Examining the Barriers and Facilitators that Impact Adult End-of-Life Conversations and Decision-Making in Hospital: An Integrative Literature Review

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A Project Submitted in Partial Fulfillment of the Requirements for the Degree of Master of Nursing in the School of Nursing
University of Victoria
Faculty of Human and Social Development
November 25, 2015
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Dedication

*It is not the amount of time you devote, but what you devote to the time that counts.* ~ Anonymous

For my mother, who inspired me to pursue a genuine life full of giving, caring, and love, and is for so many reasons, why I became the nurse I am, this is for you.

For all the patients and families I cared for, cried with, and held while they died. What a beautiful experience, I carry them all with me.

For all health providers, no matter how difficult it is to talk about death and dying we can all contribute to a “good death” where everyone deserves that chance.
Acknowledgements

*Opportunity is missed by most people because it is dressed in overalls and looks like work.*

~Thomas Edison

Many thanks to Rosalie, my brilliant graduate supervisor, who through the past five years has walked me throughout the graduate process and graciously offered her expertise time and time again, keeping me on track, I thank you.

And to Karen, your patience is incredible, I will never forget your kindness.

To my husband Kent, my new lease on life, reason for being, and my biggest fan, I thank you for all your love and support.
Abstract

In acute care, end-of-life (EOL) communication is limited between healthcare providers (HCP)s and recipients suffering progressive, life-limiting-illnesses, who appear to be at the end of their lives. Few researchers have demonstrated how increasingly sicker and aging patients affect the quality of EOL care, or have evaluated the effectiveness of the current EOL care in hospitals. Ineffective communication is a major source of poor, overall EOL experiences. In this integrative literature review (ILR) project, I explore the barriers and/or facilitators in relation to EOL communication, particularly conversations about EOL decision-making, and identify what factors prevent HCPs from engaging in EOL decision-making with patients and families. Communication barriers and facilitators identified in this review include: (a) HCP factors such as intrapersonal and professional issues, ethical and learner factors; (b) interdisciplinary factors such as teamwork, hierarchies, and divergent EOL paradigms; (c) hospital system factors such as policy, education, and resource allocation; and (d) recipient factors such as knowledge, attitudes, age, and illness type. Nurses care for, spend significant amounts of time with patients and their families in acute care, and are well positioned to improve EOL communication practices.
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Discussing end-of-life (EOL) care options with patients and families is complex. Questions about death and dying are highly sensitive subjects where the healthcare provider (HCP) should consider what a patient thinks about their own mortality, or, for the family, the possibility someone close to them might soon die. I experienced the negative consequences, both personally and professionally, of not discussing patients’ wishes prior to implementing invasive life-sustaining care procedures. Interventions performed to save lives can go against the care recipients’ wishes and can be ethically challenging for HCPs. I think HCPs should act professionally and be morally obligated to direct EOL care appropriately.

Palliative care (PC) is not a priority in the current acute care environment (Initiative for a palliative approach in nursing: Evidence and leadership [IPANEL], 2014). Most health professionals worldwide do not understand the principles of palliative care despite a growing body of knowledge on the topic in the past 40 years (World Health Organization [WHO], 2014). HCPs share the responsibility to ease the fears, frustrations, and helplessness experienced by distressed patients and families who face uncertain futures and must make EOL decisions. It is not easy to initiate a conversation about choosing life or death, yet having this discussion is a social obligation and represents a personal offering for those directly affected (Field & Cassell, 1997). How should HCPs approach patients and ask the question: How do you or your loved ones feel about dying? Communication improvements between HCPs and care recipients are needed to assist in determining optimal EOL choices (Fowler & Hammer, 2013; Hartrick Doane, Stajduhar, Causton, Bidgood, & Cox, 2012; Heyland et al., 2010; Reinke, Shannon, Engelberg, Young, & Curtis, 2010; You, Fowler, & Heyland, 2014).

Improvements in EOL communication have the potential to affect the health of a large number of people. The WHO (2014) found that in 2011, 29 million people globally died from
diseases requiring PC, and there are estimates that 19 million adults are now at the EOL and can benefit from specialized EOL care. Dying persons are arguably the most vulnerable patients due to the emotional and physical challenges unique to the dying process (Wilson et al., 2008). The majority of EOL care (70%) is provided in hospitals, and this is where 20 to 50% of Canadians die (Fowler & Hammer, 2013; Stajduhar, 2011). Of these individuals, only 13 to 16% actually receive hospital based PC (Fowler & Hammer, 2013). Greater than 70% of those who die each year are over the age of 65 (Field & Cassell, 1997), and, in Canada, this group is expected to double between 2005 and 2036 (Stajduhar, 2011). Care is becoming more complex within a rapidly aging world population and the demand for EOL care services in acute care is increasing (Anselm et al., 2005; Fowler & Hammer, 2013).

In my project, I examine the literature to uncover what known factors prevent or support EOL discussions between HCPs, patients, and families. My goal is to explore the literature to: (a) uncover the barriers or facilitators in relation to EOL communication, particularly conversations about EOL decision-making; and (b) identify what factors HCPs perceive preventing them from engaging in EOL decision-making with patients and families while shifting the focus from curative to comfort based care. To achieve this, I use Whittemore and Knafl’s (2005) 5-step integrative literature review (ILR) framework. Further, I use a relational inquiry (RI) perspective to navigate and structure my inquiry process and devise recommendations.

In what follows, I provide an extensive review of the background research and detail the important concepts that lay the foundation for my area of interest and the initial search terms in my ILR. I review RI as a theoretical perspective and discuss the role of the HCP (specifically the nurse) in terms of EOL care. I focus on ethics as a priority, because of the HCP’s moral responsibility in supporting EOL care conversations, and because of the emphasis on ethics in
RI. I then explain the ILR process and detail how I follow this method. I reveal my data search and analysis techniques, and explain how my inclusion and exclusion criteria lead to the chosen 13 articles. From the chosen research, I inductively identify pertinent data as barriers and facilitators, and iteratively develop four major themes including HCP factors, interdisciplinary factors, hospital/system factors, and recipient factors, along with 18 subthemes. I then integrate these themes and provide a discussion of these findings from an RI perspective. I discuss limitations of the inquiry process and make fourteen recommendations.

**Background**

Confusion surrounding available EOL care options can negatively affect a patient’s decision-making ability and influence HCPs’ practices. Boyd, Merkh, Rutledge, and Randall (2011) point out that when considering EOL care and communication, it is necessary to have conceptual clarity and define terms. Whittemore and Knafl (2005) suggest that articulating the pertinent terms in an ILR can assist the investigator in defining the variables of interest, and develop inclusion and exclusion criteria to narrow the topic of focus. I identified key, conceptual issues associated with EOL decision-making at both the patient-clinician and HCP-system level, which include goals-of-care, advance directives, PC, life-limiting-illness, and age factors. Additionally, I considered the impact of EOL conversations in the context of active treatments, acute care, nursing care, ethical HCP practices, and examined RI as a theoretical approach.

**End-of-life Decision-making**

EOL decision making is difficult for everyone involved. The overall quality of EOL care directly correlates with effective EOL communication with HCPs (Beckstrand, 2012). In some cases, it is prohibited or discouraged to inform patients of life-threatening diagnoses and prognosis (WHO, 2014). EOL care options that are difficult to understand, or are confusing, can
result in a decrease in quality-of-life, a decrease in overall EOL care experiences, and can result in increased family anxiety and depression (You et al., 2015). A patient’s emotional well-being may deteriorate due to feeling uncertain while living with a life-threatening illness, which further complicates interactions (Strang, Henoch, Danielson, Browall, & Melin-Johansson, 2014). Transitioning from an acute/curative, treatment focused approach, to a focus on comfort, is a difficult phase for patients and families experiencing EOL care (Le & Watt, 2010).

Goals-of-care.

Complex decision-making may be required in the last stage of life. This process often involves implementing, withdrawing, continuing, or withholding care treatments as a way to improve quality-of-life and relieve suffering (Albers, Francke, De Veer, Bilsen, & Onwuteaka-Philipsen, 2014). Identifying goals-of-care is a process that occurs between clinicians and patients (or substitute decision makers) where the aim is to establish a formalized EOL care-plan (including the decisions to use life-sustaining therapies) (You et al., 2015). Furthermore, clinicians provide relevant information about life expectancy, which is required to determine EOL plans (Chang, Datta-Barua, McLaughlin, & Daly, 2014). Ideally, the goals-of-care process should begin before a health crisis (Gutierrez, 2012) and be initiated by the family physician who typically knows the patient well (You et al., 2015). Identifying goals-of-care can assist with decision-making at EOL and are important for consideration when implementing communication improvements.
Advance directives.

Goals-of-care (medical orders for life sustaining treatments) compliment an advance directive\(^1\), and stems from EOL conversations (Beckstrand, Collette, Callister, & Luthy, 2012). While in hospital, HCPs can initiate EOL discussions by asking patients about the presence of an advance directive, which may trigger a discussion about death and dying (Gutierrez, 2012). Unfortunately, 40% of older adults living in the community do not have an advance directive (Kossman, 2014), and, in Canada, these are rarely incorporated into care despite the research indicating the benefits of these conversations (Fowler & Hammer, 2013). Despite efforts to improve EOL care for patients in hospital, ongoing problems with, for instance, resuscitation conversations remain (Brazil et al., 2013). Improving communication skills for all HCPs, in and out of hospital, could normalize death and encourage EOL conversations (Fowler & Hammer, 2013).

Palliative care

“The fields of palliative and end-of-life care are plagued by semantic confusion” (Powers, Norton, Schmitt, Quill, & Metzger, 2011, p. 1).

Palliative care is defined in a variety of ways including care that affirms life and where dying is regarded as a normal process; intends to neither hasten nor postpone death; uses a team approach to address the needs of patients and their families; provides relief from pain, suffering, and other distressing symptoms; integrates psychological and spiritual aspects of patient care to enhance quality of life; and guides patients and families to develop coping strategies during illness and after death (Chan, 2004; Norton et al., 2011; Smith et al., 2009). PC practitioners

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\(^1\)An advance directive is a written document that makes explicit an individual’s wishes for EOL care such as life sustaining treatment, and intends to advocate for the patient’s wishes into future situations when they become incompetent (Kossman, 2014; Storch, Starzomski, & Rodney, 2013).
claim to improve the quality of life by providing relief from suffering for individuals and families facing life-limiting-illnesses (Smith et al., 2009; Stajduhar, 2011).

Misinformed HCPs can confuse the practice of PC despite a growing body of knowledge in the past 40 years (WHO, 2014). PC can be initiated anytime along a disease trajectory and can be delivered concurrently with life prolonging, curative therapy (Norton, Hobson, & Kulm, 2011; Powers et al., 2011), or can be the focus of care (Smith et al., 2009). Both PC and life prolonging curative treatments can be offered to patients diagnosed with a serious illness, regardless of life expectancy (Smith et al., 2009). Communication is a fundamental element of good PC (Popejoy, Brandt, Beck, & Antal, 2009), and, understanding what PC is can be beneficial to hospitalized older adults dealing with illnesses and uncertainties (Powers et al., 2011).

**Acute/active Treatment Versus Comfort Care**

“Science can only ascertain what is, but not what should be, and outside of its domain value judgements of all kinds remain necessary.” ~ Albert Einstein

Thirty years ago, a biopsychosocial model of care emerged where HCPs were encouraged to understand people as multidimensional beings and not just components or parts (Wright & Brajtman, 2011). This movement shifted HCPs’ thinking and encouraged them to accept the psychological, social, and spiritual influences on the body and not just physical health (Wright & Brajtman, 2011). Stajduhar (2011) suggests clinicians develop holistic plans by focusing on not only the physical aspects of care, but also on finding out what is most important to patients through providing comfort, support, and sharing information.
HCPs can neglect EOL patients' care needs in a highly acute-focused healthcare system (Stajduhar, 2011). Contemporary biomedicine\(^2\), in many instances is informed and influenced by the scientific, material, rational, and technical aspects of patient care at the expense of devaluing the metaphysical and nonmaterial (Engebretson, 1997). Many acute hospitals offer cure-orientated care, as opposed to comfort-orientated care, creating barriers to EOL care provisions (Wilson et al., 2008). Moreover, dying is portrayed in the media as distasteful or uninteresting (Anselm et al., 2005; Field & Cassell, 1997), and is a difficult topic for discussion in many cultures (Bushinski & Cummings, 2007). Many people believe that everything can and should be done to save a life (including inappropriate use of resuscitation); consequently, death is not considered an acceptable or natural occurrence (Anselm et al., 2005). It is difficult for an individual to make the decision to allow one’s health to deteriorate naturally and withhold life-sustaining therapy (Le & Watt, 2010; Fowler & Hammer, 2013).

Despite these findings, researchers in Canada have shown that many health recipients desire a less aggressive EOL treatment plan focused on a comfort care approach, rather than on a technologically supported, institutionalized death (Fowler & Hammer, 2013; Storch et al., 2013). The scientific paradigm that informs HCPs in a medicalized model of care has not been sufficient for understanding human experiences, nor is it exclusively accountable for health and healing (Engebretson, 1997). Incorporating both curative and comfort care approaches can provide solace for patients and families who desire longevity in life and relief from suffering\(^3\).

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\(^2\) Furthermore, Pauly (2013) discusses Weber and Fore's definition of biomedicine as being concerned with biological and genetic factors as causes of disease, as ignoring social determinants of health causes of disease, and as considering the disease to be caused by the individual.

\(^3\) Rodgers and Cowles (as cited in Wright et al. [2009]) describe suffering as a “multidimensional and subjective experience that is unique to every individual and as being associated with the assignment of intensely negative meaning, such as loss of humanity or dignity to a situation” (p. 220).
HCPs can support the emotional needs of care recipients by shifting away from the biomedical approach and towards a comfort care paradigm.

**Acute Care Implications**

In the acute care context, HCPs are required to make improvements to EOL communication and care. More than 58% of all deaths occur in hospitals (Popejoy et al., 2009), hence, there is a need to examine EOL care in this setting (Brazil et al., 2013). In addition, Le and Watt (2010) found that the highest numbers of inpatients in hospitals die on acute, medical units. Compounding this issue are nurses in the acute care setting who believe they do not have enough time to give compassionate and comprehensive PC (Beckstrand et al., 2012). However, Beckstrand et al. (2012) also discovered that nurses in acute care experience difficulty and distress when being called away from EOL patients due to other acute patient issues. In acute care, there is an expectation of nurses to provide effective PC while coping with multiple competing priorities (Strang et al., 2014). It is prudent to consider all factors that influence the context for nursing practice in order to understand what facilitators and barriers prevent EOL communication (Stajduhar, 2011).

**Life-limiting-illness and age factors.**

Recently, there is a growing interest in examining the nature of non-cancer chronic illnesses, and the role of EOL care decision-making in meeting the needs of this population. There is very little research assessing quality of EOL care for those people with a chronic life-limiting-illness (non-cancer) (Stajduhar, 2011). Much is known about the role of PC in meeting the needs of cancer patients; however, patients afflicted with progressive, long-term conditions, and who are in the last year of their lives, are rarely offered PC unless they have cancer (Mason et al., 2013; Stajduhar, 2011). Patients with terminal diagnoses such as heart disease, stroke,
respiratory diseases, diabetes, dementias, and renal diseases are recognized to benefit from specialized coordinated PC (Mason et al., 2013; Stajduhar, 2011; WHO, 2014). Patients with a terminal diagnosis should be offered both active and PC treatments concurrently regardless of the care context (IPANEL, 2014; Stajduhar, 2011).

Patients are living longer with life-limiting illnesses and multiple chronic conditions, which can be problematic, because, treatments are more complex (Garner, Goodwin, McSweeny, & Kirchner, 2013; Powers et al., 2011), and the dying process is extended (Field and Cassell, 1997). The progression of chronic disease generally results in a period of impaired health with increased disability, as well as progressive pain and suffering as one nears death (Albers et al., 2014; Fowler & Hammer, 2013). It is difficult to support those who require high quality PC due to a lack of available resources (Stajduhar, 2011). This dilemma will present a challenge for HCPs in the next half century (IPANEL, 2014; Stajduhar, 2011).

As society’s population ages, HCPs must effectively communicate EOL care options and patients’ wishes in a coordinated manner. Older people can experience repeated hospitalizations, complicated discharge planning, prolonged hospital stays, poor continuity of care, suffer painful deterioration, and poor overall quality of life (Powers et al., 2011). Williams (as cited in Stajduhar, 2011, p. 10) claims that by the year 2026, one in five Canadians will be a senior, reinforcing the growing need for specialized EOL care planning. The population is aging rapidly in developed nations (Albers et al., 2013); EOL care and decision-making should be of utmost interest to all HCPs.

**Nurse factors.**

The philosophical values and theoretical perspectives of the nursing profession are congruent with the needs of individuals and families facing life-threatening illnesses (Reed,
Nurses spend more time with people who face death than any other HCP (Thacker, 2008), which means they have the opportunity to provide leadership when making improvements to EOL communication. Many nurses approach EOL decision-making by understanding and being sensitive to the recipient’s emotional state, which can then guide the direction of conversation (Strang et al., 2014). Nurses support others by becoming involved at a personal level, and enacting a genuine presence (Strang et al., 2014).

Nursing is considered by many to be a moral practice (Wright, Brajtman, & Bitzas, 2009), where nurses demonstrate a unique understanding of human needs, and possess a disciplinary ethic that promotes quality-of-life when patients transition towards death (Reed, 2014). Furthermore, nurses strive towards the ideals of compassion, respect, equitable relationships, honouring life, and the desire to do good for others (Hartrick Doane & Varcoe, 2015). Nursing has a mandate to use a specialized body of knowledge and skills that must evolve with the changing health goals of society (Reed, 2014). Specifically, nurses provide holistic care and engage resources, individuals, families, and teams of providers to enhance quality of care at the EOL (Stajduhar, 2011). In general, nursing’s movement away from a paradigm of control to one that focuses on relationships is useful when caring for those at the EOL (Wright & Brajtman, 2011).

**Ethics.**

Caring for EOL patients and their families can present moral and ethical challenges for HCPs. There is a moral imperative for all HCPs to initiate EOL conversations in an appropriate and timely manner, enhance and promote EOL language, and facilitate the most suitable direction of care for patients. The nature and quality of EOL relationships with patients and families are the moral responsibilities of HCPs, which has ethical implications (MacDonald,
2007). Patients may receive care that is against their wishes, and family members may be at odds with deciding what is best for their loved ones (Lindh, Severinsson, & Berg, 2007). In some cases, EOL treatments can seem ineffective and actually contribute to the patient’s suffering. It is essential for HCPs to act in morally responsible ways, otherwise moral distress may result (Kalbian 2013).

The technological imperative where some people promote life preservation at all costs can contribute to the moral distress experienced by patients, families, and HCPs (Storch et al., 2013). When nurses are part of only the technical aspects of EOL care, tensions between HCPs can escalate (MacDonald, 2007). HCPs may unknowingly engage in immoral action while conforming to institutional pressures, which, consequentially, perpetuate moral distress, guilt⁴ and the suffering of providers (Kalbian 2013; Lindh et al., 2007). Nurses can suffer from emotional distress⁵ when unable to provide the kind of care they are educated to give (Hartrick Doane & Varcoe, 2015). A moral crisis can precipitate when nurses act in ways that violate their values and beliefs (Kalbian, 2013). It is important for HCPs to understand patients as individuals and not focus treatment on only the physical aspects of care (Bergum, 2013).

