

**An Intercultural Analysis of End-of-Life Consultation Practices in
Palliative Medicine in Germany**

By

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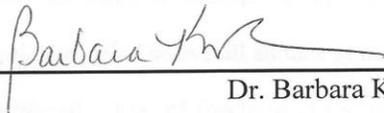
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ABSTRACT

End-of-life discussions are a difficult but important facet both within the daily routines of an individual's life, as well as within the medical sphere. The care of a patient, in regards to the management of their symptoms and livelihood, is different for each patient that the physician oversees. The management of their care through various examinations or regimens is tailored towards the needs of each individual patient. Since its conception in 1972 as a recognized field of medicine, palliative medicine has grown to become a tool that physicians utilize to aid patients suffering from terminal illnesses. "Palliative care is the active, total care of an individual patient's body, mind and spirit, as well as the supporting family members¹." Palliative care begins when the illness is first diagnosed, and continues regardless of whether or not a patient receives treatment directed towards the diagnosed diseases. Providing appropriate palliative care for patients is a problem that hospitals face worldwide. Nearly 39% of patients and family members cite that there are issues during treatment to initiate these conversations, when they otherwise would like to hold these discussions². A tactic being employed in the health care setting is humor and effectively clarification. Despite the seriousness of these care settings, humor and laughter are common in consults. Humor has come to function as an important tool in facilitating discussions towards advanced directives. Humor operates as a realm of subjective identity and affect that, as noted by sociologist Michael Billig, manifests into "a sense of humor³⁻⁵." This social utility or dependence on humor comes from the ideology that it is a physical and mental cure that can cause a decrease in stress, a boost in morale, and make effective communication obtainable⁴. The overall attitude of humor in clarifying discussions showed great success. Humor served a host of functions at the facility in Germany, the most important of which, were to build therapeutic interrelationships, relieve tension, and to understand the

patient's wishes. Humor was also significant for the staff at the facility as it maintained relationships between coworkers, managed the daily stresses of the ward, and it allowed clinicians and their coworkers to maintain a positive perspective on the outlook of their patient's care and management. Patients were more prone to discussing end-of-life care than survival once effective relationships were built. Longer consultation times resulted in stronger and more open relationships to discussing further care. The findings of this study presented the outlook that individuals at the three hundred and ten bed facility in Germany have on palliative care, as well as their varied approaches to initiating care for their patient through protocols such as SPIKES. The team's approach, as observed within the clinic's setting in Germany, lends credit to the need for further cross-cultural analyses to mandate proper training in end-of-life care.

Keywords

America, Advanced directives, Cancer, End-of-life decisions, Germany, Oncology, Palliative care

INTRODUCTION

Physicians are trained to maintain the livelihood of patients on an individual basis. Foucault coined this process of clinicians having the capability to dehumanize a patient and their disease as the “medical gaze⁶.” This process, cited widely from the 18th century up until the mid-20th century, allows clinicians to separate the patient’s body and their ailments from the identity of the person. Through thorough examination (or through the medical gaze) of the patient’s body, a clinician can deduce the symptom, illness, and potential cause of the ailment. This in turn leads to an incomparable understanding of the patient and discover hidden truths. Despite the intensive training these physicians receive on maintaining health and fighting the latest disease, they receive little training on being able to communicate with a dying patient and their family¹⁻³. The true fault in utilizing the medical gaze is that it ignores the experiences and perceptions of the patients. At the time, no one could challenge the stories of the illness as perceived by the gaze because of the status and power generated by these physicians⁶⁻⁸.

However, this trend began to dwindle in the mid-20th century as the perceptions of patients began to take notice as important facet in care. Despite recent efforts to move past solely using the medical gaze, clinicians still have trouble bridging the gap between what they have perceived in their gaze, as well as the perception of the patient and their family. The sole culprit for this issue is a lack of communication standards. Communication standards are still being developed across the globe as to how clinicians should communicate news, regardless of whether it is bad or good, to their patients⁴. With respect to advanced directives, there are large discrepancies on the views of death in society. This makes it difficult for physicians to engage in end-of-life discussions with their patients and family members.

