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Last Hours of Life: Encouraging End-of-Life Conversations

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In a culture rooted in a medical ethos of saving life, beginning a conversation on how a person wants to die can be challenging. Research such as the Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment (SUPPORT) describe the difficulties in encouraging people to make plans for their end-of-life care by completing such documents as advance directives. SUPPORT reported that the needs and preferences of dying individuals were not being addressed in an effective and adequate manner.¹ Beyond such studies, anyone who has given talks, led seminars, or provided clinical conversations with individuals knows the resistance involved in furthering such conversations.

In an attempt to improve the quality and the facility of having end-of-life care conversations, beginning in 1996 the Nevada Center for Ethics & Health Policy (NCEHP) developed "Last Hours of Life." This brief worksheet enables healthcare providers, individuals, and even groups to have a rich and informed conversation about end-of-life issues. The worksheet gives a person a contemplative space to address death and dying issues in a nonthreatening manner that permits introspection and thoughtful response. The completed tool also can provide a launch pad for discussions between an individual and careproviders, family and friends, as well as for seminars on end-of-life issues. This article discusses our analysis of the results of the first "Last Hours of Life" worksheet (1996), and how the investigation of more than 466 participants' answers led us to develop a new and improved version that follows from an "emic" perspective — that is, the new version was derived from the participants' categorizations, rather than from a schema imposed from outside. The new version appears as an appendix at the end of this article.

BACKGROUND

The first phase of SUPPORT identified failures within the medical community to recognize dying patients' needs, especially in relation to aggressive treatment (such as cardiopulmonary resuscitation) and pain control.² The study reported that communication, or lack thereof, between healthcare providers and patients was largely to blame for these failures.³ The second phase of SUPPORT was designed to address the problems in patient-provider communication and the understanding of patients' preferences during the dying process.⁴ The interventions used in Phase II of SUPPORT included providing physicians with information regarding rates of survival and quality of life following cardiopulmonary resuscitation. Additionally, specially trained nursing staff facilitated increased communication between physicians, patients, and families of

patients to increase awareness of patients' preferences and needs, specifically through pain control and advance care planning. Unfortunately, the interventions designed to increase the quality of the end of patients' lives did not yield successful results.⁵ A follow-up study conducted 10 years later found that the state of end-of-life care and research was little changed and that work reevaluating the use of advance directives was still occurring.⁶

Recent trends in research and literature relating to death and dying place significant emphasis on determinants that affect the quality of the dying experience.⁷ The dying process has a profound and powerful effect on the individuals who are experiencing death and the people who bear witness to those deaths. Investigations into the preferences expressed by the dying and individuals involved in the dying process have identified three dominant themes: (1) spirituality, meaning, and emotional well-being; (2) pain and physical suffering; and (3) adequate communication between patients, healthcare providers, and patients' family members.

Spirituality, Meaning, and Emotional Well-Being

Spirituality, the search for life's meaning, and emotional well-being are integral components of the dying process.⁸ The concept of spirituality is not confined to a traditional and common association with organized religion.⁹ While organized religion remains a definite component of the spiritual experience for some, others find spiritual satisfaction through prayer, meditation, and social interaction. Christina M. Puchalski identified spirituality as having a profound effect upon the dying by providing patients with hope and a sense of meaning that allows a comfortable transcendence. Puchalski contended that the experience is dependent upon the values and beliefs of each individual. Spirituality has been found to have particular importance for those who are directly confronted with death and who are in search of life's purpose.¹⁰ Assisting patients to address spiritual concerns allows an easier transition or transcendence from life to the experience following life.¹¹

Craig D. Blinerman and Nathan I. Cherny described meaning as it relates to patients' desire to raise a family, have faith in God, and hold personal spiritual beliefs.¹² Identifying the aspects that provide a sense of meaning to one's life is up to the individual. Adequate preparation for death and the attainment of a sense of completion and meaning in one's life are dominant forces that can add to patients' satisfaction with the dying experience.¹³

The dying process can be characterized as emotionally demanding and stressful. Attending to the spiritual needs of individuals who are at the end of life has been associated with reduced stress and anxiety.¹⁴ Douglas K. Miller and colleagues reported that the inclusion of interventions such as support groups that address the psycho-socio-spiritual needs of patients with life-threatening illnesses reduced the incidence of depression, feelings of meaninglessness, and anxiety in the group of patients who received the intervention.¹⁵