The preceding foundational review of the literature helped me identify which terms provided conceptual structure for my integrative literature review (ILR). Important concepts were located and discussed in relation to their importance in EOL communication including PC, goals-of-care, advance directives, life-limiting-illness and age factors, acute/active and comfort-care ideologies, nurse specific factors, and ethical considerations. Although EOL is complex and

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⁴ The experience of guilt “is a measure of the persons moral health and well-being,… the guilt one feels when making difficult moral decisions such as allocating scarce medical resources….The moral person must suffer the anguish of the ‘impossibility of the task’” (Kalbian, 2013, p. 285).

⁵ When HCPs are faced with acting in a way that goes against a deeply held value, intense moral conflict and distress results when grieving violating that value (Kalbian, 2013).
sometimes difficult for nurses, EOL care provision falls within the scope of nursing practice where nursing’s theoretical approaches can be applied.

**Theoretical Perspective**

**Relational Inquiry**

Death and dying are inherently difficult experiences and topics to discuss for most HCPs, patients, and families. Because of the unique circumstances surrounding the sensitive care in this population, HCPs should approach dying people and their families in an ethically responsive way. Reflecting on the value of ethical practice is a method for the HCP to enact a relational way of being irrespective of the discipline (Lindh et al., 2007), and can facilitate a moral approach to EOL care.

Hartrick Doane and Varcoe (2013) suggest RI is an approach that HCPs can consider when caring for dying patients and families. They describe RI as:

>[A] reflexive process where one is always assuming and looking for the ways in which people, situations, contexts, environments, and processes are integrally connecting and shaping each other. People are contextual beings, who exist in relation with others and with social, cultural, political and historical process.[…] Nursing practice as a process of inquiry focuses on the question ‘How might I most responsively and effectively be in-relation to promote health and healing?’ (p. 150)

HCPs can optimize relationships by adopting a relational perspective whereby the patients' individual and personal context is most important, which contributes to a good death (Wright et al., 2009). Although many professionals use a relational approach, a perspective for improving care in ethical relationships is still needed (Bergum, 2013).
Nurses are active communicators within the nurse-patient relationship and can facilitate understanding the importance of EOL decision-making through RI (Storch et al., 2013). Nursing’s values, knowledge, skills, ideals, and imperatives align within RI, where the patient, nurse, and system well-being is valued (Hartrick Doane & Varcoe, 2015). Enacting RI through nursing practice reveals patients’ capacities and resources and encourages them to understand the meaning of their experiences (Hartrick Doane & Varcoe, 2015).

In creating a relational space, the nurse allows individuals to express their feelings and ideas in meaningful ways (Hartrick Doane & Varcoe, 2015). In nursing, relational practice is a conscientious effort to enact the profession’s values and goals, emphasizes the uniqueness of an individual, and considers one’s own and others’ interpretations as equally important (Hartrick Doane & Varcoe 2013). Although all HCPs are able to contribute to EOL relationships, nurses are uniquely positioned to engage closely with patients and families.

**Relational ethics.**

“In a relational ethic one is ‘inescapably, dialogically, in the midst,’ and it is this relational space that gives moral meaning to our actions” Gaita (1991), in Bergum (2013, p.142).

Nurses can approach EOL relationships with patients and families by adopting a relational ethical perspective, which builds on the notion all relationships are moral (Bergum, 2013). Moral responsibility is the desire to do good for people and, therefore, can be useful when considering human suffering (Lindh et al., 2007). Relational ethics provides a framework for a moral nursing practice, where nurses can conceptualize people as embodying individuals, and where the family is important (Wright et al., 2009).

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6 Embodiment is an integrative view of the body as a physical object, an experience lived through the person, and that emotion, and feelings are as important to human life as physical signs and symptoms (Wright et al., 2009).
Relational engagement.

Relational engagement is one way in which a HCP can understand the individual’s unique situation and perspective. When fully engaged, the HCP can determine what the patient really needs (Bergum, 2013). Bergum (as cited in Macdonald, 2007) explains that full engagement can occur between the nurse and the patient when an emotional connection exists; only then can a meaningful understanding of the patient’s experience take place. Hartrick Doane describes engagement (as cited in Wright & Brajtman, 2011) as the ability to connect and “be with” another person in an intersubjective, mutual, and authentic way while respecting the relationship’s complexities (p. 24). Wright et al. (2009) add that when engaged “in-relation” with others, compassion can then occur and issues can be resolved. Enacting compassion requires courage and the ability to enable oneself to witness human suffering, which leads to the creation of a genuine connection (Wright et al., 2009).

For Hartrick Doane and Varcoe (2013), “understanding difficulty and suffering as windows into meaningful relationships and as the base for ethical decision-making and responsive nursing care creates the relational space for nurses to better understand multiple and competing obligations, goals, and perspectives” (p. 154). Relational engagement represents an informal and personal contact with others, whereby hopes and wishes are openly shared, and quality of life is understood as a personal meaning (Reinke et al., 2010). Through relational engagement, the nurse honours the personal meaning ascribed to the EOL experience which is fundamental to supporting a PC perspective.

Trust.

Developing trust in an EOL caring relationship provides the integrity and structure for an open and sincere relationship. Respecting and accepting others, listening, and understanding,
treating people equally, and being sincere develops trust (Hartrick Doane & Varcoe, 2013). When trust forms in the relationship with patients and families, communication becomes more effective (Bushinski & Cummings, 2007). The nature of the nurse-patient relationship is critical for developing a trusting relational space for EOL conversations to occur.

**Mutual respect.**

Mutual respect is the most important and central theme of relational ethics (Wright et al., 2009). Relational tensions between HCPs and patients can develop when family perspectives and interests are ignored, which threatens the integrity of the provider-patient relationship (Wright et al., 2009). Appreciating others’ differences establishes respect, avoids negative judgements and prior assumptions, and strives to realize a common understanding (Wright et al., 2009). It is within the nature of nursing to seek ways to improve quality of care through every phase of life, including towards death.

The RI approach to EOL communication can support HCPs and recipients through difficult times. Identifying current communication barriers enables tailored interventions that are more likely to improve practice (You et al., 2015). When nurses advocate for a patient/family's EOL wishes, they embody the relational perspective that is the foundation of the nurse-patient relationship (MacDonald, 2007), and can contribute to a good death for recipients (Wright et al., 2009).

The goal of RI is the promotion of patient well-being, system well-being, nurse well-being, and informs HCPs to recognize the way in which all elements are connected (Hartrick Doane & Varcoe, 2015). RI provides me with a theoretical lens that informs my conceptualization and interpretation of the data throughout this ILR process.
Methodological Approach

Paradigms\(^7\) ensure philosophical and ontological congruency of research and can help the researcher link the aims of a study with the methods used (Houghton, Hunter, & Meskell, 2012). A paradigm includes ontology (i.e., beliefs about reality), epistemology (i.e., the relationship between the researcher and what can be known), and methodology (i.e., how to carry out the research relative to the question and context) (Houghton et al., 2012). Weaver and Olson (2006) suggest that adopting a paradigm can guide and structure an inquiry process. Foster and Kirkevold (as cited in Weaver and Olson [2006]) believe integrative reviewers assimilate findings from differing paradigms and focus on the strength of the evidence and issues of rigour\(^8\) to create a comprehensive account of the findings (p. 466). Examining what factors impact EOL care discussions, from a variety of methods, can build nursing knowledge and improve EOL care delivery.

Integrative Literature Review

ILRs are the broadest form of literature reviews and include both experimental and non-experimental research to explore, describe, and understand a phenomenon of concern (Whittemore & Knafl, 2005). Through the ILR process, the investigator reviews, critiques, and synthesizes representative literature in order to generate a new framework and perspective (Torraco, 2005), and includes a discussion of the findings within the context of the clinical question (Cronin, Ryan, & Coughlan, 2008; McGrath, 2012). Whittemore and Knafl (2005) believe that “the varied sampling frame of integrative reviews in conjunction with the multiplicity of purposes has the potential to result in a comprehensive portrayal of complex...

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\(^7\) “Paradigms are lenses for viewing and interpreting significant substantive issues to the discipline” (Weaver & Olson, p. 460).

\(^8\) Rigour is “the strictness with which a study is conducted to enhance the quality, believability, or trustworthiness of the study findings” (LoBiondo-Wood & Haber, 2013, p. 307).
concepts, theories, or health care problems of importance to nursing” (p. 548). An ILR assists the inquirer to draw overall conclusions from a body of literature on a topic, including all related studies, by providing a summary of past research (Beyea & Nicholl, 1998).

According to Whittemore & Knafl (2005), it is best for the writer to first adopt a theory, competing model, or point of view about the topic, to assist in developing a conceptual structure early in the writing phase. Then, the main conceptual ideas and relationships related to an issue or research question can be uncovered (Mallidou, 2014; Torraco, 2005; Whittemore & Knafl, 2005). In integrative nursing research, the inquirer first clarifies what theoretical perspective is used, devises a starting point for theory development, establishes the current state of the science, and incorporates theoretical thinking on the major and/or central conceptions in question (Eun-OK, 2005).

I incorporated a RI approach in my ILR, because I noticed similarities between my area of interest, and the RI theoretical perspective. Hartrick Doane and Varcoe (2015) describe RI as an approach that can be used by HCPs to examine the ways in which people, situations, contexts, environment and processes are integrally connected and shape each other; understand how to be present, respond, and relate within situational circumstances; and know how to practice responsively in complex situations. There are many ethical implications to consider while caring for EOL patients in acute care, adopting an RI perspective can encourage HCPs to develop a moral practice and enhanced ethical awareness.

The goal of RI is the promotion of patient well-being, system well-being, nurse well-being, and an RI approach can inform HCPs to recognize how all elements are connected (Hartrick Doane & Varcoe, 2015). Use of an RI approach assists the HCP to understand how to generate relationships in the EOL hospital environment and improve the decision-making
process (between HCPs, patients, and families, and among HCPs). Through RI, the HCP can consciously examine how to relate to the intrapersonal, interpersonal, and contextual forces that shape each situation (Hartrick Doane & Varcoe, 2015).

In the following sections, I discuss how I developed my inquiry through incorporating Whittemore and Knafl’s (2005) 5-step ILR framework. The ILR framework includes problem formulation, literature search, data evaluation, data analysis (reduction, display, comparison, conclusion drawing), and presentation. Embarking on the ILR process furthered my understanding of my topic and helped me clarify my research goals during the iterative process.

**Step 1: Problem formulation.**

The problem formulation stage is when the inquirer clearly identifies the problem that the review is addressing (Whittemore & Knafl, 2005). A well-defined focus is necessary to establish an outline of the boundaries for the review, and to identify the pertinent variables, concepts, target population, health problem, and type of studies associated within the research (Whittemore & Knafl, 2005). I was able to develop my inquiry question by extensively reading about my topic, identifying the variables of interest, and differentiating between pertinent and extraneous information (Whittemore & Knafl, 2005). Based upon my findings, I determined which concepts added clarity to my inquiry, which sources were most relevant, developed inclusion and exclusion criteria, and developed review boundaries (Whittemore & Knafl, 2005). I identified pertinent concepts from my background literature review, which assisted me to frame and focus the ILR literature search stage.

**Step 2: Literature search stage.**

To enhance rigour in my literature search, I developed a well-defined search strategy through developing inclusion and exclusion criteria. According to Whittemore (2005) research
should clearly display the search terms, search strategies, databases, inclusion and exclusion criteria, sampling frame, targeted population, treatment, interventions, and outcomes of interest to add credibility to the literature review. Additionally, Whittemore and Knafl (2005) believe a comprehensive search can be done by identifying as many sources as possible, including two to three search strategies, and incorporating purposive sampling⁹ to assist in identifying subgroups for knowledge integration.

I used three reference databases for my review including CINAHL, MEDLINE, and PUBMED because of the relevance of the material in these databases to nursing practice (LoBiondo-Wood & Haber, 2013; Wakefield, 2014). With the help of the University of Victoria librarian, I performed two computer literature searches and explored concepts related to my topic as identified in the problem formulation stage. My target population for data retrieval in my ILR was initially located through the search terms “end-of-life,” OR “life limiting illness,” AND nurs*, AND “acute care,” OR hospital*, AND adult*, AND communication*. Additional limiters included English only, and peer reviewed research articles published between the years 2005 to 2015. Although it is most ideal in synthesis research to include all previous findings and attempt to retrieve an entire population’s studies (Cooper, 1998), limiters were used to focus my review to manageable numbers and to maintain conceptual clarity and rigour.

Immediately, I was able to apply inclusion and exclusion criteria to a large amount of research (226 articles) in the initial search. First, while reading the articles’ abstracts, I applied purposive sampling criteria to locate literature that discussed HCP perspectives, within the context of adult, acute care hospital settings, and where the topic focused on care of patients who were suffering with chronic or life-limiting-illness. Second, I included only primary sources that

⁹ A purposive sample is “a group consisting of particular people who can elucidate the phenomenon they want to study” (LoBiondo-Wood & Haber, 2013, p. 151).
were empirical and/or theoretical in nature, as suggested by Whittemore and Knafl (2005). I retained articles where the sample of participants included exclusively nurses or nurses in a combination with other HCPs who care for patients in the acute care context. I excluded physician only perspectives, and excluded articles if the main goal of the researcher was to scrutinize the validity of a questionnaire tool. In addition, I excluded research if EOL care conversations were the focus of care in paediatric, community health nursing, extended healthcare only settings, or if data represented the perspectives of EOL care recipients.

While further searching the literature, additional inclusion and exclusion criteria became evident. I noticed specific patterns within specific demographic types that equated to differing communication strategies by HCPs. For example, investigators in intensive care only units (ICU) specified the basis for most EOL discussions to include *futility of care* and *withdrawing* of life support. These terms are typically used within the critical care EOL literature and not in the general medical/surgical setting. Reconsidering the context of my inquiry (acute care), and the knowledge gaps inherent in this setting, prompted me to focus on seeking research to understand the conversation barriers and facilitators on general acute care units only. In developing my inclusion and exclusion criteria, I opted to exclude research where the setting was exclusively in critical care.

I excluded demographic groups where the focus of the researchers was oncology patients and/or oncology specialty-care providers only. I discovered that cancer patients’ and oncology HCPs’ experiences were different when compared to the general medical, life-limiting-illness context. Within this literature, my belief is that patients seem to be *fighting* and *combating* their cancers and HCPs seemed to perpetuate this thinking. Additionally, specialty cancer-care nurses with oncology certificates were often privy to advanced EOL education and possessed high
quality EOL communication skills (Beckstrand et al., 2012). For example, Beckstrand et al. (2012) found well-trained oncology nurses were better communicators with oncology patients, families, and HCPs, which contrasts to generalist acute care nurses. I excluded research focusing specifically on oncology patients and their specialty care providers because the context of this care involves different factors that shape the patients’ and nurses’ experiences. From this finding, I considered research articles where authors specifically discussed oncology patients only in the context of chronic or terminal care delivered on a general medical unit. I chose research articles based on my review of the data and through identifying which pertinent concepts and target population related best to my topic. Inclusion and exclusion criteria were applied to obtain specificity, maintain rigour, and to enable me to generalize my findings to the identified target population.

Through applying my inclusion and exclusion criteria, I reduced my sample from a possible 226 to 13. A CINAHL search included 42 results: two articles were inaccessible when requested through University of Victoria library; 11 were excluded through reading the abstract; 29 were fully read and the John Hopkins evidence appraisal tool was applied. A further 19 articles were excluded leaving 10 articles remaining. A Medline search revealed 91 results: 24 were copies already identified in CINAHL; 31 were excluded when reading the abstract; 36 were fully read and the John Hopkins appraisal tool was applied and 33 articles were excluded, leaving 3 remaining. A PubMed search revealed 93 results: 88 were copies already identified from Medline; five abstracts were read; one was excluded, four were fully reviewed and the John Hopkins evidence appraisal tool was applied, and all were excluded. This process is illustrated in the following figure 1.0.
Figure 1.0.

Research Data Inclusion/Exclusion Flow Diagram

CINAHL 2005-2015
42 Citation(s)

MEDLINE 2005-2015
91 Citation(s)

PUBMED 2005-2015
93 Citation(s)

114 Non-Duplicate Citations Screened

Inclusion/Exclusion/Unable to Obtain Criteria Applied

45 Articles Excluded After Title/Abstract Screen

63 Articles Retrieved

Inclusion/Exclusion Criteria Applied

44 Articles Excluded After Full Text Screen

6 Articles Excluded During Data Extraction

13 Articles Included
Step 3: Data evaluation.

The data evaluation stage is when the inquirer judges the data for merit and rigour, then determines which data meets the final criteria for the review (Whittemore & Knafl, 2005). I reviewed research articles for merits of authenticity, methodological quality, informational value, and representativeness as discussed by Whittemore and Knafl (2005), and by using the John Hopkins evidence appraisal tool (see Appendix A for tool) to initially review a large amount of research. Appraising the strength and quality of research evidence can be achieved through using a structured rating scale (Dearholt, Dang, & Newhouse, 2012). Dearholt et al. (2012) explain, “The underlying assumption is that recommendations from strong evidence of high quality would be more likely to represent best practices than evidence of lower strength and less quality” (p. 107). The John Hopkins evaluation tool is appropriate for nursing research because it allows the inquirer to: assess a large diverse data group; considers study design as “level of evidence”; determines study quality by methods, execution, limitations, confidence; and assesses for directness (how well the subjects, interventions and outcomes measure the area of interest) (Dearholt et al., 2012).

While using the Johns Hopkins evidence appraisal tool, I scrutinized and summarized each research source for applicability in my research project. Throughout this process, I considered the quality of all the sources for my review, and found most of the research articles that met my inclusion or exclusion criteria had quality rating (scientific evidence) score of “B”–Good, with a strength of evidence level 3 (non-experimental and qualitative studies). Dearholt et al. (2012) explains evidence level B is: “Good quality: Reasonably consistent results; sufficient sample size for the study design; some control, fairly definitive conclusions; reasonably consistent recommendations based on fairly comprehensive literature review that includes some
reference to scientific evidence” (p. 108). I determined level B as the minimum requirement for quality of evidence in my ILR. I excluded articles of lower evidence quality C (low quality with major flaws), but included strengths of evidence levels 2 to 3. My search and evaluation for credible research resulted in 13 varied studies.

I performed an in-depth critique of the chosen research articles’ strengths and limitations to determine if aspects of the research findings were credible and believable for use in my project. Consideration was given to quality of the primary reports that were used in the analysis as is suggested by Whittemore and Knafl (2005). Coughlan, Cronin, & Ryan (2007a, 2007b) propose two guidelines for critiquing qualitative and quantitative research to determine credibility and believability of the studies. I demonstrate this critiquing process with the chosen 13 articles in Appendix B.

**Step 4: Data analysis.**

The data analysis stage is where I coded, categorized, and summarized the data into main ideas to draw a unified and integrated conclusion about the research problem (Cooper, 1998). I aimed to perform a thorough and unbiased interpretation of the available primary sources by categorizing and grouping together the extracted data so that further comparative ideas could emerge. I used a systematic analytic method to perform iterative comparisons across primary data sources of the mixed-methods, quantitative, and qualitative designs of the research that met my criteria. A constant comparison\textsuperscript{10} method of analysis was used to convert the extracted data into systematic categories that enabled me to identify patterns, themes, variations and relationships, which I then compared item by item and grouped similar data together as

\textsuperscript{10} A constant comparative method: “[d]ata are compared with other data continuously as they are acquired during research” (LoBiondo-Wood & Haber, 2013, p. 178).
suggested by Whittemore and Knafl (2005). I then collated findings from each research article in this manner to facilitate comparisons between each and begin to conceptualize themes.