Death is often regarded as a failure of our recent medical advances². However, recent study designs in the last forty years recognize the contrary to be true. Medical advancements have allowed clinicians to target specific issues that patients have with regards to their care. In this respect, saving a life does not state alone that medical advancements have been made. Instead, steps have been made regarding how to target the illness of a patient, as well as discuss these findings with the patient and their family to develop a method or plan towards their care. Proper communication skills help alleviate fears, target and handle pains and suffering, and it gives patients and family members the chance to explore various means of treatment. Poor communication on the other hand may result in suboptimal care. Patients and family members may feel neglected, and this resulting feeling of negligence can cause physical and mental harm to those affected.

The majority of patients are interested in discussing end-of-life plans for care with their attending physicians⁵⁻⁷. However, there are some individuals that would rather not be informed of their prognosis¹¹. Patients that wish to be informed often believe that physicians should initiate this discussion⁷⁻⁸. For this matter, a specialized field of medicine known as palliative care began to take notice.

Palliative care is defined as an “active, total care of an individual patient’s body, mind and spirit, as well as the supporting family members¹.” Primarily they assist those with terminal illness, and focus their efforts on being able to maintain comfort and care in the patient’s final hours⁹⁻¹⁰. Key aspects of care including the following: symptom management, personalized care planning with respect to a patient’s and the families’ wishes, and the coordination of services in a home setting as well as within the hospital. This does not mean that palliative care should be

confused with hospice care. While palliative care is typically seen with individuals facing terminal illnesses, palliative care is also for patients suffering from varying disease stages.

Although the concept behind palliative care is not new, some physicians have rejected this pathway until recently. As it begins to take more notice, advanced directives and qualitative studies are beginning to appear more frequently⁷⁻¹³. Traditional medicine has concentrated on attempting to cure patients. Treatments for alleviation of symptoms have often been viewed as not addressing the main problem¹⁴. Instead of treating the disease, managing the symptoms alone might be perceived as a failure to being able to cure a patient. There are varying views on these methods of working with a patient¹⁴. Individuals believe that there are different realms for holistic and evidence-based medicine, and they cannot be utilized together.

The following report is meant to provide a brief outlook on the practicing tools of individuals within a clinic in Germany, as well as America. Palliative medicine has become a focus of this institution in recent years. It is their goal to address fundamental issues pertaining to end-of-life care with patients and family members within Germany in rural and urban settings. Herein I will present a brief overview of the background of palliative care in Germany, as well as observations made with doctor and patient interactions. Italicized dialogues presented within the contents of this paper are actual wordings used by clinicians at the clinic that I was able to coordinate with. I believe that these scripts will offer an outlook on varied techniques that can better assist physicians across the globe in refining their current practices managing end-of-life care.

AMERICAN PORTION OF RESEARCH

Previous and Current American State Agendas

The first time the term “hospice” was used can be traced back from its linguistic roots into medieval times. At that time, it was referenced as a place of shelter and rest for individuals that have traveled the roads on long journeys wearily (Classen). However, in 1948, a physician by the name of Dame Cicely Saunders applied this term to a specialized care and program to assist those that were dying (cite). Within London, she opened one of the first modern hospice centers. Settled in a residential suburb within London, St. Christopher’s Hospice began to grow and reach out to ears in the West. A new future for healthcare was approaching America.

Saunders introduced her concept of hospice centers in the United States in 1963 while presenting her traveling seminars at Yale University¹⁵⁻²⁰. Her lecture was provided to the medical students, nurses, and local healthcare workers of the area. All individuals were called to the seminar to hear about the importance of holistic care approaches in times of death and dying. Saunders, who worked predominately with providing care to terminally ill cancer patients and families at the time, presented her work and the effect that it has had on families. Families and patients alike showed dramatic differences on the outlook of death and dying in the hospital. Patients became more receptive and open to discussions about their care. The healthcare system of that age began to take a more holistic approach and launched a chain of successive events to bring hospice and palliative care into the developing field that we now see it today.

Upon the conclusion of her lectures, Saunders was invited as a visiting professor and faculty member. She began to lecture more in depth regarding her results with St. Christopher’s Hospital in London. Physicians and nurses alike from Yale School of Medicine and Nursing

began to take routine visits at the facility in London. Individuals worked at the institute to learn everything they could about hospice in hopes of bringing it back to America.