Pain and Physical Suffering

Concerns regarding pain and other forms of physical suffering are well documented in the end-of-life literature.¹⁶ James Hallenbeck reported on a study in which 310 critically ill patients identified the desire to be free of pain and suffering as their first and foremost concern regarding the end of life.¹⁷ The inadequate management of pain and other symptoms frequently have been found to be among the failures of modern medicine.¹⁸

Pain and other physical symptoms have been attributed to a decreased quality of life at the end of life for a number of reasons: inadequate pain management in the in-patient hospital setting causes moderate to severe pain for patients within the last few weeks of life.¹⁹ Studies report that 30 to 80 percent of patients living in nursing home facilities receive inadequate pain management.²⁰ In the case of nursing homes, Sandra H. Johnson identified three dominant reasons for poor pain management: (1) the existence of regulations that seek to avoid the overuse of pharmaceuticals, (2) healthcare providers and family members tend to underestimate the patient's level of pain, and (3) patients inaccurately report their level of pain to avoid being a burden to others. Johnson reported that pain and suffering can negatively influence patients' "thought, self-

awareness, emotional engagement, and social relationships [so] that it can rob the individual of the experience of being human."²¹ The breadth of distress, aside from physical discomfort, that pain and suffering have upon patients indicates the importance of appropriate pain management.

Communication

Inadequate communication has been identified as a dominant barrier to the provision of high quality end-of-life care.²² Although SUPPORT failed to identify effective interventions that would increase the quality of life as death approaches, it accentuated the importance of communication between healthcare providers, patients, and the families of patients during the dying process.²³

As Jeanie S. Kayser-Jones noted, "Health care provider-patient relationships (i.e., interactions) are critically important when providing care to people who are dying."²⁴ The provider-patient relationship, like many others, is dependent upon the adequacy of communication between all of the parties involved, including the provider, patient, and family.

METHODS

As part of a series of statewide seminars and lectures on advance care planning, speakers from NCEHP administered the "Last Hours of Life" worksheet. This instrument was designed to stimulate conversations on end-of-life issues and not as a research survey. Worksheet questions mixed open-ended and pre-coded answers and provided room for answers/comments from the participant's own frame of reference. Additionally, the worksheet requested the participants' age, gender, occupation, and income level. Although the seminars were offered across Nevada, participation was not dependent upon residency in Nevada. Many participants were from Western states including California and Oregon. The seminars and lectures targeted healthcare professionals, but many attendees were students and retirees. The worksheets were completed anonymously by workshop participants who voluntarily attended end-of-life seminars and lectures conducted between 1996 and 2003.

Seminars would begin by having the attendees complete the worksheet and then sharing their answers with others in small groups. Later, the participants could share select answers with others at the seminar. After several hundred worksheets were collected, two of the authors (Thornton and Klugman) realized that they had a rich source of data about people's desires during their final hours of life. Therefore, we sought and received approval from the University of Nevada, Reno Social-Behavioral Institutional Review Board to analyze these worksheets.

A thematic codebook was developed for the open-ended questions based on topics that appeared in a large number of the worksheets. After the thematic codes were created and tested, all of the worksheets were coded. To increase inter-rater reliability, two coders reviewed each worksheet. When coding results differed, the raters negotiated the appropriate coding. The coded results and responses to closed-ended questions were entered into Microsoft Excel XP. Due to the overall goal of the project and the ways in which data were collected, analysis was restricted to descriptive information. A frequency analysis was conducted and results were also presented in percentages. A free response answer was considered statistically significant if it comprised at least 5 percent of all of the responses to a particular question.

RESULTS

A total of 466 people completed the 1996 "Last Hours of Life" instrument. The ages of the respondents ranged from 18 to 94, with a mean age of 45.06 and a median age of 46.0. Regarding the gender of respondents, 375 were female and 91 were male. Of the 466 respondents, 40 were physicians, 135 were nurses, and 291 were other health professionals, students, retirees, and others (see table 1). The majority (50 to 91.3 percent, depending on the question) of written responses to the instrument were provided by less than 5 percent of all of the subjects.

The first question was, "What would you like to have happen during the last hours of your life?" The total number of responses provided by all 466 of the participants was 1,250. Participants provided 63 different responses that fell into two recurring themes. The first theme (799 responses) was related to the state of the participant's mind and body at the end of life. Many people said that they wanted pets (19), friends and family (387), and music (67) present at the deathbed. The second theme (341 responses) concerned the respondent's desired physical state at the time of death, such as freedom from pain (86) and a sense of peace for patient and family (152). The remaining 110 comments (in more than 11 categories) were placed in a miscellaneous group that included notions such as wanting a quick death (23), being comforted and pain-free (33), and having religious needs fulfilled (43).