**Data reduction.**

The intention in data reduction is to systematically compare primary sources on specific issues, variables, or sample characteristics (Whittemore & Knafl, 2005). Data reduction represents a process that divides the primary sources into subgroups to facilitate analysis, which includes research design type, chronology, setting, sample characteristics, and article perspective (Whittemore & Knafl, 2005). Once literature is chosen, the characteristics (barriers & facilitators) of the target population can be identified through a data extraction table. Figure 2.0 illustrates the data extraction sheet I used to reduce data into subgroups for analysis as suggested by Wakefield (2014). In this process, I was able to compare all 13 sources, identify patterns and themes that pertained to my topic of inquiry, and further reduce data to compare.

**Figure 2.0.**

<table>
<thead>
<tr>
<th>Full Reference for article including publication date</th>
<th>Population Targeted and numbers of participants</th>
<th>Intervention or area of interest</th>
<th>Study Method used by author/authors</th>
<th>Summary of the findings</th>
<th>Conclusions</th>
<th>Themes</th>
<th>Similarities and differences between other studies</th>
</tr>
</thead>
</table>

**Data display.**

In a data display, data are presented in matrices, graphs, charts, or networks that visually group individual variables to form subgroups for comparison (Whittemore & Knafl, 2005). I created a concept map (Appendix C) to illustrate major and minor findings and to conceptualize
the relationships that take place in acute care between HCPs, patients, and families in hospitals. In addition, I created a visual comparison of the research methods articles to frequency of data episodes in figures 2.0, 3.0, and 4.0. Finally, I developed a narrative highlighting the major domain themes and subthemes in the findings section of this paper.

*Data comparison.*

Data comparison is the examination of the displayed data as variables and groups in systematic categories of patterns, themes, and relationships (Whittemore & Knafl, 2005). The elements of data analysis can be applied to illuminate higher meanings in the literature. Strategies include identifying patterns and themes, seeing plausibility, clustering, counting, making contrasts and comparisons, discerning common and unusual patterns, subsuming particulars into the general, noting relations between variability, finding intervening factors, and building a logical chain of evidence (Whittemore & Knafl, 2005).

To begin comparisons between the data, from the data extraction process, I created a facilitators and barriers table (Appendix D). I then identified similar barriers and facilitators with the same colour. These themes were constructed and informed by the concept map, and were iteratively further developed and coded into clusters of themes and sub-themes as data was obtained. To maintain rigour during data analysis and data reduction, I reviewed each research article with the completed data reduction chart (Figure 2.0) to ensure accurate transcription prior to drawing conclusions, and that my findings aligned with the researcher’s intended findings. I analyzed the data according to Whittemore and Knafl’s (2005) ILR framework, and conceptualized my findings as themes.

Second, I compared the data drawn to the methods used by the researchers. I noticed that the quantitative survey reports resulted in fewer barriers or facilitators data (themes) when
compared to qualitative studies, which were rich in data and contributed greatly to my ability to conceptualize sub-themes. Second, while vote counting facilitators and barriers, I identified 94 episodes generated from the qualitative data generating reports, 57 episodes from mixed-methods data, and 37 episodes from the quantitative research data. I created the following figure displays to depict the differences in data between the research types. Figures 2.0 to 4.0 illustrate these findings.

*Figure 3.0.*

![Comparative Display A](image)

<table>
<thead>
<tr>
<th></th>
<th>Qualitative</th>
<th>Mixed-Methods</th>
<th>Quantitative</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Barriers</strong></td>
<td>72</td>
<td>37</td>
<td>19</td>
</tr>
<tr>
<td><strong>Facilitators</strong></td>
<td>22</td>
<td>20</td>
<td>18</td>
</tr>
</tbody>
</table>

Figure 2.0, labelled “Comparative Display A,” is a line graph that illustrates the frequency of barriers and facilitators data with each corresponding methodology.
Figure 4.0.

Figure 3.0, “Comparative Display B,” is a bar graph that illustrates the frequencies of research types that contributed to the final analysis and generating of barrier or facilitator themes.
Figure 4.0, “Comparative Display C,” is a simple pie chart depicting research type to the ratio (percentage) of data contributing to overall theme development. This corroborates similar values entered in Displays A and B, but is a visually summative way of viewing the research findings.

**Conclusion drawing.**

A final synthesis of the ILR reveals a conclusion or a summary of each subgroup where a new conception of the findings is unveiled (Whittemore & Knafl, 2005). Conclusion drawing occurs when the inquirer identifies patterns and relationships at a more abstract level, and generalizes the findings to populations of interest (Whittemore & Knafl, 2005). The researcher identifies what conflicting evidence is uncovered, and explores possible confounding and contributory influences. In the discussion section, I provide an integration of my findings and
develop recommendations for practice. Data reduction, display, comparison, conclusion drawing, and verification are all necessary steps in data analysis (Whittemore & Knafl, 2005).

**Step 5: Presentation stage.**

The presentation stage is represented by developing a diagram or table that includes explicit details from the sources and helps the inquirer display the evidence to support the overall conclusions (Whittemore & Knafl, 2005). Gaps in the literature are discussed and a new understanding of the phenomena emerges along with suggestions for future research and policy initiatives (Whittemore & Knafl, 2005).

When I identified the major themes through an RI perspective (including patient and family factors, HCP factors, and system factors), I placed them into groups and uncovered four main, domain themes. Whittemore and Knafl’s (2005) 5-step ILR framework includes problem formulation, literature search, data evaluation, data analysis (reduction, display, comparison, conclusion drawing), and presentation. The intention of an ILR is to generate new findings in relation to a clinical question for practice, policy, and research recommendations. What follows is my conception of the findings as determined through an RI perspective.

**Findings**

In my ILR, I identified a number of barriers and facilitators to EOL conversations including: (a) HCP intrapersonal factors such as provider attitudes, values, ethics, and learner considerations; (b) interdisciplinary factors such as focus of care, teamwork, and hierarchies; (c) hospital system factors such as policies and resource allocation; and (d) patient and family factors such as knowledge, attitudes, age, and illness type. I considered these findings using an RI perspective and aimed to understand how these factors influenced the EOL conversation space in acute care hospitals between patients, families, and HCPs.
HCP Factors

HCPs’ attitudes can affect the prospect for EOL decision-making conversations with patients and families. These attitudes contribute to preventing and discouraging EOL conversations from taking place and subsequent EOL decision-making from materializing. In addition, there is conflicting evidence in the literature about who should initiate and encourage these conversations, precipitating the need for further development on this topic. Physicians seemingly do not want to discuss death and dying with patients (Lenherr, Meyer-Zehnder, Kressig, & Reiter-Theil, 2012; Robinson, Cupples, & Corrigan, 2007; Sheward, Clark, Marshall, & Allan, 2011; Thompson, McClement, & Daeninck, 2006; Zapka, Hennessy, Carter, & Amella, 2006), and some authors indicate that nurses are more willing (Albers et al., 2014; Robinson et al., 2007; Thompson et al., 2006).

Unfortunately, nurses are not authorized, encouraged, or supported by their leaders to participate in EOL conversations (Robinson et al., 2007; Thacker, 2008; Thompson et al., 2006), which can result in active treatments being performed and result in HCP moral distress (Sherward et al., 2011; Whitehead, Herbertson, Hamric, Epstein, & Fisher, 2015). Confusion about who is responsible for initiating and participating in EOL conversations has ethical implications for recipients (Grbich et al., 2006; Robinson et al., 2007). In the following section, I discuss HCP factors affecting EOL communication, including intrapersonal factors and attitudes; clarification about who decides the plan of care; issues of not telling, not knowing, too late, resuscitation dilemmas; HCP ethical considerations, and learner factors.

Intrapersonal factors.

HCPs’ personal attitudes, beliefs and values can prevent or complicate EOL conversations with patients and families. Several researchers acknowledge that HCPs experience
personal factors preventing them from engaging in EOL conversations and, consequentially, deter recipients from making EOL decisions. Individual HCPs may have personal or cultural beliefs that can impact the patients’ decision making (Robinson et al., 2007), suffer personal discomfort when dealing with the emotional aspects of EOL conversations and care (Anselm et al., 2005), be personally impacted by the situation, and provide biased or subjective information to care recipients (Lenherr et al., 2012). They may struggle when they know the patient personally and be unable to provide a neutral perspective (Robinson et al., 2007). In contrast, they may also have trouble relating to the patient’s EOL issues (Thacker, 2008). In addition, HCPs can fear acts of litigation by the care recipients and avoid EOL conversations (Anselm et al., 2005; Robinson et al., 2007).

Ideal HCP traits associated with assisting in EOL conversations (as identified by Thacker [2008]) include providers with life experience, maturity, and confidence. Sashara, Miyashita, Kawa, & Kazuma (2005) found that professional maturity might be related to clinical experience. However, overall, several intrapersonal HCP factors prevent EOL decision-making conversations in acute care.

**Depressing or difficult.**

HCPs’ attitudes towards EOL conversations vary among professions and affect how recipients are approached. Many HCPs consider death as a *taboo subject* and not a natural part of life (Lenherr et al., 2012). Because of this attitude, EOL care conversations and decision-making are difficult and/or depressing for HCPs (Lenherr et al., 2012; Zapka et al., Hennessy, Carter, & Amella, 2006). HCPs can experience problems managing troubling symptoms or be reluctant to deal with the needed emotional work that is involved (Grbich et al., 2006; Sheward, Clark, Marshall, & Allan, 2011). This may result in individual or professional dissonance from the
situation (Sheward et al., 2011). Physicians may also have difficulties relating to EOL issues (Thacker, 2008) and struggle with determining the appropriate care direction for the patient (Sheward et al., 2011). As well, nurses on busy acute care wards do not always want to deal with dying patients, view PC as a part of their routine roles (Gardiner, Cobb, Gott, & Ingleton, 2011), or view the PC approach as a priority (Lenherr et al., 2012). Due to these difficult elements, HCPs can de-emphasize the importance of EOL decision-making conversations.

**Who decides?**

Decision-making regarding direction of care is the responsibility of medical teams (Sheward et al., 2011) and it is the physician’s role to inform patients about their diagnosis, prognosis, and proposed therapies (Lenherr et al., 2012). Physicians will often not take the lead on initiating decision-making conversations with patients, and nurses will often initiate talks without authorization (Robinson et al., 2007). In addition, nurses believe that physicians often create false hope for patients, dismiss the recipient’s emotional needs (Zapka et al., 2006), and will reveal only medical (factual) information to dying people and their families (Lenherr et al., 2012). There is a belief that physician’s assume the responsibility deciding the direction of patients EOL care; however, researchers show physicians are not always willing to be part of the decision-making process (Lenherr et al., 2012; Robinson et al., 2007; Sheward et al., 2011; Thompson, McClement, & Daeninck, 2006; Zapka et al., 2006).

**Not telling.**

Many HCPs are willing to talk about death and dying with patients and families; however, are reluctant to initiate the topic. Even fewer providers are willing to discuss an imminent EOL situation (Lenherr et al., 2012). Most HCPs are not discussing EOL issues with patients and families even when recipients appear to be comfortable with the discussion (Grbich
et al., 2006). HCPs will often wait until being asked by patients or families if death is approaching before acknowledging it as a possibility (Gribich et al., 2006). Gribich et al. (2006) discovered a tendency for some physicians to avoid disclosing a terminal situation to patients and families until the very end of the illness. As well, Thompson et al. (2006) found physicians were poor communicators who were unwilling to deliver bad news and leave advance care planning and EOL discussions until it is too late. HCPs’ experience ethical challenges when they do not tell patients the truth about their grave situations and consequentially do not allow informed EOL decisions to follow (Robinson et al., 2007). This practice is associated with low patient satisfaction, poor quality of EOL care, and is, therefore, not an acceptable practice. Physicians are responsible for accurate diagnosis and for providing patients with a realistic and honest prognosis (Lenherr et al., 2012). All HCPs can contribute to and encourage open and honest conversations that will ideally influence more people to make confident EOL care decisions.

Not knowing.

Withholding the true nature of an illness may lead patients to making EOL decisions without fully understanding the implications (Robinson et al., 2007). There can be many negative consequences for HCP team members and recipients when honest or timely health information is not given. HCPs may delay diagnosing a terminal situation preventing goals-of-care discussions, and consequentially resulting in poor symptom control (Sheward et al., 2011). In addition, patients may quickly become too ill to have discussions, or may deteriorate late at night, on weekends, or when only on call physicians (who do not know the patients well) are available (Robinson et al., 2007). Heavy workloads may strain HCPs’ opportunities to build a rapport with patients and families, and prevent relationships that encourage EOL talks (Anselm et al., 2005; Gribich et al., 2006; Lenherr et al., 2012; Robinson et al., 2007; Sheward et al., 2011). Zapka et
al. (2006) noted that nurses are challenged and uncomfortable planning care when physicians hesitate about deciding on a course of action. HCPs who do not know their patients can have trouble with EOL topics, and avoid the conversations. Not knowing patients can strain the HCPs’ ability to initiate EOL conversations with recipients.

Too-late.

There are many causes for leaving EOL conversations too-late in the course of a life-limiting-illness (Robinson et al., 2007). Physicians may be unwilling to deliver bad news delaying EOL decision-making, which prevents nurses from facilitating conversations (Thompson et al., 2006), and also creates nurse dissatisfaction (Sheward et al., 2011). In addition, when HCPs know that dying is a possibility and do not disclose this to patients or families, or establish a plan of care, professional dissonance between nurses and physicians can develop (Grbich et al., 2006; Robinson et al., 2007; Sheward et al., 2011).

HCPs cannot always identify dying in the early stages, and patients may quickly deteriorate and become unable to make decisions themselves (Anselm et al., 2005; Lenherr et al., 2012; Robinson et al., 2007). Earlier do-not-resuscitate (DNR) orders and EOL care discussions can benefit families by reducing stress and anxiety, resulting in fewer active treatments near death, and may reduce patient suffering (Grbich et al., 2006). The HCP should explicitly acknowledge death as imminent, which allows the nurse to explore feelings about the impending loss, and provides time for families to say their goodbyes (Thompson et al., 2006). Discussions left too late prevents EOL communication from occurring, neglecting the needs and wishes of patients and families, and adversely affects HCP teams.
Resuscitation dilemma.

Determining what direction to take and which resuscitation measures to implement can be a complicated process for a patient and their family. Robinson et al. (2007) found that physicians are concerned nurses may reduce nursing care when a DNR is ordered. Similarly, Anselm et al. (2005) found that physicians attribute DNR orders to mean abandoning a patient or to giving less aggressive care. In addition, other issues with DNR orders include confusing or ambiguous instructions (Anselm et al., 2005; Robinson et al., 2007), confusing advance care planning, advanced directives (Grbich et al., 2006), and the fear that resuscitation conversations may actually cause harm to patients (Robinson et al., 2007). In some cases, physicians may choose to continue active treatments even when DNR orders exist (Grbich et al., 2006), or perform resuscitation when HCPs are unable to make a DNR decision (Robinson et al., 2007). HCPs may leave resuscitation conversations to the patients to bring up (Lenherr et al., 2012). Pessimistic HCPs’ attitudes towards EOL care can confuse HCPs in understanding resuscitation orders and further complicate EOL conversations.

Ethical considerations.

HCPs are ethically obligated to support openness, autonomy, and foster a culture that accepts death and dying (Lenherr et al., 2012). There are many barriers that prevent a supportive EOL care environment and decisions from taking place. Hospitals and families can expect HCPs to continue active, aggressive therapies for deteriorating patients, which poses challenging ethical situations and moral dilemmas (Sheward et al., 2011). Ongoing curative treatments for patients, who appear to be dying, can precipitate denial and false hope for patients, and cause nurses to experience moral distress and emotional exhaustion (Sheward et al., 2011; Thompson et al., 2006).
Nurses, and other direct EOL providers, can experience high levels of moral distress, which contrasts significantly with the experience of physicians and other indirect staff (Whitehead et al., 2015). Whitehead et al. (2015) found that a greater occurrence of moral distress, and desire to leave the workplace, correlates with morally distressing experiences for front line staff with less decision-making authority. Poor team communication, working with incompetent providers, witnessing patient suffering, and a lack of continuity of care are causes of HCP's moral distress (Whitehead et al., 2015). Moral distress affects the EOL caring environment and can have negative outcomes on HCPs, particularly nurses.

Education can influence HCPs’ experiences of moral distress. EOL education is beneficial for nurses and can augment EOL conversational abilities. Sashara et al. (2005) found increases in moral distress positively correlated with advanced EOL education, because of the HCP’s improved ability to recognize situational difficulty, and through identification and witnessing of poor care. Similarly, Whitehead et al. (2015) attributed advanced EOL education with escalating moral distress; an educated HCP might recognize situational issues but was unable to act due to subordinate positioning within teams. The experience of witnessing poor EOL care can lead to moral distress and burnout for HCPs. PC and EOL education can precipitate an awareness of the many ethical issues involved with caring for EOL recipients.

**Learner factors.**

HCPs promote EOL conversations through advances in education and mentor and support nurse and patient experiences. In this review, researchers unanimously recommended that all disciplines require specialty EOL training (Thacker, 2008) because of current education shortfalls (Anslem et al., 2005; Grbich et al., 2006; Robinson et al., 2007). Recommendations included adding EOL education in undergraduate programs (Thacker, 2008), using real life
education scenarios (Robinson et al., 2007), and ensuring that education programs incorporated the terms “death and dying” (Lenherr et al., 2012). From this research, it was determined that EOL training ought to be tailored and specific for both physicians and nurses, and include a focus on improving interprofessional concerns such as role clarification and optimizing attitudes within a diverse staff mix (Robinson et al., 2007). The aim of education should be to normalize palliative and EOL care in various care settings (Zapka et al. 2006). Raising a HCP’s awareness through education can assist providers to identify those who are most in need of PC expertise and promote compassionate EOL care.

HCPs are not always able to identify a terminal phase of a patient’s illness (Grbich et al., 2006; Robinson et al., 2007). Sheward et al. (2011) suggest that it is important for HCPs to recognize actively dying patients, in order to change the direction of care and implement a PC approach. However, it can be difficult for HCPs to identify the end stage of an illness due to fluctuations in health status and conditions (Robinson et al., 2007). This unpredictability, unfortunately, affects care recipients when things deteriorate quickly, consequentially leaving conversations too late (or not having them at all) and missing the opportunity for the patient’s wishes to be honoured (Robinson et al., 2007).

Education about EOL communication can increase the nurse’s skills and abilities when caring for patients and can significantly influence new nurses (Moir, Roberts, Martz, Perry, & Tivis, 2015). Education about communication should commence right after registration (Sashara et al., 2005) with corresponding curricula development geared towards nurses who will care for the EOL patient population (Moir et al., 2015). Experienced nurses are more confident in their EOL abilities (Moir et al., 2015), whereas new nurses need time to develop skills in proficiency and communication patterns (Thacker, 2008). Experienced nurses have better access to EOL
education than new nurses do, despite recent effects to enhance undergraduate education (Thacker, 2008). Advanced EOL education prepares nurses to develop greater professional confidence and autonomy when assisting patients to make EOL treatment decisions (Albers et al., 2014). HCPs, at both the undergraduate and graduate levels, should be given the opportunity for EOL and PC education initiatives, and build the needed skills, knowledge, and expertise to improve EOL decision-making conversations.

Advanced EOL education is associated with supporting advocacy behaviours in EOL care (Thacker, 2008). Advocacy behaviours are not typically part of EOL care training (Thacker, 2008) and education alone is not enough to affect change (Gardiner et al., 2011). For experienced nurses, more EOL clinical experience is equated with less difficulty communicating with recipients, relates to fewer personal issues with the experience (Sashara et al., 2005), and is associated with more confidence in EOL nursing skills (Moir et al., 2015). Exploring the emotional needs of the nurse, in turn, will enhance the nurse’s comfort level engaging in EOL conversations, and support patient and family’s decision-making (Moir et al., 2015).