These visits prompted the publication of a book that detailed more than five hundred interviews with patients that were dying and faced terminal illnesses across the world. The book was entitled *On Death and Dying*, written by Dr. Elizabeth Kubler-Ross, and it became an instant catapult towards a push for hospice and palliative care in America. The contents of Dr. Kubler-Ross's novel detail the stages of death and dying in terminally ill patients. Individuals became fascinated with learning how to deal with these stages of life in a patient's life nearing death. Political stances began to take hold. Pleas from the public began to erupt, stating that patients should have the decision and right to actively participate in the maintenance of care that affected their death.

Dr. Kubler-Ross had her moment to bring this topic to the public and the Senate when in 1972 she testified on the subject that individuals should be able to participate in death with dignity. Ross understood the importance of the need for this special care in America. During the hearing, she had the following to state:

“We live in a very particular death-denying society. We isolate both the dying and the old, and it serves a purpose. They are reminders of our own mortality. We should not institutionalize people. We can give families more help with home care and visiting nurses, giving the families and the patients the spiritual, emotional, and financial help in order to facilitate the final care at home.”

Her movement and hearing were influential to society because in two years, the first hospice was founded in Branford, Connecticut. Legislation was introduced later that year as well. Federal funds began to be diverted into the production of hospice programs as well as hospice research. At the time, the legislation failed to pass and it was not enacted.

Over the next fifteen years, money begins to pour into the production of hospice programs as bills begin to be introduced by the Senate. The first hospice centers, as well as an expanded approach towards generating tension in palliative care research began to rise during the latter part of the 20th century in the United States. At the time in the United States, a higher percentage of patients that did not have cancer were being diagnosed and placed under the care of palliative care teams (Klinger et. al)¹. As individuals heard about palliative care, tension began to drive palliative care to treat other patients with more terminal illnesses. Palliative care was on the path to becoming a distinguished, specialized field of medicine. The greatest breakthrough in America for hospice and palliative care began in 1997 when the growing movement for advanced healthcare directives in hospice and palliative care urged a greater public awareness for public and physician education. Thus, a report from the Institute of Medicine (referred to as the IOM) of the National Academy of Sciences provided individuals insight into large gaps of knowledge that physicians and the public had regarding the care of patients at the end of life. This demanded immediate social attention from the biomedical, social sciences, and health care providers¹⁵⁻²⁰. These gaps in knowledge indicated major barriers to providing advanced directives. Recommendations were made in the following report that dictates how to address these gaps in knowledge.

In the recommendations outlined below, the focus was to target specific areas of care that were lacking. By addressing these concerns, the medical approach to discussing death could

alleviate tension or stress with the patient, their family, and even health care team. An interesting point to note within the recommendations is the very first clause itself: “People with advanced, potentially fatal illnesses and those close to them should be able to expect and receive reliable, skilful and supportive care.¹⁰” This further denotes the intention that palliative care initially and always had had. This specialty within medicine was directed to be for individual of all illnesses. Medicine wanted to create a specialty within medicine that could directly care for individual patients suffering from a range of terminal or advanced illnesses. In no way did the patient need to have a fatal illness to be prescribed into palliative medicine. This is a rather large leap in terms of medical practice as it was one of the first specialties within medicine to target patients of all accordance.

Recommendations from the Institute of Medicine's Approaching Death¹⁰

- 1. People with advanced, potentially fatal illnesses and those close to them should be able to expect and receive reliable, skilful and supportive care*
- 2. Physicians, nurses, social workers, and other health professionals must commit themselves to improving care for dying patients and to using existing knowledge effectively to prevent and relieve pain and other symptoms*
- 3. Because many deficiencies in care stem from system problems, policymakers, consumer groups, and purchasers of healthcare should work with healthcare practitioners, organizations, and researchers to:*
- 4. Strengthen methods for measuring the quality of life and other outcomes of care for dying patients and those close to them*
- 5. Develop better tools and strategies for improving the quality of care and holding healthcare organizations accountable for care at the end of life*
- 6. Revise mechanisms for financing care so that they encourage rather than impede good end-of-life care and sustain rather than frustrate coordinated systems of excellent care*