Question 2 ("What do you fear most about dying?") offered five possible responses (pain, fear of the unknown, suffering, things left undone, and seeing family and friends grieve), to stimulate thought in each participant. Question 2 also offered space for participants to identify individual answers that were not provided in the five above-mentioned options. The total number of responses provided by all 466 of the participants was 934. Participants identified 33 different responses to Question 2 ("What do you fear most about

dying?"). Three common themes were identified. The first theme (318 responses) related to fears of mental, emotional, or spiritual suffering, such as fear of the unknown (119) and leaving things undone (156). The second theme (215 responses) expressed fear for the suffering of others who would bear witness to the end of life. The final theme (331 responses) addressed fear of pain or other physical suffering at the end of life. The remaining responses (70 responses over 12 categories) comprised a miscellaneous category, including concerns about leaving people behind (22) and having no fears of dying (14). No single response in the miscellaneous category had statistical significance.

Question 3 ("Who would you like to have with you during those last hours of life?") offered six selections (spouse, healthcare providers, children, spiritual advisor, friends, and animals), to stimulate thought in each participant. Question 3 also offered space for participants to identify individual answers that were not provided by the six above-mentioned options. The total number of responses provided by all 466 of the participants was 1,466. Question 3 elicited a total of 14 different responses. The first of three dominant themes in response to Question 3 was "family or friends" (1,073 responses). The second theme identified a desire to have a spiritual advisor present during the final hours of life (144 responses). Finally, a small portion of the participants desired healthcare providers to be present at the end of life (49 responses). The remaining 200 responses (over six categories) to Question 3 comprised a miscellaneous category. The only statistically significant response in this third category was wanting animals present (174).

Question 4 ("Do you want to be told you are dying?") included "yes" or "no" answer options with space for an explanation as to why or why not. "Yes" was chosen by 439 subjects, "no" by 17, and 10 chose "uncertain." All 466 respondents provided a total of 606 responses; 31 different responses were provided in the comments section of Question 4. Three dominant themes were identified after examining the responses to the "why or why not" section. The first of the three themes (275 responses) related to a desire

Table 1. Professions of Respondents

Profession	<i>n</i>
Nurse	135
Social worker	80
Student	77
Physician	40
Clergy	26
Administration	22
Teacher	15
Healthcare (other)	9
Home caregiver	9
Pharmacist	6
Mental health	6
Respiratory therapist	6
Retired	6
Volunteer	5
Attorney	3
Coroner	2
Dental hygienist	2
Ombudsman	2
Sales	2
Server	2
Technical	2
Author	1
Baker	1
Communications	1
Geologist	1
Juvenile Services	1
No answer	1
Public guardian	1
Researcher	1
Self-employed	1

to make the remainder of the time left in this world count. A number of the responses under this theme identified tasks that the participants would undertake if they were informed that they were going to die. The second theme (101 responses) identified participants' desires to gain a sense of closure and peace prior to death. The final theme (115 responses) identified the desire of participants to spend the remainder of their time alive with family and friends and to repair damaged relationships. These 115 responses fell into 15 categories that were not individually statistically significant.

Question 5 ("Do you believe in life after death?") included "yes" or "no" answer options, with additional space for personal comments. In this question, 355 subjects answered "yes," 73 said "no," and 38 were "uncertain." All 466 participants provided a total of 125 responses; 23 different responses were provided in the open-ended section of Question 5. The first of the three themes identified in the open-ended section of Question 5 related to religious beliefs and spirituality (77 responses). The second theme was comments identifying uncertainty about an afterlife (16 responses). The remaining 32 responses in eight categories did not provide any statistically significant themes or categories.

Question 6 ("Where would you like to die?") offered three selections (hospital, hospice, and home), to stimulate thought in each participant. Question 6 also offered space for participants to identify individual answers that were not provided by the three above-mentioned options. All 466 participants provided a total of 607 responses. The first theme (398 responses) identified participants' desires to die in a familiar setting, such as dying at home (382). The second theme (116 responses) related to a desire to die in a healthcare setting. The remaining 93 responses (more than 17 categories) were not statistically significant except for the desire to die outdoors (37 responses).