Providers in PC areas who receive advanced EOL education can influence key aspects of EOL care communication. Specialized PC trained nurses claim physicians are more prepared to listen to their opinions about EOL patient care issues, and do not experience inferiority issues when compared to nonspecialized nurses (Albers et al., 2014). Grbich et al. (2006) believes complementing specialized education courses with a resource nurse to provide mentoring for all HCPs is beneficial in meeting individual learner needs. In addition, meeting emotional needs of nurses through PC education, and focusing on a non-oncology nurse population can support HCPs in the EOL acute care environment (Moir et al., 2015). Moir et al. (2015) suggests
oncology nurses are comfortable with EOL conversations and are likely to discuss EOL care options with recipients compared to non-oncology nurses.

HCPs should possess PC experience when caring for patients transitioning from acute/curative care to palliative and EOL care (Moir et al., 2015). Staff development, education, and policy development can focus on nurses in acute care settings and is where the majority of nurses are employed (Thacker, 2008). HCPs’ learning should focus on pain management, symptom control, ethical decision-making, and ways to engage in difficult conversations to support the overall provision of EOL care (Sheward et al., 2011). Specialized EOL education can positively affect team communication, patient care, improve HCP intrapersonal factors, and assist with policy development and enhancement.

Experienced nurses can role model effective communication behaviours for inexperienced junior nurses, which contributes to the overall development of skills in PC (Zapka et al., 2006). Senior nurses can mentor junior nurses who have difficulty caring for and supporting patients’ and families’ decision-making (Sashara et al., 2005). Specialized PC teams can support and advise nurses who manage EOL care for patients and families (Sashara et al., 2005). Education, experience, and mentorship are important elements that facilitate and enhance the HCP’s ability to engage with EOL care recipients and facilitate decision-making conversations.

**Interdisciplinary Factors**

**Teamwork.**

Supporting a team approach to patient care has a positive impact on EOL conversations with recipients. The presence of a multidisciplinary healthcare team has been associated with supporting advocacy behaviours in EOL care (Thacker, 2008). When everyone is focused on the
same goals, a collaborative care plan is fostered, and a smoother transition to EOL can occur
(Thompson et al., 2006). A HCP’s willingness to work in a team is vital when facilitating
changing the direction of care such as when dying is likely to occur (Sheward et al., 2011). The
multidisciplinary nature of PC implies that close collaboration and communication between the
professions can serve as a model for general care settings (Albers et al., 2014).

The team dynamic can be difficult to support in some EOL care settings where
professional disagreements may be present. Sheward et al. (2011) believes a supportive team
approach encourages collaborative working relationships to form; however, professional or
individual disagreement can prevent HCPs from engaging in respectful team discussions.
Differences in staff cultural backgrounds, personal values, beliefs, and attitudes to death and
dying, can precipitate and weaken multidisciplinary engagement (Sheward et al., 2011). For
example, Thompson et al. (2006) discovered there is difficulty supporting EOL conversations
when patients are removed too early from medical teaching services (when designated PC),
interrupting continuity of care (where important relationships were already formed), and
fragmenting further EOL care planning from occurring. Moreover, pursuing aggressive therapies
in end-stage illness can cause conflict and moral distress within the teams, further disabling a
supportive team environment (Robinson et al., 2007).

Thompson et al. (2006) identified how differing professional paradigms between
medicine and nursing can divide a team and compromise patient care. Grbich et al. (2006)
suggested that shared decision-making is one way to approach EOL care from a collaborative
perspective as it is associated with fewer problems, enhances communication, improves
continuity of care, and promotes respect between the disciplines. Poor team communication can
result in poor continuity of care and can lead to a diminished overall EOL care experience (Grbich et al., 2006; Whitehead et al., 2015).

Staff hierarchies.

Hierarchical practices within an interdisciplinary team can complicate EOL communication and recipient decision-making can suffer. Professional hierarchies exist in healthcare, usually where nurses are subordinate to physicians, diminishing collaborative skills and preventing nurses from communicating patients’ EOL wishes (Albers et al., 2014). A paternalistic attitude by some physicians leads to a lack of respect between professions and, can negatively impact the team dynamics (Grbich et al., 2006). Nurses can be relatively powerless when advocating for patients who desire a comfort care approach when active treatments are ordered (Grbich et al., 2006). Nurses may experience role ambiguity, not know what to say, and fear overstepping boundaries while engaging in EOL discussions (Anselm et al., 2005). Practitioners in patriarchal systems can suppress nurses from advocating on behalf of suffering, despite the right to informed consent and appropriate treatments (Thacker, 2008). Hierarchical issues between physicians and nurses can prevent efficient and effective teamwork leading to the devaluation of the nurse’s contribution (Robinson et al., 2007). Support for respectful interdisciplinary care is needed to reduce hierarchies and promote collaboration.

Divergent paradigms.

Many authors identify that there is a recognizable dissonance between physicians and nurses related to each representative paradigm. For physicians, a medical culture exists where a curative approach to illness can be favoured over comfort care (Robinson et al., 2007; Thompson et al., 2006). The medical model of care includes a disease centered, curative care perspective, which may be prioritized over psychological aspects of care (Gardiner et al., 2011; Robinson et
al., 2007). For some HCPs, a PC approach means giving up, losing hope, and can be interpreted as professional failure (Gardiner et al., 2011; Lenherr et al., 2012; Sheward et al., 2011). Physicians can experience feelings of guilt when failing to pursue a disease-centered model of care, even when active treatments are inappropriate (Robinson et al., 2007). A curative approach, consequentially, can delay PC treatments (Gardiner et al., 2011). Changing the direction of care from a curative to a comfort based EOL care plan can create tensions among professionals and may adversely impact timely EOL decision-making (Sheward et al., 2011).

Contrasting with a medical model of care is a holistic approach, where the patient and family is the center of care. This approach is consistent with the philosophy of PC (Thompson et al., 2006) where nurses are holistic care providers, and patient advocates (Robinson et al., 2007). Promoting timely DNR orders prior to a clinical deterioration demonstrates how nurses advocate for EOL patients (Thompson et al., 2006). Unfortunately, some physicians can become irritated with nurses’ proactive tendencies and advocacy behaviours (Robinson et al., 2007), leading to conflict between the professionals, and low quality EOL care delivery (Thompson et al., 2006).

Many nurses believe they are well positioned to discuss EOL decisions with patients and families, and believe that care recipients would rather have this conversation with a nurse, rather than a physician, because of the close and frequent contact (Albers et al., 2014). In addition, nurses believe they can identify dying earlier than a physician can (Sheward et al., 2011), and should discuss withdrawing or withholding of life support, and when to intensify EOL treatments (Albers et al., 2014). Nurses can support EOL recipients’ decisions through advocacy, which underpins a PC approach. Receptive HCPs who promote and engage in EOL conversations meet EOL patient needs through timely discussions about death and dying (Lenherr et al., 2012).
Palliative care teams.

Specialized PC teams can benefit overall EOL patient care delivery (Albers et al., 2014; Gardiner et al., 2011; Sashara et al., 2005) PC specialists can provide mentoring, clinical expertise and model effective care for new staff. In most hospitals, the role of the PC team is to provide support for staff in EOL decision-making rather than assume the responsibility (Robinson et al., 2007). PC experts should not assume full care of a PC patient, which can lead to a reduction in the generalist HCPs’ ability to provide sufficient EOL care. Although the need for PC expertise is increasing, supporting the generalist HCP’s role to engage in EOL conversations is important, which prevents them from losing EOL skills (Robinson et al., 2007). Interprofessional collaborative care is an important step for supporting EOL decision-making. Role clarification can guide and unite specialized PC teams with general HCPs to deliver effective team based care.

Hospital Factors

Too busy.

The acute care environment poses unique challenges for providers when promoting EOL care and decision-making. Reduced numbers of staff prevent EOL care conversations by reducing the time available for patient care. Staff believe there is not enough time to discuss EOL issues or concerns with recipients (Anselm et al., 2005; Gardiner et al., 2011; Thacker, 2008), they are too busy with other patients (Grbich et al., 2006), preoccupied with multitasking other priorities (such as answering phone calls) (Lenherr et al., 2012), and are challenged with heavy workloads (Sheward et al., 2011; Zapka et al., 2006). The viability of current funding patterns in acute care is questionable; leaders should re-evaluate how to support complex EOL recipients most effectively while in acute care.
System factors.

System factors can affect the HCP’s ability to promote EOL conversations. Large acute hospitals are busy, can be impersonal and experience short term patient admissions. In these environments HCPs may provide poor continuity of care (Whitehead et al., 2015) resulting in uncertainty and PC treatment delays (Anselm et al., 2005). A lack of dedicated spaces to facilitate private EOL conversations complicates the provider’s ability to engage in delicate talks (Sheward et al., 2011). Additionally, a unit philosophy supporting PC may be lacking (Thompson et al., 2006). PC is traditionally rooted in an institutionalized approach focused on caring for the cancer patient and is not routinely applied to general medical patients (Gardiner et al., 2011). Leaders in acute care may not value or support a PC approach in clinical practice, leaving HCPs with a lack of policy and educational initiatives (Anselm et al., 2005; Thacker, 2008). The acute care hospital environment poses many barriers to promoting effective EOL care.

Policy.

A lack of effective policies can complicate and compromise EOL care practices (Anselm et al., 2005). HCPs working in acute care need clearly developed PC policy initiatives (Thacker, 2008) that can be effectively translated into practice (Robinson et al., 2007), and includes specific PC approaches, definitions, and indicators (Grbich et al., 2006). A lack of organizational goals and guidelines can result in poor care outcomes for EOL recipients (Sheward et al., 2011). For example, hospital policies should be explicit and clarify when HCPs should perform active resuscitation, specify what DNR orders exist (Robinson et al., 2007), and promote continuity of care for EOL patients (Sheward et al., 2011). Gardiner et al. (2011) suggests combating the
current behaviour and attitude barriers by expanding PC policy initiatives geared to make a positive impact.

**Recipient Factors**

**Attitudes.**

It is important to build effective relationships with patients and families when discussing EOL care options (Thacker, 2008). HCPs tend to engage in EOL care conversations with relatives instead of patients, preventing advocacy behaviors (Robinson et al., 2007). Situations may exist that prevent EOL communication with patients such as delirium or dementia, altered level of consciousness, confusion, not understanding the content, or a language (or other cultural) barrier (Lenherr et al., 2012). HCPs should attempt to develop relationships with families and patients in the event of a sudden clinical deterioration. It is ideal to discuss EOL decision-making and care with patients; nevertheless, it is important to build relationships with families. Clear communication can assist with developing a congruent plan of care for EOL recipients.

Families may not know the patient’s situation, may have unrealistic goals, and may misunderstand the nature of the illness (Sheward et al., 2011; Thompson et al., 2006). According to Anselm et al., (2005) and Robinson et al., (2007) families can complicate EOL communication by making attempts to protect the patient from harm by avoiding or diverting EOL discussions, or by not appointing a designate decision maker. Tensions may escalate and HCPs may be confronted when family members are under stress. Family members may have different cultural values from those of the HCP, may not understand, not be ready to receive the information, or may be indecisive about DNR decisions. When patients deteriorate and families are not informed, they can become angry and wonder why more has not been done (Thompson et al., 2006).
Recipients can experience fears and frustrations with HCPs when not fully informed about the situation, which can lead to poorly planned future care and goals, and may cause families to experience feelings of regret. Patients and families can be viewed as difficult and can interfere with a patient’s terminal illness care (Zapka, et al., 2006). Poor coordination and transfer of patient care can be confusing and lead recipients to become frustrated (Grbich et al., 2006). Transitioning to EOL can be troubling for patients and families. Many questions may surface while working through the emotional and logistical aspects of the experience (Moir et al., 2015).

When communication about EOL care options is lacking, misconceptions can exist and negative attitudes about PC can emerge. Changing the focus of care for patients and families can mean to lose hope (Thompson et al., 2006). For example, families can perceive PC as care that is actually absent and where nothing is done by HCPs (Thompson et al., 2006). In addition, recipients may believe that death is unacceptable, that the rate of survival from resuscitation is unrealistically high (Anselm et al., 2005), and that the potential to prolong a life is of benefit (Gardiner et al., 2011). HCPs and recipients may perceive dying as taboo and not an appropriate topic for discussion (Lenherr et al., 2012). Furthermore, there can be a lack of trust in the HCP where patients and families may not believe the diagnosis/prognosis (Anselm et al., 2005), or the patient may be in denial (Thompson et al., 2006), and want to fight the illness (Lenherr et al., 2012). The HCP can provide guidance, be a resource, and clarify misconceptions about the intentions of PC.

**Age/illness factors.**

The patient’s age is a factor that influences attitudes towards the need for EOL care. Some believe that older people find it easier to come to terms with a terminal diagnosis and
fewer require PC services than younger people (Gardiner et al., 2011). Gardiner et al. (2011) found that older people die of conditions other than cancer, and because of this, are less likely to receive PC. For younger people, there is a tendency to receive active treatments because of the attitudes and beliefs that the young person has not yet lived a full life (Thompson et al., 2006). The patient’s age can influence his/her ability to receive PC services (Gardiner et al., 2011). Old age is a patient factor that can present a barrier to EOL conversations because equitable access to healthcare services may not be available.

Along with age, the nature of a recipient’s illness can influence receipt of adequate EOL care. It is difficult to determine the appropriateness of a DNR order early in a fluctuating illness; therefore, it is common to postpone these discussions (Robinson et al., 2007). HCPs avoid EOL discussions until they are certain of a dismal prognosis (Anselm et al., 2005) leaving resuscitation conversations too late in an illness (Grbich et al., 2006). There is difficulty in accurately prognosticating acute progressive chronic diseases, where episodic periods of improvements occur, which increases the difficulty in determining a trajectory of illness and reluctance to pursue a PC approach (Thompson et al., 2006). Both age and illness are factors that affect the patient’s chances of receiving specialized and valuable PC. Raising awareness of these issues may improve EOL communication strategies for these groups.

Through my ILR, I uncovered the barriers and facilitators that influenced EOL communication, particularly conversations about EOL issues, and identified the factors that impacted HCPs ability to engage in EOL decision-making. The findings from this review have implications for the patient, family, HCP, and system levels and enabled me to consider some of the ways that people, situations, contexts, environments, and processes are integrally connected and shape each other, as is suggested from a RI perspective. My review of current literature
revealed major and minor recommendations related to supporting EOL conversations in the acute care. RI provided me with a useful perspective while navigating EOL research. What follows is my discussion of the main findings using the theoretical approach that underpinned my inquiry.

**Discussion**

Transitioning patient care from an active/curative to comfort/PC approach is not a straightforward process (Thompson et al., 2006). HCP attitudes complicate and make EOL care conversations difficult. Generally, HCPs do not want to discuss EOL issues, such as death and dying with patients or their families. Physicians are the only HCPs who can formally determine resuscitation status, yet, researchers show that many physicians could avoid EOL conversations, give vague or false hope, leave discussions too late, avoid the truth, or avoid these conversations altogether (Lenherr et al., 2012; Robinson et al., 2007; Sheward et al., 2011; Thompson et al., 2006; Zapka et al., 2006).

Some physicians may insist on performing aggressive therapies to sustain patients’ lives because of a paternalistic attitude and traditional biomedical approach that underpins their profession (Albers, et al. 2014; Gardiner et al., 2011; Grbich et al., 2006; Robinson et al., 2007; Thompson et al., 2006). Additionally, physicians may think patients want aggressive therapies, even when this may be ethically inappropriate because of society’s attitude to avoid death at all costs (Anselm et al., 2005; Lenherr et al., 2012; Whitehead et al., 2015). Nurses can become morally distressed when witnessing suffering related to active, curative therapies imposed by some physicians (Whitehead et al., 2015). This experience can result from hierarchical practices and lead to interdisciplinary conflict and strain professional relationships, where HCP teams suffer moral distress (Sashara et al., 2005; Sheward et al., 2011; Thompson et al., 2006). From an
RI perspective, relationships among HCPs must be considered and cared for in such a way that recognizes the impact of the EOL context on all individuals.

When analyzing research regarding the nurse’s involvement in EOL care decisions, I found conflicting information. Some nurses wanted to discuss death and dying with patients, but were unsupported, and did not have the authority to determine a formal plan of care, such as a resuscitation order (Albers et al., 2014; Robinson et al., 2007). Researchers have suggested nurses are appropriate HCPs to engage in EOL decision-making conversations because of the fundamental approach of most nurses to be holistic caregivers (Robinson et al., 2007; Thacker, 2008). Some nurses (educated, experienced, and knowledgeable) were in a strategic position and could be empowered to initiate and engage in conversations (Moir et al., 2015).

Conversely, not all nurses in all settings were prepared to have EOL discussions. For example, Zapka et al. (2006) found nurses’ pessimism in dealing with EOL conversations with patients and families were related to additional contextual factors in their environments such as workloads, patient difficulties, changing health status, physician hesitance, and personalized nurse discomfort. Education can aim to ameliorate these issues; however, education can also be associated with increased moral distress in EOL caregiving.

Moral distress can be positively correlated with advanced EOL education because ideal care can be recognized and differentiated from the actual care provided. That is to say that when educated providers cannot give ethical care to prevent suffering in EOL patients, they can experience increased moral distress (Sashara et al., 2005; Whitehead et al., 2015). Consequentially, HCPs can become stressed, desensitized, or want to leave the workplace when they are repeatedly exposed to morally difficult situations such as experiencing powerless in EOL care (Whitehead et al., 2015).
When HCPs perceive a high ethical climate in their workplace, lower moral distress results, and there can be improved staff retention (Whitehead et al., 2015). Not all HCPs are interested in engaging in EOL conversations with recipients; however, avoiding these conversations can cause harm to patients, and contravene HCP ethical mandates (Sheward et al., 2011; Thompson et al., 2006). It is beneficial for healthcare leaders to understand the importance of supporting an ethical practice environment, and the impact a positive moral climate can have for dying patients and families. HCPs should act ethically and take the time needed to engage in EOL conversations, provide appropriate care, and promote patient autonomy.

Practical supports such as enhanced staffing, financial supports, and educational initiatives can be important for addressing structural and knowledge barriers. Education can be individualized to support HCPs to recognize patients who may be in the early stages of dying, and enhance communication skills to improve PC competencies (Moir et al., 2015; Robinson et al., 2007). All disciplines involved in EOL care can benefit from EOL education (Albers et al., 2014, Anselm et al., 2005; Grbich et al., 2006; Lenherr et al., 2012; Moir et al., 2015; Robinson et al., 2007; Sashara et al., 2005; Sheward et al., 2011; Thacker, 2008; Zapka et al., 2006).

Addressing both individual and group educational needs may precipitate improvements in teamwork and communication, reduce hierarchies and tensions (Robinson et al., 2007; Sheward et al., 2011; Thompson, et al., 2006) and support shared decision-making (Grbich et al., 2006). Building an interdisciplinary team, whilst clarifying each individual’s professional role, and aiming to dissolve unit hierarchies, can reduce negative HCP attitudes, and promote a collaborative team approach.

Specialty trained PC nurses can provide support for staff and patients because they are more confident in their knowledge and skills and are respected by physicians (Albers et al.,
2014; Sashara et al. 2005). Experienced nurses can provide mentorship and demonstrate effective communication techniques while involved in EOL patient care (Grbich et al., 2006). In addition, specialist PC teams are EOL experts and they could support other HCPs in having discussions (Robinson et al., 2007; Sashara et al., 2005). Also, it is important that specialized PC providers act in a consultative way and not take over the care of the patients as this may lead to the deskilling of general-care providers (Robinson et al., 2007). In the acute care setting, a PC approach needs to include an emphasis on respectful, multidisciplinary care (Grbich et al., 2006).