7. *Reform drug prescription laws, burdensome regulations, and State medical board policies and practices that impede effective use of opioids to relieve pain and suffering*
8. *Educators and other health professionals should initiate changes in undergraduate, graduate and continuing education to ensure that practitioners have the attitudes, knowledge and skills to care well for dying patients*
9. *Palliative care should become, if not a medical specialty, at least a defined area of expertise, education, and research*
10. *The nation's research establishment should define and implement priorities for strengthening the knowledge base for end-of-life care*
11. *A continuing public discussion is essential to develop a better understanding of the modern experience of dying, the options available to patients and families and the obligations of communities to those approaching death.*

These initial recommendations created ground work for creating a specialty within medicine by which individual patients could directly work with physicians on coping and handling their terminal illnesses. By the year 2011, there was a sixty-seven percent presence of fifty or more hospital beds for individuals under palliative care (CAPC, 2013), nearly eighty-five percent of the hospitals in the United States had more than three hundred beds (CAPC, 2011). Programs began to flourish across America (CAPC, 2011-2013). These programs were more prominent in larger hospital settings. These settings had the funds necessary to keep these programs running. These hospitals were also able on average to conduct more research and meet the needs of more people due to the larger volume of hospital beds reserved for their patients (CAPC, 2011-2013).

However, each state at this time did not have palliative care programs. During these early year of 2011, only seven states were recorded at having palliative care programs. Eighty percent of all hospitals in these states had funds and beds to provide for palliative care patients (CAPC, 2011). Fast forward to 2012 and seventy percent of the children hospitals in these states had palliative care programs (CAPC, 2012). These numbers have only continued to evolve and progress as more funds are processed and diverted into palliative care programs.

In general, however, the greatest problem that America has faced in the dawn of standardizing palliative care has been in the acceptance of recommendations for patients into these programs, as well as the majority of society. The process is rather slow. Physicians have been shown to take extended periods of time to begin discussing and counseling their patients regarding seeking palliative care assistance¹⁵⁻²⁰. Individuals have cited a host of examples and reasons for this reluctance, but the most commonly cited source is with regards to societal views. Individuals it appears are still confined by the ideas of death and dying. Overall, one can thus assume that if these issues were directly targeted, palliative care standards and acceptance into these programs would rise significantly.

Observations and Discussion of Key Points of Conducting Consults in America

Observations of patients and healthcare providers began on August 8, 2014 in a thirty-six bed oncology and hematology ward. Observations and analysis of consultations lasted one week long. Initial interactions with residents and senior physicians with their patients and fellow teams began each day with morning rounds. Morning rounds began at 9:00 AM each morning and lasted until 12:00PM. Consultation time varied on average from twenty minutes to an hour. The range in consultation time depended on the volume of patients and amount of questions that each parent or patient had. The conclusion of morning consultations lead into a daily routine of

infrequent room visits as the patients needed it. The information obtained within the American hospital wards suggests the appearance of interpersonal awareness and concern for their patients. However, individuals focused more on clarification and frequent visits as opposed to laughter and longer consultation times. Physicians promoted an environment where patients could ask questions as needed despite there being many questions ever asked. This may lend credit to the idea that the patients were afraid to speak out or questions despite being prompted by physicians that their patients ask questions and become involved with their care. More often than not, physicians spoke with and answered the questions of the patient's family members. This is likely due to the fact that the patients are generally younger and might not fully comprehend their circumstances. Overall, these interactions with patients and family members were crucial to direct conversations towards clarifying current prognoses and treatment options.

Clinic's Atmosphere

The hospital ward is a ten minute car ride from the downtown city center. The hospital is nestled among a bustling community of college students, as well as local families and senior citizens. A leading figure in medical care, this hospital is split into two campuses to accommodate for the spread of the general community. Each campus also specializes in various care techniques with the North campus specializing in oncology and hematology. On August 8, 2014 I walked through the front doors of the North campus to begin morning rounds with the hematology and oncology ward.

As I walked through the front doors of the hospital, I was not greeted by a bustling scene of physicians and patients alike immersing themselves in conversations. Instead, I saw a rather barren lobby with only a few patients and

doctors scurrying about. Individuals were guided towards their destination on mental ques.

