender, diagnosis, sexual orientation, type of illness, and ethnicity can have on healthcare providers' beliefs, communications, and expectations (Hall, Epstein, DeCiantis, & McNeil, 1993; McKinlay, Potter, & Feldman, 1996; Rathore et al., 2000; Royak-Schaler et al., 2002; Schulman et al., 1999; van Ryn & Fu, 2003). The present study's findings highlight the importance of training healthcare professionals in the content, timing, and potential biases associated with information delivery about EOL and hospice care to facilitate informed decisions by dying patients with cancer and their families.

Study Limitations

In the current study, all of the participants were family members of deceased patients with cancer who were treated at one site, which may serve to limit the generalizability of the findings to other settings. Although the sample size was relatively small and consisted largely of female participants

(79%), the representation of African Americans (29%) was significantly greater than that in the general population. In addition, the educational background of the participants (42% high school graduates, 58% college or beyond) was higher than that of the general population. Generalizability also might be affected if the family members who agreed to participate had different feeling (e.g., more pleased or displeased with the care their relative received) than those who declined participation. Finally, eliciting family members' descriptions of their experiences and those of the deceased patients may limit the relevance of the findings for better understanding of the process of promoting informed decision making about EOL care among dying patients. Nonetheless, this study was one of the first to use qualitative methodology to investigate family-physician communication issues among patients with cancer that may be barriers to making informed decisions about EOL and hospice care.

Implications for Nursing

The current study's findings underscore the importance of the quality of communication about EOL care, including hospice care, with terminally ill patients with cancer and their families. They highlight the need for communica-

tion training for nurses, physicians, and multidisciplinary healthcare teams that focuses on maintaining access and addressing the specific concerns of patients and families about EOL care in a timely, straightforward, and sensitive manner. EOL discussions should include early introduction of the option of hospice care and should address related concerns of patients and families. Increased use of hospice care could mitigate unnecessary suffering while maximizing patient autonomy and involvement in decision making. A number of training programs have been developed to improve EOL communication (Emanuel et al., 2000; Faulkner, Webb, & Maguire, 1991; Gallagher, Pantilat, Lo, & Papadakis, 1999; Larson & Tobin, 2000; McCann et al., 1998; Reilly & Ring, 2004; Ross et al., 1999), and the findings of this study suggest that the broader implementation of such training would benefit the family members of dying patients in addition to the patients.

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