HCPs cannot easily prognosticate a patient’s clinical deterioration in acute care, so recognizing dying can be difficult (Anselm, et al., 2005; Grbich et al., 2006; Robinson, et al., 2007; Thompson et al., 2006). Chronic illnesses include varying levels of acuity that fluctuate along the illness trajectory. In addition, Gardiner et al. (2011) believes PC services could be implemented throughout a patient’s illness as part of continuous treatment. This integration of PC principles is consistent with researchers who suggest patients with a terminal diagnosis should be offered concurrent active and PC treatments regardless of the care context (IPANEL, 2014; Stajduhar, 2011). Given these requirements, more detailed EOL training and preparation for HCPs is needed (Lenherr et al., 2012). A priority is to teach HCPs how to identify dying in the general medical population, and through a team approach, consider what comfort care treatments will support the goals, needs and values of care recipients.

EOL care policy revisions are needed to provide explicit details about the changes that are needed to support collaborative practice for EOL care (Grbich et al., 2006). Comprehensive policies should include specific definitions, indicators, and PC practices (such as using a team approach) aimed to shift attitudes and behaviours (Grbich et al., 2006). Implementing and supporting EOL policies can guide HCPs to incorporate much needed EOL care into practice.
improvements in hospitals (Anselm et al., 2005; Gardiner et al., 2011; Grbich et al., 2006; Robinson et al., 2007; Sheward et al., 2011). The current acute-care, hospital culture should transform and foster open life and death conversations. Researchers could evaluate the impact of expanding PC services in acute care (Gardiner et al., 2011).

There are many ethical considerations for HCPs when dealing with EOL recipients where relational inquiry (RI) can be employed as a communication philosophy. RI can influence the EOL care conversation process by encouraging the HCP to understand that people’s situations, contexts, environments, and processes are connected and shape each other (Hartrick Doane & Varcoe, 2015). HCPs can better understand and be in-relation with the patient and family by developing an emotional connection and appreciating the personal meaning of the dying experience (MacDonald, 2007). HCPs avoid EOL talks because of the emotionally difficult work inherent to this care (Anselm et al., 2005; Grbich et al., 2006; Sheward et al., 2011; Moir et al., 2015). Emotional clinical supports are needed for HCPs who experience difficulty when treating dying patients.

Approaching EOL communication from an RI perspective can assist HCPs to find ways to meet the current needs of the EOL population, allowing recipients and providers to make ethically congruent decisions. The traditional biomedical model of care can be expanded by realizing that multiple perspectives exist, that relationships are constructed socially, and that people are embodied, embedded, or in-relation with each other, and are not separate from their experiences (Hartrick Doane & Varcoe, 2015). HCPs can approach dying patients and families by recognizing that others who inform and shape patients’ and families’ health decisions and actions influence their unique experience of illness.
The nature of patients’ experiences is influenced by their environments, which in turn are influenced by the presence of families (Hartrick Doane & Varcoe, 2015). HCPs should be aware of the environmental factors that influence an individual’s decisional readiness, and try to improve the circumstances that amplify these opportunities. Any healthcare intervention can be offered through a relational understanding (Hartrick Doane & Varcoe, 2015). Patients identify which relationships are important, and which ones will assist them through their troubling EOL experiences.

Each person has a unique personal identity, experience, interpretation, and way of being in the world (Hartrick Doane & Varcoe, 2015). People are shaped and connected by everyone and everything, and, conversely, they shape others’ responses, situations, experience, and contexts (Hartrick Doane & Varcoe, 2015). Mutual respect is the most important aspect of relational ethics and is achieved through showing an appreciation of differences (Hartrick Doane & Varcoe, 2015).

The current traditional approach to EOL care conversations, as depicted in this research review, contrasts with the ideals of the relational approach. A priority, then, is to motivate HCPs to engage in conversations with recipients and through showing respect, explore the options that are plausible, and from a team approach, work to meet the unique needs and values of EOL patients. Developing trust and meaningful relationships is central to an RI perspective; honouring and promoting treatments that align with patients’ needs and wishes helps develop trust (Hartrick Doane & Varcoe, 2015).

HCPs need to consider the context in which the patient is situated, and then determine with the patient/family which action is the most ethically congruent for that particular situation. Moreover, when staff are open and ready to engage in EOL conversations, they become more
sensitive to the patients’ needs, and more attuned to talking about death and dying (Strang et al., 2014). Furthermore, with support from providers, patients may be more comfortable and willing to express their needs, fears, insecurities, and reveal what dying means (Lenherr et al., 2012). In witnessing suffering, a genuine connection is formed, which can generate compassion (Hartrick Doane & Varcoe, 2015). The development of trust is not an easy task for HCPs, yet, through it, an RI approach to EOL conversations is supported.

HCPs vary in their capacities to engage with patients and families at the relational level and discuss EOL decisions. HCPs can fear opening up emotionally because of the difficult work in caring for EOL recipients. Despite this knowledge, little has been done to improve EOL care delivery, and HCPs remain too busy, suffer heavy workloads, are poorly educated, and lack experience in caring for EOL patients effectively.

More is demanded of providers in acute care settings. Prompt and effective EOL communication in acute care can be further challenged with increasing numbers of older, sicker, and complex patients, who require more resources. In addition, front line HCPs lack support from healthcare leaders (and a lack of useful policies) further preventing decision-making conversations, and worsening an already existing care gap in overall EOL care. Hartrick Doane and Varcoe (2015) claim that RI is not about having the necessary time to practice in the way that is ideal, but rather making conscious choices about how to spend the time that is available. Much work in practice, research, and policy development is needed to enhance EOL care and decision-making which can improve patient and family satisfaction with the dying experience in a hospital setting.
Limitations

While conducting my ILR project, I discovered some limitations in my literature search and evaluation processes. I performed an ILR because of the potential to inform evidence-based-practice while combining a diversity of research sources. When developing inclusion and exclusion criteria to narrow my search, I used the John Hopkins evidence appraisal tool. This tool enabled me to assess a large, diverse data group and screen my articles for informational value and representativeness of primary sources. However, while further analyzing the articles, I found the Johns Hopkins rating tool ineffective in helping me to determine overall quality of research sources, and the tool did not provide me with an effective screening process.

My search resulted in several quantitative, survey style reports from non-experimental research, which did not provide me with new, data-rich or high information value in my findings. Survey data tended to be superficial, with a greater breadth than depth of data, and variables in the surveys were typically opinions, attitudes, or facts and could not demonstrate causation (cause and effect) (LoBiondo-Wood & Haber, 2013). When completing my analysis, I found the qualitative reports rich in data and informational value; whereas the quantitative survey style studies and mixed methods research did not reveal as detailed data and tended to be more generalized and vague. See figures 3.0, 4.0, and 5.0 where I compare the frequency of data collected to each research method approach.

An additional limitation from my literature search resulted in poor theoretical quality of quantitative articles. For example, in these reports, researchers did not claim a theoretical framework to inform the research process, which consequentially increased the difficulty of conceptualizing and operationalizing the variables of interest (LoBiondo-Wood & Haber, 2013). This was a problem because a theoretical framework is a conceptual model used to guide a study,
and set boundaries for the research through identifying concepts and relationships (Coughlan et al. 2007a). When completing my analysis, I found the qualitative reports rich in data and informational value whereas the authors of the quantitative survey style studies did not reveal many additional findings.

In reviewing the literature, the qualitative research designs were rich with descriptive data, and helped inform my identification of patterns and themes with greater frequency while I explored my topic. I attribute this finding to the inherent position of qualitative researchers who focus on the human experience as depicted by those experiencing it, and aim to understand meaning, concepts, and phenomenon of an experience (LoBiondo-Wood & Haber, 2013). Specifically, qualitative methods are concerned with the experiences, feelings, and attitudes associated with understanding phenomena through holistic approaches (Coughlan et al. 2007b). Due to the nature of my inquiry, I believe the findings of the qualitative researchers provided me with the most valuable data, leading me to identify several variables of interest pertinent to my inquiry, and assisted me in identifying the common barriers and facilitators to EOL conversations as perceived by HCPs.

Whittemore & Knafl (2005) remark if the chosen research designs are similar among studies, the data evaluation stage of the ILR can be strengthened in terms of quality scoring and is ideal (Whittemore & Knafl, 2005). Moreover, comparing similar articles with similar methods improves the authenticity of results, provides adequate information, and facilitates identifying representativeness in the conclusions (Whittemore & Knafl, 2005). Despite this limitation, I was able to complete the review, incorporate 13 articles for my analysis, and uncover 4 main domain themes and 18 subthemes.
A final limitation in my ILR is that my literature search was not exhaustive. Whittemore and Knafl (2005) suggest that a comprehensive search should include a maximum number of eligible primary sources. I used several computer databases and strategized my search to identify effective inclusion and exclusion criteria. Despite the search techniques I used, I was unable to locate higher rated research literature. Whittemore and Knafl (2005) suggest that computerized data bases yield only about 50% of eligible studies because of limitations with terminology and that indexing, ancestry searching, hand searching, networking and searching registries are valuable. My findings may not be complete because I did not use all possible search processes.

**Recommendations**

In performing a focused integrative literature review, I discovered communication barriers and facilitators including: (a) HCP factors such as intrapersonal and professional issues, ethical implications, and learner factors; (b) interdisciplinary factors such as teamwork, hierarchies, and divergent EOL paradigms; (c) hospital system factors such as policy, education, and resource allocation; and (d) recipient factors such as knowledge, attitudes, age, and illness type. These findings, combined with my previous knowledge and reading on my topic lead me to make the following recommendations for practice, education, and research:

1. **Recommendations for Practice:**
   - An expert resource nurse, such as an advanced practice nurse, should be involved on units to model and mentor ideal EOL care including communication to junior nurses.
   - Policy development should focus on DNR process and role expectations.
   - PC specialists should be expert consultants, not primary care practitioners.
   - Supportive care that meets nurses’ emotional needs should be offered.
• Additional funding should be made available to assist in supporting a comfort-care, unit philosophy, and appropriate continuing PC education.

2. Recommendations for Education:

• Should include explicit DNR language and care expectations.
• Should be focused on recognizing suffering and dying states in medical patients with life-limiting-illnesses.
• Additional support for general medical non-oncology nurses should be offered.
• Training should be focused on interdisciplinary team thinking (shared decision-making) and include both individualized and team based learning.
• Emphasis should be placed on building a cohesive team (interdisciplinary/collaborative) approach to care.
• Undergraduate and postgraduate education should include PC and EOL communication.
• Clinical education should focus on pain management, symptom control, and ethical decision-making (honest, relationship-based care).

3. Recommendations for Research:

• Additional research in the area of EOL care and communication should be considered using qualitative methods.
• Additional research aiming to uncover barriers to ethical EOL care should be conducted.

Conclusion

In this integrative literature review, my intention was to explore the literature to: (a) uncover the barriers or facilitators that impact EOL decision-making, and (b) understand how
these factors impact HCPs. I identified several contributing factors that impact adult EOL care conversations in acute, hospital environments including HCP factors, interdisciplinary factors, hospital/system factors, and patient/family factors. I visualized main domain themes and subthemes through an RI perspective, which served as a fruitful approach for my inquiry. Throughout this process, I examined EOL communication provisions in-relation to a good death, and found several important implications for HCP practices. Provision of good EOL care means that all HCPs, nurses, nurse leaders, and policy makers must take the lead and implement quality improvements to support patient and families’ rights to informed, ethical care.
References


Appendix A: Johns Hopkins Nursing Evidence Based Practice Appraisal Form

JHNEBP Research Evidence Appraisal

Evidence Level: ______

<table>
<thead>
<tr>
<th>Article Title:</th>
<th>Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author(s):</td>
<td>Date:</td>
</tr>
<tr>
<td>Journal:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Setting:</th>
<th>Sample (Composition/Size)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experimental</td>
<td>Meta-analysis</td>
</tr>
<tr>
<td>Quasi-experimental</td>
<td>Non-experimental</td>
</tr>
<tr>
<td>Qualitative</td>
<td>Meta-synthesis</td>
</tr>
</tbody>
</table>

Does this study apply to my patient population? [ ] Yes  [ ] No

If the answer is No, STOP here (unless there are similar characteristics).

Strength of Study Design
- Was sample size adequate and appropriate? [ ] Yes  [ ] No
- Were study participants randomized? [ ] Yes  [ ] No
- Was there an intervention? [ ] Yes  [ ] No
- Was there a control group? [ ] Yes  [ ] No
- If there was more than one group, were groups equally treated, except for the intervention? [ ] Yes  [ ] No
- Was there adequate description of the data collection methods? [ ] Yes  [ ] No

Study Results
- Were results clearly presented? [ ] Yes  [ ] No
- Was an interpretation/analysis provided? [ ] Yes  [ ] No

Study Conclusions
- Were conclusions based on clearly presented results? [ ] Yes  [ ] No
- Were study limitations identified and discussed? [ ] Yes  [ ] No

Pertinent Study Findings and Recommendations

Will the results help me in caring for my patients? [ ] Yes  [ ] No

Evidence Rating (scales on back)

<table>
<thead>
<tr>
<th>Strength of Evidence Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>High (A)</td>
</tr>
</tbody>
</table>

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Appendix B: Article Critique According to Research Approach

i) Qualitative Critiques Adapted from:


#1

| --- | --- |

<table>
<thead>
<tr>
<th>Writing Style</th>
<th>Clear, topics are highlighted.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author</td>
<td>Physicians, PhD and MN graduate nurses, science majors from a variety of backgrounds are the researchers.</td>
</tr>
<tr>
<td>Report Title</td>
<td>Clear to the purpose and objectives. 10 words</td>
</tr>
<tr>
<td>Abstract</td>
<td>Provides an overview of the study including the problem, sample, method, findings, and recommendations are stated.</td>
</tr>
<tr>
<td>Statement of the phenomenon of interest</td>
<td>Determine HCP perspectives on communication barriers to EOL discussions in Canada.</td>
</tr>
<tr>
<td>Purpose/Significance</td>
<td>To design and implement interventions that would adequately educate HCPs on initiating end-of-life discussions. It is important to clearly delineate the barriers that actually exist in that context and environment. The purpose is to identify what HCPs perceive as barriers to end-of-life discussions in a Canadian health care setting. Design aim was geared to elicit information about who is responsible for initiating EOL discussions and what the various roles are in this process; perceived institutional, patient, and family barriers to discussions; personal barriers to initiating and participating in discussions; views on what should happen in decision making; personal and institutional problems; leadership facilitation issues; and educational strategies to improve practice.</td>
</tr>
<tr>
<td>Literature Review</td>
<td>Literature review supports research plan. Is not always needed at this depth in qualitative research.</td>
</tr>
<tr>
<td>Theoretical framework</td>
<td>A theoretical approach was not identified or inductively discussed by the researcher. The concept of autonomy is mentioned in the introduction and is a guiding principle in an approach to life support.</td>
</tr>
<tr>
<td>Method and philosophical underpinnings</td>
<td>Descriptive, qualitative, focus-group interviews were completed. No worldview is made explicit by the researchers.</td>
</tr>
<tr>
<td>Sample/Context Canada</td>
<td>Sample was purposive and homogenous, group interviews were performed and included experienced attending MDs (10), residents (24), and bedside nurses (33). Staff who care for internal medicine patients in a 600-bed tertiary center in Toronto, Ontario Canada.</td>
</tr>
<tr>
<td>Ethical considerations</td>
<td>Ethics approval was obtained, consent from subjects was obtained (they were paid to participate), anonymity was discussed and identifying information was removed from the transcripts.</td>
</tr>
<tr>
<td>------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Data collection/analysis</td>
<td>“Interview schedule” is not explicitly explained in how these questions are derived (no theoretical framework or concepts to draw on). Experienced interviewers collected data and seem semi-structured but is not stated in the report (credibility). 11 separate focus groups for each discipline and level of experience and training to facilitate “frank and open discussions.” Skilled transcriptionists identified word clusters in themes from audiotapes. Theme frequency was identified. Delphi method was used to categorize themes. Data saturation was not discussed (limited number of participants and theoretical sampling was not performed).</td>
</tr>
<tr>
<td>Rigour</td>
<td>Cronbach’s alpha used to determine internal consistency and reliability of the analysis coding process, enhancing rigour. Data is reported in quotations to gain trustworthiness for the results from this data, which displays an emic view enhancing credibility.</td>
</tr>
<tr>
<td>Findings/Discussion</td>
<td>57 themes initially were identified. Through 4 iterations, reduced to 51, 31, and then 20 themes revealed 4 categories of barrier findings. 1. Recipient issues: opposing views, poor education, timing issues. 2. System: Large impersonal short-term relationships between HCPs and patients in hospitals; deskillled providers, poor coordination and transfer of care, no time to spend with patients; lack of policy to support EOL initiatives. 3. Providers: Poor education and training, no clear role, avoiding conversations until future is certain, prognostic uncertainty. 4. Dialogue barriers: societal values, public misconceptions, DNR unclear, lack of trust in HCP. Findings are correlated to broader findings in other studies and reflected in discussion. Literature review expanded on and discussion placed context of current findings within other literature enhancing rigour (dependability) Data saturation is not made explicit by the researchers.</td>
</tr>
<tr>
<td>Conclusions/Implications</td>
<td>Limitations were discussed re: focus group design and there is less control in group interviews than 1:1 ratios, yet this issue was offset with well-developed questions, appropriately recruited participants, skilled moderators, and systematic analysis. Research recommendations were made: Research patient perspectives of barriers.</td>
</tr>
<tr>
<td>References</td>
<td>Adequate for this time interval, yet 14 articles cited are &gt; 10 years old research. Ideal is for &lt; 5 yrs.</td>
</tr>
<tr>
<td>Writing Style</td>
<td>Well written, no jargon, organized with headings and easy to read tables.</td>
</tr>
<tr>
<td>------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Author</td>
<td>University and hospital affiliated staff (unclear of the professional association).</td>
</tr>
<tr>
<td>Report Title</td>
<td>Clear title, implies article topic and is 11 words (short, concise).</td>
</tr>
<tr>
<td>Abstract</td>
<td>Clear overview of the research is presented including the objectives, sample, method, results, and recommendation for research.</td>
</tr>
<tr>
<td>Statement of the phenomenon of interest</td>
<td>To explore the perspectives of health professionals regarding barriers to optimal palliative care for older people in acute hospitals.</td>
</tr>
<tr>
<td>Purpose/Significance</td>
<td>It is unclear why there are inequalities of referrals to specialist palliative care resources for older people. Barriers to providing palliative care in acute hospitals are not well understood and there is a paucity of published literature in relation to older people. This study contributes to the limited United Kingdom (UK) evidence base by exploring perspectives of health professionals regarding barriers to optimal care for older people in acute hospitals.</td>
</tr>
<tr>
<td>Literature Review</td>
<td>Literature review supports the need for the study (this should have come after data analysis if true grounded theory approach).</td>
</tr>
<tr>
<td>Theoretical framework</td>
<td>Grounded theory framework was used to develop themes (instead of a priori). Although does not follow all grounded theory tenants.</td>
</tr>
<tr>
<td>Method and philosophical underpinnings</td>
<td>Descriptive qualitative method is appropriate for exploring phenomena of interest due to paucity of information. Grounded theory is discussed as a data analysis method but is not explicit. Interview guides are derived from the literature and are semi-structured.</td>
</tr>
<tr>
<td>Sample/Context</td>
<td>Sample includes 58 Participants: 4-consultants, 9-physicians, 6-GPs, 4-practical nurses, 11-CNSs, 19-Other nurses, 5-Allied health from: 1. General practice (28), 2. 2 acute large city hospitals (10) 3. Special PC unit (5) 4. 2 hospices (15) Sampling included multiple disciplines and maximal variation of experiences and opinions (no theoretical sampling followed). Researchers experience is not captured. United Kingdom</td>
</tr>
<tr>
<td>Ethical considerations</td>
<td>No conflict of interest was identified. Funding was provided by NIHR. Ethical approval and written informed consent was obtained.</td>
</tr>
<tr>
<td>Data collection/analysis</td>
<td>Explorative focus groups and interviews occurred. Field notes were taken. The authors analyzed further themes and subthemes. 3 Authors all interpreted data (enhancing credibility) into core themes where a coding framework was developed by grounded data techniques.</td>
</tr>
</tbody>
</table>
No emerging theory is made explicit. Themes and subthemes were identified with N Vivo version 8 used for coding and data management, but was not discussed as constant comparative analysis as is characteristic of grounded theory. Data saturation not evident (dependability lacking).