I located the elevators and began to take my slow ascend up towards the ward for the start of morning rounds. As I reached the level of the ward, I entered a small waiting room that family members and visitors would frequent in the early mornings. Some individuals in the waiting room engaged in conversation. However, for the most part, most individuals were quiet and lost in thought. Even as physicians filed through the main doors of the ward to the elevators there was little conversation. Individuals passed and were seemingly not fazed.

The lack of initial interactions of physicians with local community members or patients and family members was somewhat disheartening to see after having experienced an environment that promoted healthy interactions between these hierarchical health care differences.

Interactions were more frequent and prone after entering the ward's doors. Despite being constantly greeted in the opening doors of the hospital in Germany, I was never greeted in such a way at the hospital in America. Perhaps individuals knew I was not a physician, or maybe they were afraid to speak with me in the event that I was a physician.

I began to feel there was a disparity between the roles of a doctor, patient, and loved ones. This was not an event that the physicians promoted. On the contrary, physicians attempted to promote a healthy environment whereby patients and family members alike could speak on personal levels with their care providers. The physicians wanted constant feedback in order to provide the

appropriate, holistic care that their patients needed. But as the days passed, I saw that patients within the hospital ward began to be more receptive of me. They began to engage with me in conversation on a more frequent basis as they saw me each day.

The social interactions between physicians and patients in the American setting appeared to be more closed off at first glance. Individuals were less inclined to stop and speak with me as I passed them. As mentioned, this can be due to several reasons. The first most likely reason is that I did not present myself as a doctor. Despite wearing a suit each morning to rounds, I was missing a crucial item that individuals perceive one to be a physician: a white coat. The white coat commonly signifies that you are an individual that practices medicine, especially given the fact that I was within a medical setting.

On the contrary, individuals were reluctant to engage in conversations with physicians on the ground floor of the hospital. The hospital setting might play a role. The hospital is home to over four hundred and eighty-seven beds to care for their patients in the various wards at the North campus. Individuals might not feel as comfortable in this environment to engage in immediate conversation with physicians as they would in the smaller setting observed within Germany. The small clinic environment of three hundred beds, while not significantly smaller, allows physicians to see physicians more frequently. Physicians are constantly bustling about the main floor and are more prone to interact with patients since there is a smaller volume of overall patients to attend to.

A plausible reason might be due to cultural outlooks and interactions with other people. Overall, the individuals in Germany were more prone to speak with old and new faces alike.

They were equally engaged with each face that they passed. As mentioned previously, this could have been due to cultural markers. Individuals might feel more prone to engage in conversation with foreign individuals as opposed to individuals from their native land. However, this was not what was observed in Germany. Citizens spoke with their physicians and foreigners, such as me, equally. Individuals in the American hospital were probably reluctant to speak because of the cultural outlook of physicians. Individuals might feel that they cannot speak on equal levels with physicians. Physicians are often perceived as saviors to the community. These individuals are meant to cure the community and promote a sense of safety and reserve. These patients and family members only feel comfortable in a setting with their personalized care givers. In these settings, patients can more freely discuss their standing emotions.

Overall, it is apparent that there is a variance in the atmosphere between these two clinical settings in America and Germany. Individuals in America promote a healthy and natural environment to care for their patients and family members. Patients in America seem to require safety and recognition when attempting to consult with physicians. Only within these personalized environments do patients appear to discuss their prognoses more willingly, let alone engage with health care providers. Individuals are more prone to discussing delicate topics once they are openly engaged by their health care team. These patients need a guiding hand to engage in these topics for only by creating these open-minded atmospheres can individuals feel safe.

Clinic Setting

Research and consultations at the American campus was conducted in one ward that was separated into two wings based on the severity and age of patients. Both of these wings saw individuals with varying forms of hematological and oncology cases. The south wing was for patients that were in less severe conditions. They were generally younger also. Age of patients

ranged from toddlers to individuals in their mid to late twenties. Care of these patients was directly managed by individuals in hematology and oncology. Oftentimes neurology would visit a patient if an MRI was needed. The north wing was for individuals with generally more serious cases. These individuals needed constant care and maintenance. The care of these patients in the north wing was conducted with varying health care providers: hematology, oncology, vascular, surgery, neurology, ER, etc. These patients also fluctuated in age range.