DISCUSSION

Results from the present project identified several issues in relation to end-of-life concerns and discussions. Most important, the wide variety of responses to the open-ended questions pointed out the inadequacies in the worksheet that was originally developed in 1996. A response that appears in a free-response section, but not in the listed choices, represents a lost opportunity. Unless a person thought of an idea on his or her own to write in, he or she would not be prompted to consider that notion. For example, the listed options did not include a choice for smells. Unless a person thought of this idea on his or her own, smells may never even be considered. The lesson is that one should be wary of trying to impose "etic" categories — that is, categories that are imposed from outside a subject's experience, such as by a researcher — regarding dying. Thus the 1996 worksheet is flawed, as it tried to impose just such a schema. A richer conversation would be possible by creating a worksheet that draws on an emic categorization, such as could be developed from this data.

Many of the common themes in response to the worksheet coincided with results from previous research. Spirituality, the search for life's meaning, and emotional well-being have been identified as important concerns at the end of life.²⁵ Responses pertaining to spirituality, meaning, and emotional well-being were dominant themes in this worksheet. Additionally, in response to Question 6, two participants said that they wanted to die in a monastery or other religious building, and four participants said they wanted to die where God wanted them to die. Clearly, spirituality, meaning, and emotional well-being must be addressed to increase the quality of the end-of-life experience.

Previous research has also noted pain and physical suffering as important concerns relating to the end of life.²⁶ In the present project, 35.44 percent of the responses to Question 2 ("What do you fear most about dying?") were related to experiencing pain and other physical ailments at the end of life.

The researchers did not expect to find that so few participants would want a healthcare provider by their deathbed. Likewise, we did not expect the large numbers of respondents who wanted a pet present at the end of life. These findings suggest that individuals do not fall neatly into categories, but rather are unique in their wishes. Thus, there is a need for more flexibility in death planning, such as programs like hospice that enable people to die at home, and for more bending of hospital rules that do not allow animals on the wards.

Communication and issues related to shared decision making during the end of life comprised the third dominant area of concern.²⁷ In the current analysis, aside from one participant who expressed a fear of not being able to communicate, there were not any responses on the worksheet that related to these issues. The authors believe that the results do not indicate a lack of concern, but, rather, a failure of the worksheet to directly address communication and shared decision making. The nature of the information gathered highlights two important factors relating to communication during advance care planning: (1) tools, such as the worksheet used in this project, should be used to guide and stimulate conversation and thought during discussions relating to the end of life; and (2) the breadth and variability of answers provided by the participants in the end-of-life seminars and lectures necessitates addressing needs and desires in relation to the end of life on an individual basis.

The first factor is related to the importance of using tools, such as the "Last Hours of Life" worksheet, to stimulate and guide conversation on the end of life. The worksheet was helpful in provoking thought and facilitating conversation when identifying participants' needs and preferences. Shirley S. Travis and colleagues identified the difficulty of initiating conversation between patients and their families during discussions about the end of life.²⁸ We suggest that using these tools can increase the ease of initiating discussion. Providing questions and examples of concerns of people experiencing the death and dying process could help facilitate conversation about an individual's personal needs and desires.

The second factor was identified from the breadth and variance in responses to the open-ended portions of the worksheet. With the exception of Question 3, the majority of the participants' open-ended responses were provided by less than 5 percent of the participants. This lack of free responses indicates a need to increase the prepared choices, as most people did not partake in the free-writing sections. Also, this lack suggests a need for facilitators to encourage participants to write in the free-response areas. The breadth of answers in the free-response sections highlights the need to address each person's needs and desires in relation to the end of life on an individual basis and to improve the quality of life for people who are dying. Using tools to guide and stimulate conversation between individuals and their families provides an opportunity to identify an individual's unique preferences — other than medical treatment choices — rather than assuming that people want preconceived, etic notions of a "good death."

In addition to facilitating communication on end-of-life issues, the results from the worksheet indicate the importance of describing the setting in which one wants to die. As Jan Selliken Bernard and Miriam Schneider note in *The True Work of Dying: A Practical and Compassionate Guide to Easing the Dying Process*,

It is through creating a safe place that the process of letting go is eased. The preparation for these life-changing events is critical. The quality of a person's death experience is directly related to the preparation of a home environment — no matter whether it is in a hospital, nursing home, adult foster facility, hospice house, or a family home. The physical space is not what creates a "home"; it is the people that create it.²⁹

A number of participants identified the desire to listen to music, hear birds singing, have windows open, and to have light at the end of life. Descriptive comments discussing the setting in which participants wanted to die comprised 64.82 percent of the responses to Question 1. As identified by Bernard and Schneider, adapting the setting of death to fit with the desires of the dying can increase the quality of life at the end of life.³⁰ The need for an instrument that uses an emic perspective from those thinking about their death is evident.