<table>
<thead>
<tr>
<th>Rigour</th>
<th>Transcripts were read by 3 authors to develop core themes. Data reported in quotes to gain trustworthiness of the data and display an emic view.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Findings/Discussion</td>
<td>The study was performed and resulted in meeting the intention of the researchers’ goal: to uncover significant barriers exist in the provision of optimum palliative care (generic qualitative research). The authors interpreted the data and drew overall conclusions applicable for the target population as discussed in the context of older people in acute care. No emerging theory was identified or cultural processes and meanings.</td>
</tr>
</tbody>
</table>
| Conclusions/Implications | Numerous barriers exist, some evidence of ageism, differing understandings of roles (specialist palliative care providers, generalist HCPs), who should discuss what about conversations when, and gaps in care are identified. Hospital factors and policy implications are discussed. Cure vs. comfort is discussed, and culture is discussed. Recommendations:  
  - Policy translation improvements are needed.  
  - Early interdisciplinary care involvement in patient care.  
  - Dispersed model of PC for older patients and continuous palliation. |
| References | Recent references pertain to topic. |

---

**#3**

Lenherr, G., Meyer-Zehnder, B., Kressig, R. W., & Reiter-Theil, S. (2012). To speak, or not to speak -- do clinicians speak about dying and death with geriatric patients at the end of life? *Swiss Medical Weekly, 142*, w13563-w13563

<table>
<thead>
<tr>
<th>Writing Style</th>
<th>Detailed and slightly wordy at times. Some poor literary writing skills, long run on sentences, ideals a bit scattered in the document and some use of jargon.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author</td>
<td>Credentials are not clearly stated, affiliations to ethics and research support, psychiatry, ICU, and geriatric health are made explicit. An interviewer is stated to be a medical student (first author) in his “scope of dissertation.”</td>
</tr>
<tr>
<td>Report Title</td>
<td>Long 22 words, confusing and ambiguous when asking “to speak”.</td>
</tr>
<tr>
<td>Abstract</td>
<td>Provides an overview of the study including the question, method, results, and conclusion restates the importance but does not make specific recommendations.</td>
</tr>
</tbody>
</table>
| Statement of the phenomenon of interest | Questions arise about whether and how the topic of death and dying is addressed in conversations with patients at the EOL. This topic is considered insufficiently researched by the author. Involving patients in EOL decision-making is often neglected in clinical
practice despite wide agreement HCP should assist patients in preparing for EOL. Death and dying were common in geriatrics, however are not routine in the hospitals in this study.

<table>
<thead>
<tr>
<th>Purpose/Significance</th>
<th>This study explores the willingness and difficulties of physicians and nurses to speak about dying and death with geriatric patients. This is an under researched topic.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Literature Review</td>
<td>The literature review supports the need for the study based upon most studies dealing with cancer-specific patients. A need is identified for EOL conversation improvements in this target population. Lengthy literature review prior to commencing investigation.</td>
</tr>
<tr>
<td>Theoretical framework</td>
<td>No theoretical approach is identified by the author.</td>
</tr>
<tr>
<td>Method and philosophical underpinnings</td>
<td>Qualitative descriptive semi-structured interview study. No further description is given by the researchers. No philosophical underpinning identified. Researcher states: method used is deemed most appropriate when exploring unknown fields and sensitive issues such as EOL care conversations.</td>
</tr>
<tr>
<td>Sample/Context</td>
<td>31 Participants: (14) Physicians, (17) nurses working in an acute geriatric department in a university hospital, and in a geriatric community hospital. This study focused on geriatric interviews only and not the second part of the study that was done in the ICU.</td>
</tr>
<tr>
<td>Ethical considerations</td>
<td>Ethics approval &amp; consent was obtained. Confidentiality and anonymity was “guaranteed”, but was not described.</td>
</tr>
<tr>
<td>Data collection/analysis</td>
<td>Semi-structured guidance was elaborated and focused on issues of EOL decision-making and related difficulties. The themes were determined in advance. Interview guide was drawn from the literature and practice experience, and focused on a subjective approach in 2 parts: 1. EOL decision making and treatments. 2. Conversations about dying and death. Interviewers were: (a) a medical student, and (b) a psychologist. One manually coded the data, although this is not stated. Questionable credibility as researchers are not PC experts. Systematic content analysis was used to assess a purposive sample of clinician’s subjective perspectives and “gain meaningful insight.” The researchers claim this is most appropriate when exploring unknown fields and sensitive issues such as EOL care conversations. Questions are limited to the existence of an advance directive, desire for resuscitation, and potential for transfer to an ICU. Main themes were identified ahead of time but “a framework of categories was progressively developed from the material.”</td>
</tr>
<tr>
<td>Rigour</td>
<td>Systematic content analysis was performed to maintain consistency. Data was reported to gain trustworthiness of the data and display an</td>
</tr>
</tbody>
</table>
emic view. Researcher was a medical student and the second psychiatry, not experts in the field.

Findings/Discussion | Findings address the researcher’s purpose and phenomena of interest as well as are placed in context of other research. Doctors use medical facts, nurse use a holistic focus. Most HCPs claim to be willing to discuss death and dying, but most wait for patients to bring up the topic. Hospital factors, i.e.) time and space issues. HCP personally holding back (facing their own mortality). Recipients’ confused, not willing, not understanding, cultural/social implications. Recruitment was closed at 30-35 yet in the limitation, states the sample was too small for (transferability/generalizability). Small numbers are ok in qualitative research but validity is increased when data saturation occurs with smaller sample, which is not made explicit in this article. One of the limitations suggests data should be collected from internal medicine and LTC areas (this may be a recommendation for future research and not a limitation of the current study?)

Conclusions/Implications | Additional EOL “training” and education is needed in medical education. HCP, hospital system, patient factors are barriers. Open communication fosters a culture change (emotional & spiritual) support Recommendations are adequate for the findings. Recommendations: Timely conversations needed and to leave it up to patients to bring up the topic. PC is supported with timely decisions. HCP ethics should support open and respect autonomy of patients.

References | Several research articles >10 years. A neonatal article is referenced.

#4


<table>
<thead>
<tr>
<th>Writing Style</th>
<th>Short concise flow of titles through to conclusion. No jargon</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author</td>
<td>Research was a MSc dissertation</td>
</tr>
<tr>
<td>Report Title</td>
<td>18 words used to describe the study</td>
</tr>
<tr>
<td>Abstract</td>
<td>Long detailed results are discussed and include all other components. Not concise.</td>
</tr>
<tr>
<td>Statement of the phenomenon of interest</td>
<td>Attitudes to do not attempt resuscitation (DNAR) for patients with end-stage illness may be relevant, but little evidence exists how staff attitudes impact policy implementation.</td>
</tr>
<tr>
<td>Purpose/Significance</td>
<td>Qualitative approach to explore attitudes and experiences of medical and nursing staff in relation to resuscitation for patients with end-stage illness in acute hospital.</td>
</tr>
<tr>
<td>Literature Review</td>
<td>Brief background literature review supports a need for intended research and is appropriate for qualitative discovery.</td>
</tr>
<tr>
<td>Theoretical framework</td>
<td>Theoretical perspective was not described. It was mentioned that categories were linked together with a theoretical perspective and</td>
</tr>
<tr>
<td><strong>Method and philosophical underpinnings</strong></td>
<td>Qualitative descriptive focus group and semi-structured interviews.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>Sample/Context Northern Ireland.</strong></td>
<td>16 participants: 7 nurses and 9 physicians in an acute district hospital. Purposive sampling of medical and surgical staff of differing ages and experiences were desired. Invitations were sent to junior physicians and nurses to maximize variation.</td>
</tr>
<tr>
<td><strong>Ethical considerations</strong></td>
<td>Ethical approval was obtained but it is not clear if consent was addressed, or debriefing occurred after the interviews.</td>
</tr>
<tr>
<td><strong>Data collection/analysis</strong></td>
<td>Interviews occurred in an office (desirable for a naturalistic setting). Questions were formed for the interviews through pertinent terms identified in a literature search on DNAR issues. 2 researchers developed the categories and themes. All research team members determined when data saturation was achieved. Data was coded and categorized by the researchers through a constant comparative method. N6 computer software was used. Data saturation was stated to have been achieved. Examples supported themes and discussion in the results section. Structured thematic analysis was applied.</td>
</tr>
<tr>
<td><strong>Rigour</strong></td>
<td>Low numbers of participants in this study, but data saturation was achieved enhancing rigour. Researchers attempted to portray validity of the findings through a “town hall meeting” with staff and obtained feedback that is claimed to confirm their findings. Crosschecking was done to add credibility to their findings and the researchers felt this had. Data was discussed in quotations to establish credibility. Researchers may have reduced rigour through reporting of researcher bias as a PC expert (was claimed by the researcher as bias, bracketing was not discussed).</td>
</tr>
<tr>
<td><strong>Findings/Discussion</strong></td>
<td>Findings are woven in with the data responses and results. Themes correspond with literature findings and contributed to the researchers’ questions and goals for the research. Findings align with other referenced reports. 5 barrier themes emerged: 1. Lack of clarity- poor policy translation in practice (inappropriate CPR, DNAR). 2. Communication- hierarchical issues (undervalued nurses input); talking with families, no patient consent; patients not understanding; timing issues (late at night, on-call); too late in illness; knowing patients personally; cultural; PC teams taking over care (should only support). 3. Training/Education- (lacks real life scenarios and education),</td>
</tr>
</tbody>
</table>
clarify professional’s roles.
4. Interprofessional – Medical/disease focus vs. PC, difficult identifying end stage of disease due to fluctuations, interdisciplinary conflict, DNR means less nursing care, leads to ethical distress.
5. Ethics-Discussions about CPR causes harm, recipients’ not fully aware or knowing importance, no patient consent, CPR performed as no DNAR.

| Conclusions/Implications | Strengths and limitations are discussed and suggested bias in the interviewer because of the researcher’s background (bracketing is not discussed).
Recommendations:
- Support to staff implementing resuscitation policies.
- Education support including recognizing an ethical approach and communication.
- Implement individual and team training to address gaps. |

| References | 20 All relevant recent reports are used to back up the research. |

#5

| Writing Style | New conceptions are integrated throughout the report, somewhat initially difficult to read. Verbatim data is woven in with new findings. |
| Author | University affiliated department of community health member, faculty of nursing palliative care research, and faculty of medicine. |
| Report Title | Concise and short title but might be ambiguous concerning what the research is about. “Changing lanes” can hook the reader. |
| Abstract | Overview is clearly stated including the research problem, sample, methodology, and findings. Recommendations are not listed. |
| Statement of the phenomenon of interest | Empirical evidence examining care of the dying in hospital and their family members suggests that such care is inadequate, prompting the need for explication of the factors that contribute to quality end-of-life care. Though many of these factors have been identified in the literature, an understanding of the relationships between these factors and their effect on health outcomes in needed |
| Purpose/Significance | Little empirical work has been done to assess the nurse’s perspectives working on general medical units regarding barriers, facilitators, and strategies for achieving quality patient care with a focus on the transition to PC.
To explore and describe determinants of quality of EOL care from the perspectives of nurses working on acute medical units. |
| Literature Review | Strong literature review to support need for research
But not exhaustive keeping with grounded theory methodology |
| Theoretical framework | Grounded theory methodology and symbolic interaction was used to guide the study to explore and describe what determines quality of EOL care. |
| Method and philosophical underpinnings | The goal of this method was to arrive at explanatory, inductively derived theories of basic psychosocial phenomena (social processes). Categories were determined through multiple iterations and coded for process and sub processes. Constant comparison was used to determine new insights through inductive findings |
| Sample/Context | Convenience sample of 10 nurses working in 4 adult inpatient units. Little is known about the small convenience sample size of 10 participants and how these participants were chosen and recruited, but it is described why this purposive sample was recruited. 4 adult inpatient units at 2 university affiliated hospitals. |
| Ethical considerations | Ethics approval was obtained but unclear if consent was. |
| Data collection/analysis | Rationale is given for data collection method; face-to-face semi-structured interviews were done. Unclear who retrieved the data or how the interviews progressed and what was asked to initiate these conversations. Categories were determined through multiple iterations and coded for process and sub processes through constant comparison where new insights were uncovered through inductive findings. Verbatim transcription and constant comparative analysis formed action/interaction sub-processes where a new model was formed. “Creating a haven for safe passage” and a series of subthemes. Relations between categories evident. Data saturation was achieved. Verification was not discussed. |
| Rigour | Not explicitly discussed by researchers Verbatim transcripts were displayed. No peer debriefing or member checking is noted. The researcher as a limitation did not mention small sample size of 10; however, data saturation was achieved enhancing rigour. Similarities are drawn from previous research in the discussion section and aligns with this research (Fittingness). |
| Findings/Discussion | Findings are related to the researchers’ intentions and goals. 1. Facilitators: promoting patient advocacy (communication, education, teams); perspective taking (what the patient may have wanted). 2. Barriers: medical factors (prognosticating difficult chronic disease patterns-lack of direction-not breaking bad news); patient/family factors (age, knowledge, denial); organizational factors (lack unit philosophy of care, paradigm differences) Social processes are described through theoretical statements as identified in the data i.e.) facilitating lane change, maintaining lane change. |
| Conclusions/Implications | Limitations were not discussed; research recommendations are made. Recommendations: • Changing direction of care is achieved by acknowledging cure is not possible and preparation for death is needed. Quality of EOL |
hinges on this process to occur. Nurses facilitate this process through advocacy.

- Future studies should aim to reduce the barriers that facilitate this transition.

References

Mostly recent within 10 years, applicable to topic of inquiry.

ii) Quantitative Critiques Adapted from:


<table>
<thead>
<tr>
<th>Writing style</th>
<th>Writing style is effective, no use of jargon, organized, data charts, and tables are easy to read.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author</td>
<td>End of life research group, university affiliated, health researchers, public and occupational health, palliative care experts. Sufficient backgrounds for research.</td>
</tr>
<tr>
<td>Report title</td>
<td>Clear unambiguous to the purpose of the research, 14 words.</td>
</tr>
<tr>
<td>Abstract</td>
<td>Succinct overview of the research includes purpose, method, sample size, selection findings, and conclusions. Practice implications are stated.</td>
</tr>
<tr>
<td>Purpose/research problem</td>
<td>Nurses have an important role to play in end of life decision (ELD). Factors in relation to work setting impact the nurses and physicians ability to consult about EOL decision-making for patients. Nurse work setting appears to be related to their attitudes to their role in EOL decision-making.</td>
</tr>
<tr>
<td>Logical consistency</td>
<td>In the absence of theoretical framework, unclear what theory guides and informs this research process. Research problem devised from the literature review is sensible.</td>
</tr>
<tr>
<td>Literature Review</td>
<td>Extensive literature review leading to the purpose for the research is identified and the researcher provides an argument for the current research need.</td>
</tr>
<tr>
<td>Theoretical Framework</td>
<td>No theoretical framework is discussed.</td>
</tr>
<tr>
<td>Aims/objectives/research question/hypothesis</td>
<td>Investigate nurse’s attitudes towards their role in EOL decision making and the relationships with sociodemographic and work-related characteristics. (Explores a relationship)</td>
</tr>
<tr>
<td>Sample/Context</td>
<td>(66%) response rate. Sample of 587 nurses working in hospitals home care, nursing homes, or homes for the elderly. Including RNs and CNA (3 year course) referred to as professionals. Sample was drawn from a pre-existing nationally representative (purposive) research sample of nursing staff.</td>
</tr>
<tr>
<td>Ethical considerations</td>
<td>No conflict is declared, legal issues are not discussed, informed consent and ethical approval is not stated in the report. Research is funded by</td>
</tr>
</tbody>
</table>
Definitions of concepts are identified in the literature and are measured through survey questions.

9 statements fall into 3 main topics:
1. Perceived position of the nurse with respect to the patient when an end-of-life decision is being considered.
2. Perceived position of the nurse with respect to the physician when an end-of-life decision is being considered.
3. Perceived role of the nurse in ELD.

Quantitative, non-experimental, survey/questionnaire method

Questionnaire was “developed and tested, and used...” (indicate instrument reliability) according to the researchers.

9 Survey statements fall into 3 main topics:
1. Perceived position of the nurse with respect to the patient when an ELD is being considered.
2. Perceived position of the nurse with respect to the physician when an ELD is being considered.
3. Perceived role of the nurse in ELD.

Descriptive statistics data is appropriate to meet the researchers objectives. Descriptive statistics included: Religion, Age, Gender, Level of education, Work setting, EOL decision making experience, Basic or continuing EOL education.

Hospital nurses: think patients would rather talk to them than a physicians about EOL care treatments, should decide when to intensify treatments, feel subordinate to physicians except when working closely with a specialty PC teams or units in acute care and when basic or continuing education in EOL care.

Findings are congruent with researchers intentions and purpose and reflect nurses’ opinions.

External validity is questionable because of group cohort being a volunteer regular sample of participants. Also, although a large sample is used, discussion of application of findings is in relation to only specifically European counterparts and sociodemographic from that geographic area only.

Recommendations:
- Research should focus on nurse’s attitudes and actual involvement in EOL decision making, training, and multidisciplinary guidelines.

Recommendations made are appropriate for the findings.

Low numbers of references (11), primarily only European research reviews.

<table>
<thead>
<tr>
<th>Writing style</th>
<th>Writing style is effective, no use of jargon, organized</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author</td>
<td>Specialist nurses in home care, hospice, bone marrow transplant; assistant professor-university affiliated; nursing research director.</td>
</tr>
<tr>
<td>Report title</td>
<td>Clear unambiguous to the purpose of the research (17 words).</td>
</tr>
<tr>
<td>Abstract</td>
<td>Succinct overview of the research includes purpose, method, sample size, selection findings, and conclusions. Research implications are stated.</td>
</tr>
<tr>
<td>Purpose/research problem</td>
<td>It was found there is a lack of education and uneasiness among clinical nurses in discussing palliative care with patients and families, negatively impacting the transition from cure-based care to hospice care. The purpose of the study was to determine perceived educational needs of inpatient nurses for communicating with patients and families about palliative and EOL care.</td>
</tr>
<tr>
<td>Logical consistency</td>
<td>Although no theoretical framework is discussed, the steps of the process flow from purpose through to the findings and are clearly described.</td>
</tr>
<tr>
<td>Literature Review</td>
<td>Literature is appropriate for the review and supports the significance for the study.</td>
</tr>
<tr>
<td>Theoretical Framework</td>
<td>No theoretical framework is identified.</td>
</tr>
<tr>
<td>Aims/objectives/research question/hypothesis</td>
<td>Aimed to measure educational needs among nurses regarding communicating PC and EOL care, and elicit the degree of comfort in caring for this population.</td>
</tr>
<tr>
<td>Sample/Context</td>
<td>Convenience sample surveyed using both an online and handwritten Likert style survey called the EOL professional caregiver survey (EPCS). Sample included clinical nurses on telemetry, oncology, and ICU in a 378-bed hospital.</td>
</tr>
<tr>
<td>Ethical considerations</td>
<td>Ethics and hospital approvals were received. No conflict of interest identified.</td>
</tr>
<tr>
<td>Operational Definitions</td>
<td>Questionnaire targeting EOL and PC educational needs of professionals related to: 1. Patient and family centered communication 2. Cultural and ethical values. 3. Effective care delivery</td>
</tr>
<tr>
<td>Methodology</td>
<td>Quantitative, non-experimental, survey/questionnaire design, using Likert style questions called the EOL professional caregiver survey (EPCS). EPCS appropriate for data generation (psychometrically valid).</td>
</tr>
<tr>
<td>Data analysis/results</td>
<td>Data collection via email and survey on the units were returned and anonymized. 34% return (response bias needed) Sample distribution included: • ICU nurses 37% • Oncology Nurses 26% • Telemetry 37% Descriptive stats were used to analyze demographic information; MANOVA was used to determine overall effects of age of the nurse, unit the nurse worked in, and years of experience across settings.</td>
</tr>
</tbody>
</table>
Double blind peer review was performed. Oncology nurses were more comfortable with patient/family communication likely due to greater experience communicating with patients/families about EOL PC options.