The Gravity of Consultations

A consultation provides a foundation to discuss end-of-life care. Patients and families can speak more openly and feel more trusting of their teams in this setting because the physicians can interact one-on-one. Individuals work towards finding solace in these settings by working towards assisting the needs of the patients. A caring connection can be made because of the empathy and compassion of the team. When a team can be open to the stresses and concerns of their patients, they enhance the emotional connections with their patients. This in turn can aid physicians to be alert to the needs and concerns of their patients. These bonds can allow individuals to become more in tune with their patients and how they are reacting to a new treatment regimen.

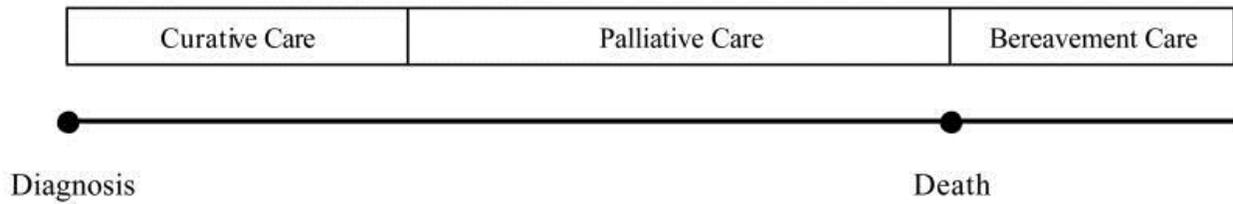
In most terminal illness cases, the prognoses are grim. Curative treatments are no longer the means of care because they have proven to be ineffective⁵. Therefore as the illness progresses, the physician and his team are faced with the challenge of discussing end-of-life care and requests. In this context, most physicians find the challenge in initiating these conversations. Most medical schools do not require continued training in communication skills, and instead, individuals must learn to navigate these conversations from experience as seen in previous

research. However, with recent pushes for end-of-life care across the globe, extended communication courses and systems have been implemented such as the SPIKES protocol.

A Push for Protocols

Currently, there are no direct protocols that are directly applied at the American clinic. Most of the physicians within the clinic had some formal training whether it was in medical school, or during their continued education courses after medical school. Instead, the majority of individuals stated that they followed a model of care depending on the patient that they were working with. Current models, as observed in Figure One, that are utilized within various clinics in America embrace a curative and supportive care approach with specific attention to physical, psychosocial, and the spiritual concerns of the patients involved²⁴⁻²⁷. Such comprehensive care requires the input of a multidisciplinary team that includes not only physicians and nurses, but also social workers, chaplains, pharmacists, physical therapists, and even child life specialists in the case of patients that are young adults or children.

Old model of Palliative Care



New model of Palliative Care

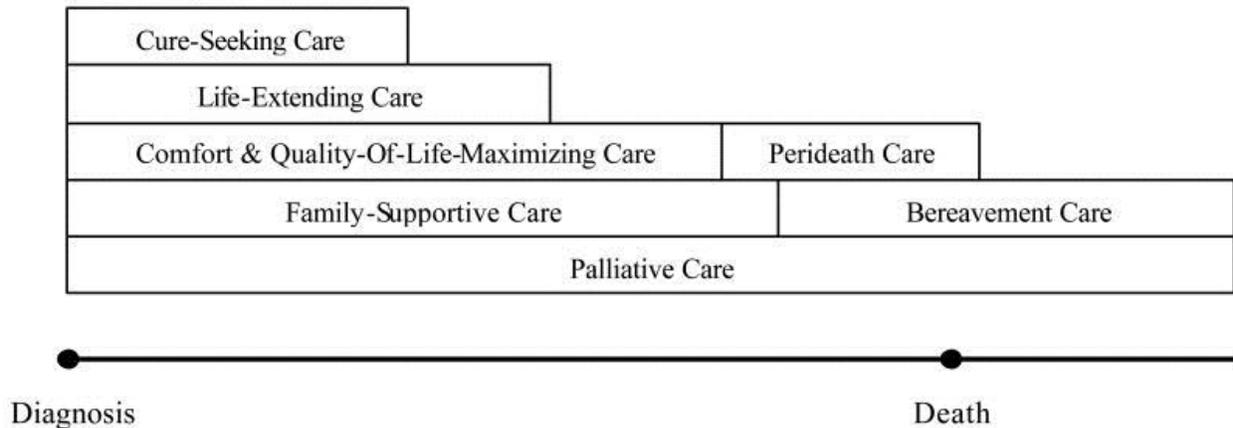


Figure One: The following figure demonstrates a comparison between the old model of palliative care, as well as the new model of care that is employed within various clinics and teaching models in America²⁴.