An Emic Worksheet

NCEHP realized that our data strongly supported the development of a new worksheet tool based on our analyzed results from the 466 previous participants. The result of that effort is the 2008 "Last Hours of Life" worksheet (see the appendix at the end of this article). This worksheet comes out of the emic concepts and categorization created by the participants rather than from an etic schema imposed from outside.

The revised worksheet is made up of eight questions, including one identifying the participant's use of advance directives. The open-ended nature of the questions on the original worksheet yielded a broad range of results that now allows participants to individualize their responses. The authors believe this to be the most important aspect of the original worksheet. Room is also provided on the revised worksheet for open-ended responses or comments on each of the questions. New directions also promote the completion of free responses. Additionally, the use of prearranged answers may have assisted in the facilitation of thought during the use of the original worksheet as well as encouraged completion by people who were reticent to write free responses. All of the revised questions contain expanded prearranged responses that not only serve as possible answers to questions, but may also serve as examples that will stimulate thought, allowing for more complete open-ended responses. The prearranged answers included in the revised worksheet are composed predominantly of common responses and themes identified in analysis of information from the original sheet.

Previous research and literature have devoted little attention to specific details concerning the setting of one's death. A worksheet that prompts individuals to explore their hopes, fears, and preferences may help the individuals, loved ones, and careproviders to create a setting that will improve the dying process and be more attuned to patients' wants and needs. The common themes in response to Question 1 of the original worksheet ("What would you like to have happen during the last hours of your life?"), including statements describing the scene of one's death and the desired state of mind and body at the time of death, were broken down into two separate questions to allow more careful examination of both components.

The original worksheet identified who the participants wanted to have present during the last hours of life, but did not identify the capacity in which those present would serve. A large portion of the literature on the end of life has devoted attention to decision-making power. The revised worksheet addresses who the dying individual would want to take part in making decisions concerning the end of his or her life. Finally, many of the responses to the original worksheet identified concerns over leaving things undone or not completing tasks. The final question on the revised worksheet pays specific attention to the tasks the dying individual would want to complete prior to death.

The setting in which one will spend the final moments of life should be designed based upon the individual's needs and desires, and not limited to settings that have been found to be statistically significant in the general population. Statistical significance alone cannot aid us in assisting patients who are at the end of life. The present project establishes the importance of addressing end-of-life preferences on an individual basis and also demonstrates the usefulness of a worksheet to stimulate conversation outside the medical setting, as well as to identify individuals' needs, values, and preferences on a basic level. The identification of elements that affect the end-of-life experience is essential in improving the quality of the last hours of an individual's life experience. This worksheet is an attempt to do just that.

ACKNOWLEDGMENT

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Appendix: 2008 Last Hours of Life Worksheet

Instructions and Suggestions on Using the End-of-Life Discussion Worksheet

This worksheet will present 8 different questions and topics for discussion. A number of possible answers and comments have been provided under each question of topic. Please select as many answers as you want.

Space has also been provided at the end of each question or topic for your individual answers. We encourage you to write down any response you want. You can also use this space for writing comments and concerns you have about your answers. Because each person has unique ideas for his or her last hours, we suggest that you write down your thoughts in your own words in the spaces provided.

This worksheet is meant to help guide a conversation with others. Close friends and family are good choices of people to include. You are encouraged to discuss your responses and concerns with others in order to help them understand your needs and preferences towards the end-of-life. Be sure to write down the names of the people involved in this discussion on the front page. You may also want to write down their relationship to you.

Lastly, you should revisit your responses and keep them up to date. If your values, preferences, or needs change after completing this worksheet, make sure your new values, preferences, or needs are known. Keeping this worksheet in a place where it will be safe but is easily accessible is suggested. Be sure your family or friends know where to find it in case of emergency.

With whom are you completing and discussing this worksheet: _____

Date: _____

Do you have an advance directive?

Yes

No

If you answered "yes" please indicate what type of advance directive you have:

Living will/directive to physician

Healthcare proxy: who is

Do-not-resuscitate order (DNR)

Out-of-hospital DNR

Other/comments _____

(continued next page)

Where would you like to die?