More experienced nurses are more confident in their skills.

Discussion

All nurses require EOL communication education. HCP must possess an EOL and PC background if working with patients frequently transitioning from acute to comfort care. Patients need assistance with questions and working through emotional and logistical aspects of their situations.

Sample sizes were small, and, data are only from one hospital; therefore, may not be generalizable according to the researchers and caution in generalizability of the results. A design flaw in a question was identified in the demographic data in terms of years of experience may have skewed the data.

Recommendations:

1. Further exploration of PC and EOL education, and meeting the emotional needs for nurses is needed. This will aim to increase the nurses’ comfort level in conversations with patients and families as well as focus on non-oncology clinical nurses.
2. Future research should aim to determine what education curricula development would meet the needs for these nurses.

References

13 references are used and are current (<5 years) and explanatory to development of the researchers study.

#3.


Writing style

Writing style is effective, no use of jargon, organized

Author

Nurse scholars and physicians affiliated with a University and Hospitals in palliative care and medicine units.

Abstract

Succinct overview of the research includes purpose, design, sample, size, findings, and conclusions, including discussion of clinical relevance.

Purpose/research problem

Current research is based upon previous research suggesting moral distress for HCP is related to aggressive prolonged futility of care. Providing care that is not in the best interests of the patients leads to moral distress. Purpose is to study moral distress, identify the “root causes,” and explore relationships between moral distress, ethics, intent to leave,
<table>
<thead>
<tr>
<th><strong>Logical consistency</strong></th>
<th>The discussion around moral distress and ethical climate is precipitated in the literature review.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Literature Review</strong></td>
<td>Extensive current literature review leading to the purpose for the research is identified and provides argument for the current research need.</td>
</tr>
<tr>
<td><strong>Theoretical Framework</strong></td>
<td>Lack of a theoretical framework. No framework discussed.</td>
</tr>
<tr>
<td><strong>Aims/objectives/research question/hypothesis</strong></td>
<td>The researchers purpose: “...to assess levels of moral distress, identify and compare root causes among all healthcare providers in one large system, and explore the relationships between moral distress and perceptions of ethical climate, intent to leave, and education in end-of-life care and pain management.” (p. 118)</td>
</tr>
<tr>
<td><strong>Sample/Context</strong> USA</td>
<td>Sample of 592 staff (all HCP) in large 825 bed tertiary hospital:</td>
</tr>
<tr>
<td></td>
<td>• 395 Nurses (67%)</td>
</tr>
<tr>
<td></td>
<td>• 111 Physicians</td>
</tr>
<tr>
<td></td>
<td>• 86 other; direct care providers-45, non-direct care providers-41</td>
</tr>
<tr>
<td><strong>Ethical considerations</strong></td>
<td>Review board approved this research but it is unclear if this is ethical approval. Informed consent is not explicit.</td>
</tr>
<tr>
<td><strong>Operational Definitions</strong></td>
<td>Devised through literature review and tools used for data collection. Tools were modified for the providers’ professional level.</td>
</tr>
<tr>
<td><strong>Methodology</strong></td>
<td>Non-experimental, quantitative, descriptive-comparative, web-based survey-questionnaire based on MDS-r (moral distress levels) scale and HEC-S (hospital ethical climate) scale.</td>
</tr>
<tr>
<td><strong>Data analysis/results</strong></td>
<td>Some questions were modified for participants’ professional level and consequential readability. New tool reliabilities were established and validated through the findings. Descriptive statistics data compared position, setting, and intention to leave, years in current workplace, pain management, or EOL education. Nurses and front line staff had higher levels of moral distress than non-direct staff, higher in adult settings, caused by witnessing suffering due to lack of provider continuity, communication, working with incompetent providers, caring for hopelessly ill (futility). Moral distress is related to a low ethical climate. EOL training results in higher moral distress</td>
</tr>
<tr>
<td><strong>Discussion</strong></td>
<td>Findings met the researchers’ objectives and were compared to other studies. Overall survey response was only 22%, which is low but according to this topic, researchers were anticipating only 10-20% response rate. This was the largest institutional survey of its kind. The low return rate of an online survey was not discussed as being a limitation. Nurses were 67% of the overall respondents and this limited generalizability to whole other institutions, according to the researchers.</td>
</tr>
<tr>
<td><strong>References</strong></td>
<td>6 references are over 10 years old, but all pertain to the area of inquiry.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Writing style</th>
<th>Writing style is effective, no use of jargon, organized</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author</td>
<td>Nurse scholars (RN, Masters Heath science, PH.Ds) in adult nursing, terminal, and long term care; University affiliated</td>
</tr>
<tr>
<td>Report title</td>
<td>Clear unambiguous to the purpose of the research (long, 19 words)</td>
</tr>
<tr>
<td>Abstract</td>
<td>Succinct overview of the research includes purpose, method, sample size, selection findings, and conclusions. Significance of results is stated.</td>
</tr>
<tr>
<td>Purpose/research problem</td>
<td>Nurses play a very important role in end-of-life care, as the focus of care shifts from treatment to support of the patient’s daily needs; however, nurses working in hospitals face various problems in relation to providing end-of-life care. Purpose: To identify factors associated with barriers to EOL care.</td>
</tr>
<tr>
<td>Logical consistency</td>
<td>In the absence of theoretical framework, unclear what theory guides and informs this research process. Research problem is minimally devised from the literature review and not clear. Researchers state only 2.5% of patients who reside in a PC unit have cancer, then go on to discuss the importance of general EOL patients, then back to terminally ill cancer patients. It is not clear what role cancer patients have in this research.</td>
</tr>
<tr>
<td>Literature Review</td>
<td>Background is not descriptive or explains specifically need for current investigation, clearly. There is minimal background details elicit or describe a need for this study. Conceptualizing the meaning of the variables of interest is a bit confusing in relation to cancer patients.</td>
</tr>
<tr>
<td>Theoretical Framework</td>
<td>No theoretical approach is identified or explained.</td>
</tr>
<tr>
<td>Aims/objectives/research question/hypothesis</td>
<td>To identify the factors associated with the difficulty in providing EOL care to terminally ill cancer patients encountered by nurses working in general wards in hospitals in Japan. Goals is to develop adequate and concrete support for nurses working in this field.</td>
</tr>
<tr>
<td>Sample/Context Japan</td>
<td>Sampling is identified as convenience of 375 (70%) subjects and included general ward staff and nurses (94%) from 3 hospitals with &gt;300 beds.</td>
</tr>
<tr>
<td>Ethical considerations</td>
<td>Ethics is not discussed.</td>
</tr>
<tr>
<td>Operational Definitions</td>
<td>3 Scales were developed, adapted, and used to depict awareness of EOL issues, evaluate knowledge of PC, and assess the nurse’s autonomy and advocacy. Difficulty is defined as: “a sense of difficulty/trouble in the process of providing high quality care to terminally ill cancer patients and their families” (p.16)</td>
</tr>
<tr>
<td>Methodology</td>
<td>Quantitative, nonexperimental, cross-sectional, survey/questionnaire</td>
</tr>
<tr>
<td>Data analysis/results</td>
<td>Instrument validity was not mentioned. Statistical analysis is addressed as having low coefficient results however, researcher claims the findings are still applicable while...</td>
</tr>
</tbody>
</table>
looking after cancer patients.
Statistical analysis: Unpaired t-test; MANOVA; Pearson’s coefficients included Gender, Age Education, Qualification type, Years of experience.
*Some data was excluded after surveys indicated that staff had not ever looked after a terminally ill cancer patient, reducing representativeness of a population.
Women experience greater difficulties than men. Higher education and clinical experience reduces communication difficulty with recipients.
Mentorship improves difficulties as a higher awareness of EOL issues equates with more difficulty with actual care (not ideal care) causing stress and burnout.

Discussion
Discussion and findings indicate the researchers have met their objectives in the study. Some results could not be confirmed.
- Longitudinal study is needed to investigate the experience of caring for EOL patients following the implementation of a PC specialized team is warranted.
- Basic communication training might reduce communication difficulties experienced by junior staff and less experienced nurses.
- Senior nurses should provide support to younger nurses.

Limitations were identified and a question was phrased incorrectly. In addition, subjects are perceived too young to generalize to larger population.

Recommendations:
- Further studies to investigate how difficulties change after interventions will raise awareness of EOL issues.
- Further enquiry into PC education and nursing difficulties is needed.

References
4 references were older than 10 years; otherwise, all others were pertinent to developing of the research purpose.

#5.

<table>
<thead>
<tr>
<th>Writing style</th>
<th>Writing style is effective, no use of jargon, organized</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author</td>
<td>University affiliated in biostatistics and epidemiology, advanced practice nurse, professor of biostatistics, and associate dean of research in college of nursing</td>
</tr>
<tr>
<td>Report title</td>
<td>Clear unambiguous to the purpose of the research, 8 words</td>
</tr>
<tr>
<td>Abstract</td>
<td>Succinct, no conclusions or recommendations stated.</td>
</tr>
<tr>
<td>Purpose/research problem</td>
<td>Purpose: To determine the impact of an educational intervention on nurses’ EOL communication abilities. Pilot of an educational seminar to explore how an education seminar impacts improving advanced planning communication between nurses and patients.</td>
</tr>
<tr>
<td>Logical consistency</td>
<td>Discussion about heart failure and cancer patients precipitate a need for research. No theoretical framework to guide research.</td>
</tr>
<tr>
<td>---------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Literature Review</td>
<td>Background information draws attention to heart failure as a chronic condition but does not emphasize patients with other life-limiting-illnesses. More background in relation to general life-limiting-illness is needed as sample includes general nurses.</td>
</tr>
<tr>
<td>Theoretical Framework</td>
<td>No theoretical framework is identified.</td>
</tr>
<tr>
<td>Aims/objectives/research question/hypothesis</td>
<td>Describe a pilot educational seminar “Healing Words: Communication with Advanced Heart Failure Patients at the End-of-life.” Describe participants’ ratings of (a) skills related to end-of-life care, (b) attitudes, and (c) most recent experiences with death.</td>
</tr>
<tr>
<td>Sample/Context USA</td>
<td>The study included staff caring for all general medical patient types. 61 cardiology and general internal medicine ward nurses who regularly interact with patients with life-limiting-illnesses, specifically heart failure. 57 survey respondents’ post intervention.</td>
</tr>
<tr>
<td>Ethical considerations</td>
<td>Medical University of South Carolina institutional review board for research with human subjects approved research. Informed consent is not apparent. Anonymity is mentioned for post survey process.</td>
</tr>
<tr>
<td>Operational Definitions</td>
<td>Measured self-assessed knowledge, skill, EOL care attitudes, and perceived experiences related to the most recent death are discussed under measures.</td>
</tr>
<tr>
<td>Methodology</td>
<td>Pilot study, quasi-experimental (Quantitative), one group pre-test/post-test (no randomization of participants), self-administered survey, pre educational intervention, and 2 months post. Pilot is to determine feasibility and justification for larger study. Appropriate method due to a lack of a control group. Testing cause and effect; self-perceived objectives before and after educational session were analyzed.</td>
</tr>
<tr>
<td>Data analysis/results</td>
<td>(93.4%) response rate survey results are informative and lead to the researcher’s findings. Data was placed into tables and descriptive statistical analysis is described. Summary communication skills score was determined reliable pre and post-tests (0.96 &amp; 0.94) Descriptive statistics and repeated measures design was used to compare pre and post scores. Findings: Brief targeted education seminar can improve self-perceived EOL skills. Nurse challenges include number of patients in care, patient, and family resistance, sudden change in health status, MD hesitation, and nurse discomfort. Oncology nurses wanted more help with communicating with family members. Caring for dying patients is depressing. An educational session on PC and EOL care ‘normalizes’ the topic and encourages discussions. Role modelling of communication between experienced an inexperienced nurses is an important consideration.</td>
</tr>
</tbody>
</table>
Discussion

Findings included the feasibility for a short education pilot did impact the staff on the desired variables:

- An educational session on PC and EOL care ‘normalizes’ the topic and encourages discussions.
- Education can be implemented in a busy shift schedule
- Role modelling of communication between experienced and inexperienced nurses is an important consideration
- Brief targeted education seminar can improve self-perceived EOL skills.

Limitations are discussed in relation to a modest sample size, lag in time lapse between pre-test and post-test scores (2 months testing delay) where clinical experience may have influenced results. Some survey responses did not match anecdotal info and resulting in less confidence to make causal assertions. Anecdotal info. Revealed difficulty discussing patients EOL issues with physicians (no changes post-test; survey did not reflect the anecdotal information).

References

Appropriate, recent, affiliated with the topic of the study.

iii) Mixed-Methods (combines both qualitative and quantitative critique adaptations)

<table>
<thead>
<tr>
<th>Writing Style</th>
<th>Article 21-37 pages (including appendix, long)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author</td>
<td>Nursing director, nursing academic professor, PC experts</td>
</tr>
<tr>
<td>Report Title</td>
<td>Simple no jargon, easy to understand 15 words</td>
</tr>
<tr>
<td>Abstract</td>
<td>Provides an overview of the study including the problem, sample, method, findings, and recommendations are eluded to but not stated.</td>
</tr>
<tr>
<td>Statement of the phenomenon of interest or Purpose/research problem</td>
<td>Research was precipitated by anecdotal evidence indicating provision of care was not achieved on acute care wards. Consideration for a PC pathway was given.</td>
</tr>
<tr>
<td>Purpose/Significance/aims objectives/question/hypothesis</td>
<td>Analyze EOL care in the acute care wards, identify deficits in care provision as related to EBP initiatives, recommend learning strategies for nurses, determine model of care.</td>
</tr>
<tr>
<td>Literature Review</td>
<td>Background and literature review (2 full pages) is quite extensive.</td>
</tr>
<tr>
<td>Theoretical framework</td>
<td>No philosophical or theoretical approach identified</td>
</tr>
<tr>
<td>Method and philosophical underpinnings</td>
<td>Mixed-Methods (not made explicit by the researcher) Retrospective case studies (quantitative, non-experimental) Interviews (qualitative &amp; quantitative data)</td>
</tr>
</tbody>
</table>
| Sample/Context | 1. Chart audit of 20 patients who had died on a medical or surgical ward in a 250-bed acute care teaching hospital (with a focus on
Australia provision of services for the older adult) in Australia. Opportunistic sampling and included inclusion/exclusion criteria (died on a medical/surgical ward).

2. 40 nursing interviews - sampling methods were purposive.

<table>
<thead>
<tr>
<th>Ethical considerations</th>
<th>Anonymity was achieved by removing identifiers. Ethics committee approval was obtained. Informed consent is not discussed.</th>
</tr>
</thead>
</table>

| Data collection/analysis | Data collection was explicit in the article:  
1. Case note audit tool (based on Beth Israel framework) retrospectively audited documentation in relation to nursing care (if comprehensive nursing assessment had occurred, if appropriate nursing interventions were implemented based on such, if outcomes of these interventions were documented, and if appropriate modifications were undertaken.  
2. An interview tool was created also based upon the Beth Israel framework and both quantitative and qualitative data was drawn (cross sectional analysis [data at one time] was used to cluster themes).  
3. Individual checking was done by the team for both quantitative and qualitative data.  
Instrument reliability was not observed. |
|-------------------------|-----------------------------------------------------------------------------------------------------------------------|

| Rigour | Inclusion/exclusion criteria were discussed leading to rigour in the findings.  
The limitation is addressed as a “preliminary nature” and a larger study is recommended.  
Small patient sample for retrospective chart audit and quantitative data extraction.  
Themes were independently drawn out by 2 researchers (to reduce bias). |
|---------|-------------------------------------------------------------------------------------------------------------------------|

| Findings/Discussion | Combined findings from chart data correlated with interview results and provided more substance to the overall findings:  
1. Patient intrinsic factors (diminished capacity; too late in illness),  
2. End stage not recognized early enough vague orders, no timely DNR orders,  
3. Nurses are powerless to advocate and lack time or desire to engage,  
4. Few family conferences (or shared decision-making opportunities), poor staffing ratios.  
Combined methods in mixed methods approach provided data rich evidence for which solutions are suggested. |
|---------------------|----------------------------------------------------------------------------------------------------------------------------|

| Conclusions/Implications |  
• Communications between patients, families, nurses, and physicians continue to be poor.  
• Poor multidisciplinary approach in PC.  
• Earlier not-for-resuscitation (NFR) conversations place less distress and fewer active treatments close to death.  
• There is a paternalistic model of communication (practitioner knows best), and lack of respect between professions. Physicians should listen to nurses. PC is not a priority in acute care. |
- Practice issues need improved surrounding acute to PC focus including increased staffing numbers and providing adequate facilities.
- Policy revision should include definition of PC, palliative interventions, PC specialty team indicators, staffing levels, task orientation, and addressing an interdisciplinary model of care.
- There are major shortfalls in PC education. PC education should be geared to assess the individual staff members professional development needs.
- “Link” (resource person) nurses/physicians could mentor others to the philosophy and practices of PC.

**Recommendations:**
1. There is a lack of holistic care in acute care and a new model of care must be sought.
2. Need to change the focus of care early enough.
3. Enhance staffing.
4. Improved facilities for privacy.
5. Policies to focus on meeting national standards and accreditation implementation.

| References | 7 articles >10 years old. |

---

**#2**


**Writing Style**
Clear concise, headings easy to read, tables concise and offset other data.

**Author**
Nurses and advanced practice nurses, physician, hospice affiliated.

**Report Title**
Short 14 words, concise, accurate.

**Abstract**
Provides an overview of the study including the problem, sample, method, and findings are stated. Recommendations are not stated.

**Statement of the phenomenon of interest or Purpose/research problem**
Caring for the dying is not perceived as a priority in acute care. This attitude impacts provision of EOL care that includes a PC focus. The nurse’s role in EOL care is pivotal to the experience of care for patients and families. Nurses are motivated to provide good PC however cannot in the context of the acute environment.

**Purpose/Significance/aims objectives/question/hypothesis**
To reveal staff perceptions of EOL care in hospital setting Through questions geared to answer:
- Care of the dying.
- Communication.
- Teamwork.
- Documentation.
- Attitudes towards death and dying.
- Barriers to care of patients.

**Literature Review**
Short background sufficient to pursue research topic and is supported.

**Theoretical**
No theoretical approach was specified.
<table>
<thead>
<tr>
<th>framework</th>
<th>Method and philosophical underpinnings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mixed-Methods Survey/questionnaire</td>
</tr>
<tr>
<td></td>
<td>(Mostly Likert style questions [quantitative], with open questions [qualitative])</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sample/Context</th>
<th>New Zealand</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Purposive sample: 179 staff (29%) in a 194 bed regional hospital from medical (36), nursing (114), and allied health (21) backgrounds and working in medical, surgical, elder health and regional cancer treatment service.</td>
</tr>
</tbody>
</table>

| Ethical considerations | Ethics approval was obtained. When staff returned surveys, consent was inferred (not appropriate). |

<table>
<thead>
<tr>
<th>Data collection/analysis</th>
<th>Data analysis not specifically stated but implied through developing themes and phrases, along with iteratively returning to original data, synthesis of themes and collaboratively returning to the original data.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Quantitative: Demographics and Likert questions underwent quantitative analysis</td>
</tr>
<tr>
<td></td>
<td>• Qualitative: key words and phrases were identified via explanatory comments to Likert style questions. In addition, open questions were related to attitudes death and dying, barriers to caring for patients/families, suggestions for improvement (not shown).</td>
</tr>
<tr>
<td></td>
<td>Both investigators independently reviewed data (enhancing credibility) Tool reliability was not established.</td>
</tr>
</tbody>
</table>

| Rigour | Discrepancy with findings generated from a Likert style question (yrs. of experience) and the answers to an open-ended question (instrumentation threat to internal validity) reducing generalizability. Unable to determine nature of the open questions to ascertain qualitative content (not stated). |

<table>
<thead>
<tr>
<th>Findings/Discussion</th>
<th>Likert scale data was considered in relation to the qualitative analysis (ideal for mixed methods approach). Facilitators were not sought to determine good outcomes of care recognized as a limitation by the researcher.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5 themes emerged:</td>
</tr>
<tr>
<td></td>
<td>1. Reality of care (emotional labor, advocating to physicians for patients, identifying knowledge gaps).</td>
</tr>
<tr>
<td></td>
<td>2. Team Dynamic- professional dissonance when advocating for patients, can include (attitudes, cultural beliefs, values) supportive teams is needed.</td>
</tr>
<tr>
<td></td>
<td>3. Changing the direction of care form cure to comfort approach (no change-ethical issues and moral distress, change-influenced by recognizing dying, timely, supported with help of others).</td>
</tr>
<tr>
<td></td>
<td>4. Knowledge and education (pain management, ethics, difficulty with conversations).</td>
</tr>
<tr>
<td></td>
<td>5. Environment/Organizational (Workload, time, space, privacy, resources).</td>
</tr>
</tbody>
</table>

| Conclusions/Implications | Results were congruent with researcher’s intentions in the purpose stage. Themes were further conceptualized and identified and depicted |
earlier by the researchers:
Nurses experience difficulty due to the medical model of care and respective roles and implications that drive decision-making even when patients are suffering:

A. Dissonance between nurses and physicians when not disclosing dying as a possibility and change plan of care. Delayed EOL decisions create dissatisfaction for nurses. Continuing active treatment for patients who appeared to be dying created ethical distress for all HCP. Identification of dying is an issue and is needed in order to facilitate EOL conversations. Recognizing dying is an issue although HCP think they can. Recognition of dying leads to changing direction of care.

B. Nurses think they can identify dying earlier than the physician can. Physicians can be overly optimistic. Decision-making regarding direction of care lies within the medical (physician) teams. Some medical staff find it difficult to determine appropriate care direction. Delaying diagnosis impacts clear communication, setting appropriate goals-of-care, enabling conversations, and ensuring symptoms are well controlled. Absence of well-documented plan of care as a guide for after-hours decision-making is key. There is a need to find ways in which to work in teams, which is imperative to facilitate changing direction of care.

Recommendations: Future research should focus on facilitators as well as barriers.

References
3 articles <10 years old. Good variety of sources.

#3.

<table>
<thead>
<tr>
<th>Writing Style</th>
<th>Clear no jargon, clear headings.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author</td>
<td>Unclear credentials but is college affiliated</td>
</tr>
<tr>
<td>Report Title</td>
<td>Clear, descriptive and easy to understand and short</td>
</tr>
<tr>
<td>Abstract</td>
<td>Provides an overview of the study including the purpose, sample, method, and some findings are mentioned.</td>
</tr>
<tr>
<td>Statement of the phenomenon of interest or Purpose/research problem</td>
<td>The disparity between the way people die and the way they wish to die is increasing. When nurses advocate for patients, they may face barriers associated with healthcare systems and professional relationships including treatment/curative focus, paternalistic care, inadequate decision-making models, and inadequate policies</td>
</tr>
<tr>
<td>Purpose/Significance/ aims objectives/question/hypothesis</td>
<td>Purpose was to describe nurse’s perceptions of advocacy behaviors in EOL nursing practice in the acute care setting.</td>
</tr>
<tr>
<td>Literature Review</td>
<td>Very short literature review congruent with qualitative approach.</td>
</tr>
<tr>
<td>Theoretical</td>
<td>Foundation of nursing advocacy behaviors was explored in the literature</td>
</tr>
</tbody>
</table>
EOL CONVERSATION BARRIERS AND FACILITATORS

<table>
<thead>
<tr>
<th>framework</th>
<th>as related to Benner’s theory of novice to expert. Benner’s novice to expert theory informs a conceptual framework related to competency, holistic care including advocacy to inform patient’s autonomy in making informed decision-making, and is illustrated in relation to EOL care in a diagram.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Method and philosophical underpinnings</td>
<td>Benner’s theory was used and assumptions that informed the research were made explicit (quantitatively). Mixed-Methods, Non-experimental Comparative descriptive Survey/Questionnaire Ethics advisory instrument to explore the perceptions and behaviors of nurses, identify advocacy behaviors and how the educational systems and health care infrastructures support or do not support those behaviors.</td>
</tr>
<tr>
<td>Sample/Context</td>
<td>Atlantic USA Convenience sample of 314 nurses from 3 regional hospitals with 185-800 inpatient beds. Med/Surg. (47.5%) and ICU nurses (23.9%). 33.3% return</td>
</tr>
<tr>
<td>Ethical considerations</td>
<td>Permission was obtained to perform survey. Rights and subject anonymity was discussed.</td>
</tr>
<tr>
<td>Data collection/analysis</td>
<td>Comparative descriptive design was used to examine differences among the differing levels of experiences of nurses to determine advocacy behaviors in EOL care in acute care settings. This was achieved through use of a questionnaire. The ethics advocacy instrument (EAI), consisting of 38 items, was used. This instrument aims to explore if the educational systems and health care infrastructures support or do not support advocacy behaviors. Demographics statistical data was obtained (quantitative). Qualitative content analysis was completed on the 2 open-ended questions. Expert researcher assisted in this process (credibility).</td>
</tr>
<tr>
<td>Rigour</td>
<td>Limitations included low instrument reliability, use of convenience sample from 1 geographic location, and timing for data collection. Instrument was determined reliable initially then was described as low &lt;.7 (.374)</td>
</tr>
<tr>
<td>Findings/Discussion</td>
<td>Findings are congruent with literature review and are discussed in relation to Benner’s theory Supports to advocacy at EOL: • Nurse managers and coworkers who support clinical practice, multidisciplinary teams, communication, relationships with patients, family, nurse knowledge and beliefs, compassion, family. Barriers to advocacy at EOL: • Physician difficulties relating to EOL issues, and traits, family, fear, lack of communication, lack of knowledge, lack of time, and a lack of hospital support.</td>
</tr>
<tr>
<td>Conclusions/Implications</td>
<td>• All disciplines need specialty EOL care education. • More experienced nurses have greater access to EOL education</td>
</tr>
</tbody>
</table>
than new graduates in spite of the recent undergraduate education initiatives, and are more mature, confident, and have life experience to navigate interpersonal and structural systems.

- Novice nurses need time to develop proficiency and communication patterns.
- Advocacy is not typically part of curricula for EOL care training.
- Demand for EOL care will increase as our elderly population grows along with burden of chronic disease and terminal illness.
- The majority of practicing nurses work in acute care settings, therefore staff development, education, and policy development must be focused in these areas.

Recommendations correlate with findings from survey results and inform overall findings:

1. Larger study with improved instrument reliability.
2. Use quasi-experimental or qualitative methods study using evidenced based practice and role of advocacy.
3. Use Benner's theory to support experience group comparison.

| References | Several references are over 10 years old (18). 58 sources (too many) |
Appendix C: Concept Map

Conceptual Map of the Findings
## Appendix D: Barriers and Facilitators Identified

Barriers and Facilitators Comparison

<table>
<thead>
<tr>
<th>Citation</th>
<th>Barriers</th>
<th>Facilitators</th>
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</table>
• Work setting (acute care vs. community) | • Nurses think they should be involved in EOL decision making and determine when to intensify treatments, when to withhold and withdraw life support.  
• Nurses working with specialty services and PC teams are less subordinate to physicians in decision-making.  
• EOL educated nurses believe patients would rather speak to nurses than physicians about EOL decisions.  
• Education enhances nurse ability to partake in decision-making; enhances conversations with patients, and physicians. |
• Variable capacity to understand information, not ready, difficulty with DNR decision when illness fluctuates.  
• Healthcare System issues; large impersonal environment.  
• Deskilled HCP, poor coordination of care.  
• No time to spend/scheduling issues.  
• Lack of privacy. |
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<tr>
<th>Citation</th>
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<th>Facilitators</th>
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</thead>
</table>
|          | - Not knowing the patient.  
- Fear of litigation.  
- Lack of policy.  
- Risk of abandoning patients.  
- Poor staffing, poor access to ethics consultants.  
- HCP poor training, education, experience.  
- Not leading prognostic discussions due to uncertainty.  
- Unable to deal with the emotional aspect of care.  
- Role ambiguity.  
- DNR unclear directions, unrealistic societal values for life sustaining treatments.  
- Lack of trust in HCPs.  
- Poor resource allocation. |          |
- Nature of life-limiting-illness; that being cancer or non-cancer diagnosis.  
- PC conceptual confusion; PC is equated with dying.  
- HCP do not view PC as a routine role.  
- Culture is curative vs. comfort  
- PC has institutionalized focus.  
- Comfort approach means giving up.  
- Psychosocial care is not a priority. | - Expanding PC and policy initiatives may change attitudes and behaviors.  
- Education isn’t enough to impact change |
| 4. Grbich, C., Parish, K., | - NFR discussed too late in  
- Earlier NFR orders create |          |
<table>
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<tr>
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</table>
  - Poor understanding of advance directive and advanced care planning.  
  - HCP not recognizing terminal phase.  
  - HCP not disclosing poor illness trajectory.  
  - Lack of respect between professions with paternalistic (Dr. knows best) attitude impacting interdisciplinary approach.  
  - PC approach is not a priority in acute care.  
  - PC education shortfalls.  
  - Staffing issues.  
  - Nurses are powerless to advocate for patients.  
  - Comfort when active treatments are ordered.  
  - Poor unit culture (not supporting PC)  
  - No family conferences.  
  - Staff too busy with other patients. | - less distress with fewer active treatments close to death.  
  - Comprehensive Policies need to include specific PC approaches, definitions, and indicators.  
  - Improvements need to be made to interdisciplinary model of care approach supporting PC philosophy.  
  - Specialized education to include resource nurse, mentoring for all HCP, and should be geared to address the individuals learning needs.  
  - Shared decision making is associated with fewer problems. |
  - Space & time for EOL conversations can present issues.  
  - HCP facing their own mortality and personally holding back.  
  - EOL care is viewed as being difficult, depressing.  
  - Patients in denial and desire fighting illness.  
  - Dying is taboo.  
  - Confused or delirious patients altered LOC. | - Most HCP think they are willing to discuss death and dying with patients but will not bring up the topic.  
  - Both medical facts and a holistic approach are used when conversing about death and dying that includes a broad approach.  
  - Physicians have a responsibility to inform patients of their diagnosis, prognosis.  
  - Open staff members to conversations.  
  - HCP are ethically |
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- MD’s view that dying means giving up and that hope may be lost. | - HCP must possess PC experience when caring for patients transitioning from acute to EOL care.  
- EOL communication increases nurse’s skill and comfort in caring for patients and communicating EOL care.  
- EOL education should focus on meeting emotional needs of the nurse and be aimed at non-oncology nurses.  
- Curricula development aimed to this nursing population needs to be developed. |
- Unclear DNAR orders  
- Role confusion.  
- Personal issues  
- Cultural barriers  
- Differences in opinion about what to do in families.  
- Physicians irritated with nurses proactive stance.  
- Hierarchical issues between nurses and physicians prevent teamwork.  
- Too early in the illness to determine DNAR status.  
- Fluctuating illness.  
- PC teams “taking over” care and reducing all HCP | - Nurses think they initiate conversations and want to be involved.  
- Nurses are providers of holistic care.  
- Ethical considerations to promote patient autonomy.  
- Specific education for physicians and nurses.  
- Interprofessional training.  
- PC teams to support staff in caring for patients rather than take over care. |
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<th>Facilitators</th>
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</thead>
<tbody>
<tr>
<td>abilities/experiences to provide this care.</td>
<td>• Poor training.</td>
<td>• Higher education &amp; clinical experience = less communication difficulties and personal issues.</td>
</tr>
<tr>
<td>• Curative vs. comfort approach favored (medical/disease focus).</td>
<td>• Physicians “not knowing” the patients.</td>
<td>• Mentorship reduced difficulty.</td>
</tr>
<tr>
<td>• Physicians feel guilty when giving up</td>
<td>• Too late to discuss options (timing).</td>
<td>• High awareness of EOL issues.</td>
</tr>
<tr>
<td>• Not identifying end stage illness early enough.</td>
<td>• Fear DNAR reduces nursing action.</td>
<td>• PC teams are best suited as experts in care and providing mentorship to nurses.</td>
</tr>
<tr>
<td>• Personal relationships with patients and beliefs.</td>
<td>• Fear of litigation.</td>
<td>• Senior nurses to mentor junior nurses</td>
</tr>
<tr>
<td>• Ethics: Not giving patients a chance to decide (autonomy).</td>
<td>• Lack of support for HCP.</td>
<td>• Communication training should commence after registration.</td>
</tr>
<tr>
<td>• Belief conversation causes harm.</td>
<td>• Higher education &amp; clinical experience = less communication difficulties and personal issues.</td>
<td></td>
</tr>
<tr>
<td>• Mentorship reduced difficulty.</td>
<td>• High awareness of EOL issues.</td>
<td>• Mentorship reduced difficulty.</td>
</tr>
<tr>
<td>Higher education = more difficulty in team collaboration, treatments and informed consent.</td>
<td>• PC teams are best suited as experts in care and providing mentorship to nurses.</td>
<td></td>
</tr>
<tr>
<td>• Also difficulty in actual vs. idealized care</td>
<td>• Senior nurses to mentor junior nurses</td>
<td>• Recognizing need to change care direction.</td>
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<td>• Senior nurses to mentor junior nurses</td>
<td>• Recognizing need to change care direction.</td>
</tr>
</tbody>
</table>


9. Sheward, K., Clark, J., Marshall, B., & Allan, S. • EOL care is difficult care-advocating, symptom
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<tr>
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<th>Facilitators</th>
</tr>
</thead>
</table>
| (2011). Staff perceptions of end-of-life care in the acute care setting: A new Zealand perspective. *Journal of Palliative Medicine, 14*(5), 623-630. | • control, knowledge gaps, and is emotional.  
• Individual or professional dissonance.  
• Hierarchical issues when Physicians do not disclose dying and have difficulty changing direction. Focus on curative care  
• Delaying diagnosis prevents clear communication, appropriate goals-of-care, enabling conversations, well controlled symptoms.  
• Challenging dynamics-professional differences, cultural background, personal values and beliefs.  
• Attitudes to death and dying negatively impact teams.  
• Changing direction of care creates tension.  
• No change can result in distress when ethically inappropriate care is expected.  
• Death as perceived as medical failure.  
• Unrealistic patient/family expectations.  
• Heavy workload  
• Poor staff skill mix.  
• Time constraints  
• Lack of organizational goals and guidelines results in (poor continuity of care such as after hour’s last minute decision making). | • Timely change in plan of care that was supportive  
• Knowledge and education enhanced engaging in difficult conversations and ethical decision making.  
• Continuity of care.  
• Adequate space, privacy, resources.  
• Teamwork that supports changing direction of care (all on the same page) |

| 10. Thacker, K. S. (2008). Nurses' advocacy behaviors in end-of-life nursing care. | • Physician traits and attitudes. | • Leadership support  
• Multidisciplinary team |
<table>
<thead>
<tr>
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<th>Facilitators</th>
</tr>
</thead>
</table>
| **Nursing Ethics, 15(2), 174-185.** | • Patriarchal systems suppressing nurses advocating for patients.  
• Family  
• Lack of communication.  
• Lack of knowledge  
• Lack of time  
• Lack of undergraduate education.  
• Lack of hospital supports.  
• New nurses need time to develop skills in proficiency and communication.  
• Nurses fear speaking up and promoting advocacy behaviors.  
• Demand increasing due to aging population and concurrent chronic/terminal diseases. | • Effective relationships built with patients and families.  
• Compassion  
• Family centered care.  
• Education to support advocacy behaviors.  
• Undergraduate education on EOL care.  
• Experienced nurses are more mature, confident, have life experience to navigate systems and issues.  
• Target area for improvements and staff developments should be directed to acute care settings as the majority of nurse’s work here. |
• Lack of recognizing dying.  
• Prognostic challenges when chronic diseases have episodic periods that increase difficulty determining trajectory and lack of direction.  
• Diverging paradigms; medical model favors a curative approach, nursing favors holistic.  
• Discussion left too late.  
• Physicians unwilling to deliver bad news.  
• Age attitude when person is young and not yet lived a full life.  
• Unrealistic expectations and misunderstanding the nature of illness.  
• Belief that changing focus | • Honest and clear communication regarding deteriorating health conditions and impending death.  
• Collaborative care plans  
• Teamwork that supports honest and clear communication and a collaborative care plan; on the same page.  
• Nurses’ building on what the patient already knows as a baseline for communication.  
• Advocating for timely DNR orders prior to deteriorating.  
• Nurses encouraging families to think about what the patient would have wanted.  
• Unit philosophy and |
<table>
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<th>Facilitators</th>
</tr>
</thead>
</table>
|          | means losing hope.  
  • Belief that nothing is being done.  
  • PC as distinct and separate phase.  
  • Nurses’ moral distress when performing curative treatments fueling denial and false hope for people.  
  • Angry family that more has not been done and in denial.  
  • Changing of practitioners once PC decision has been made (poor continuity of services and relationships). | culture of care that support PC transitions.  
  • Nursing’s holistic approach that supports patient centered care that is consistent within a PC philosophy. |
  • Diminished care is related to poor communication.  
  • Lower ethical climate relates to higher moral distress.  
  • Incompetent providers.  
  • EOL training results in higher levels of moral distress.  
  • Direct care providers have higher levels of moral distress.  
  • Lack of HCP continuity.  
  • Repeated exposure to morally challenging situations, desensitizes HCP who withdraw from situations.  
  • Poor team communication  
  • EOL issues trigger moral distress.  
  • High moral distress leads to desire to leave the workplace. | • Higher ethical climate results in lower moral distress. |
<p>| 13. Zapka, J. G., Hennessy, | • Nurses dread dealing with |
|          | • PC and EOL education |</p>
<table>
<thead>
<tr>
<th>Citation</th>
<th>Barriers</th>
<th>Facilitators</th>
</tr>
</thead>
</table>
- Caring for the dying is viewed as depressing.  
- The nature of EOL care.  
- Challenges include:  
  - Workload  
  - Patient/family resistance  
  - Sudden change in health status  
  - MD hesitance  
  - Nurse discomfort.  
  - MDs instilling false hope and dismiss need for patients to talk. | normalizes EOL topic and encourages discussions  
- Role modeling effective communication  
- Oncology nurses identify the need for more help in communicating with family members. |