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> My home | <input type="checkbox"/> Hospital |
| <input type="checkbox"/> A relative's home | <input type="checkbox"/> Hospice |
| <input type="checkbox"/> In a church | <input type="checkbox"/> Nursing home |
| <input type="checkbox"/> Outside/in nature | |
| <input type="checkbox"/> Other/comments _____ | |

Describe the setting in which you would like to die:

- | | |
|--|--|
| <input type="checkbox"/> Alone | <input type="checkbox"/> Surrounded by family |
| <input type="checkbox"/> Surrounded by friends | <input type="checkbox"/> Surrounded by friends |
| <input type="checkbox"/> With music playing | <input type="checkbox"/> In a well-lit room |
| <input type="checkbox"/> Surrounded by flowers | <input type="checkbox"/> Surrounded by pleasant smells |
| <input type="checkbox"/> Surrounded by photographs | <input type="checkbox"/> Surrounded by my favorite art |
| <input type="checkbox"/> In a warm place | <input type="checkbox"/> In my bed |
| <input type="checkbox"/> In a quiet place | <input type="checkbox"/> In nature |
| <input type="checkbox"/> Other/comments _____ | |

Describe the state of mind you would like to be in at the time of your death:

- | | |
|---|---|
| <input type="checkbox"/> Calm | <input type="checkbox"/> Accepting of death |
| <input type="checkbox"/> Free of stress | <input type="checkbox"/> Happy |
| <input type="checkbox"/> Satisfied | <input type="checkbox"/> Independent |
| <input type="checkbox"/> Other/comments _____ | |

Who would you like to have with you when you die?

- | | |
|---|---|
| <input type="checkbox"/> Nobody, I want to be alone | <input type="checkbox"/> Spouse/partner |
| <input type="checkbox"/> Parents | <input type="checkbox"/> Children |
| <input type="checkbox"/> Other relatives | <input type="checkbox"/> Close friends |
| <input type="checkbox"/> Spiritual advisor | <input type="checkbox"/> Nurses |
| <input type="checkbox"/> Doctors | <input type="checkbox"/> Pets |
| <input type="checkbox"/> Other/comments _____ | |

Who do you want to make decision about your healthcare and death?

- | | |
|---|---|
| <input type="checkbox"/> Myself | <input type="checkbox"/> Spouse/partner |
| <input type="checkbox"/> Parents | <input type="checkbox"/> Children |
| <input type="checkbox"/> Other relatives | <input type="checkbox"/> Close friend |
| <input type="checkbox"/> Spiritual advisor | <input type="checkbox"/> Nurses |
| <input type="checkbox"/> Doctor | |
| <input type="checkbox"/> Other/comments _____ | |

What do you fear most about death?

- | | |
|--|---|
| <input type="checkbox"/> Pain/physical suffering | <input type="checkbox"/> Fear of the unknown |
| <input type="checkbox"/> Things being left undone | <input type="checkbox"/> Watching family grieve |
| <input type="checkbox"/> Being a financial burden | <input type="checkbox"/> Being cold |
| <input type="checkbox"/> Losing my mind | <input type="checkbox"/> Losing my independence |
| <input type="checkbox"/> Leaving family and friends | <input type="checkbox"/> Losing my dignity |
| <input type="checkbox"/> Being forgotten | <input type="checkbox"/> Not going to heaven |
| <input type="checkbox"/> Leaving problems unresolved | <input type="checkbox"/> Leaving before mending relationships with family |
| <input type="checkbox"/> Leaving before mending relationships with friends | <input type="checkbox"/> Leaving before mending my relationship with God |
| <input type="checkbox"/> I have no fears | |
| <input type="checkbox"/> Other/comments _____ | |

Describe tasks you would like to accomplish before you die:

- | | |
|---|---|
| <input type="checkbox"/> Tell my family and friends I love them | <input type="checkbox"/> Prepare my friends and family |
| <input type="checkbox"/> Prepare myself | <input type="checkbox"/> Say good-bye to family and friends |
| <input type="checkbox"/> Mend relationships | <input type="checkbox"/> Become religious |
| <input type="checkbox"/> Gain a sense of closure | <input type="checkbox"/> Gain peace of mind |
| <input type="checkbox"/> Spend time in my favorite place | <input type="checkbox"/> Get my finances in order |
| <input type="checkbox"/> Try a new hobby | <input type="checkbox"/> Help plan my funeral |
| <input type="checkbox"/> Try new food | <input type="checkbox"/> Tell my story |
| <input type="checkbox"/> Travel | |
| <input type="checkbox"/> Other/comments _____ | |