When viewed in a broad context, utilizing such a model instead of a direct protocol recognizes individuals with a variety of medical conditions that can directly benefit from admittance into palliative care. In a setting of diversity, the pattern of death can take various forms. Each of these forms requires a different tool by which to discuss and handle advanced directives. For example, in the case of highly functional patients who experience sudden deaths, such as the case with trauma patients, discussing death and advanced directives with patient family members can be a difficult task to navigate. Discussions need to occur more quickly to

plan final arrangements. There is no time to form personal relationships with the care team. In turn, this can cause distress and misunderstanding among party members.

Despite the lack of a unified protocol by which physicians can coordinate with their patients, there is merit to the use of models. A model is simplified form of a protocol. Whereas a protocol would be more direct, a protocol is also rigid. There is a set plan or method by which to speak and work with the patient. It should be noted that this path is not always followed and individuals must diverge based on the reactions perceived from their patients. However, a model is beneficial in that a model can easily adapt to the situation. There is a loosely defined pathway by which individuals can discuss death.

Initiating the Conversation

A comprehensive approach to treating physical, psychosocial and the spiritual needs of patients facing life-limiting illnesses, as well as the needs of the family members directly involved with the patients' care, required coordinated efforts²⁴⁻²⁷. Initial communication was denoted by the physicians at the clinic to provide a foundation for determining the immediate needs of the patients and family members. This foundation allowed the medical team to assess their overall effectiveness in being able to address the needs of the patient.

- (1) My goal is to ensure the patient and parents have an understanding of their diagnosis as well as treatment. That I can build some initial trust and rapport with them. That they understand they are not alone – they have our entire team to give them support.*
- (2) My goal is for the patient to have enough of an understanding of their condition and its proposed treatments/lack of treatment for them to make a decision about their care of their own free will. This is an ideal that is probably rarely met. Most patients are very deeply confused about biology and medicine. I really do try very hard to explain things in*

terms appropriate to their level of education and their own cultural context, but I think there are still significant gaps in our communication. I feel like I probably make too many decisions “for” my patients and their families.

Despite not utilizing an overall protocol, both physicians begin by addressing the concerns of the patients. Through compassionate, sensitive conversations with the patient and their family members, their first aim is to ensure that the patient is comfortable discussing their prognosis. This provides a basis for care because before a patient can begin to make decisions, they must understand what is going on. This can pose a problem with younger and older patients that may not fully comprehend the severity of the illness²⁴⁻²⁸. This requires more direct, prolonged discussions that act to create and build upon personal relationships between the physician and patient.

The nature by which the team members initiates these discussions is important to note due to its relation with the clinic atmosphere and setting. With the variance in doctoral degrees in the United States, Doctor of Osteopathy and Medical Doctor, physicians have varied approach to discussing advanced directives with their patients and family members. For that reason, I believe it is important to discuss how initial conversations were handled between both physicians.

Medical Doctors overall were more formal with their patients. The health care team would enter the room of the patient as a single unit. As the team enters, individuals take up positions around the bed of the patient. As the physician stands by the bedside of the patient, he begins to initially inform the patient of their current prognosis. Initial discussions are predominately led by the physician. By this method of conversation, the physician is in control as he directs the conversation from an analysis of current results to what is planned for the future. Upon

discussing initial and future concerns with the patients, the patient began to ask more questions. In these situations, the patient was often reluctant to speak at first. Depending on the age of the patient, the family members of the patients would often speak more than the patient after hearing the physician speak²⁴⁻²⁸. While there may be no strong correlation, it should be noted that this can be followed up in a future study that directly asks the patient about the flow of the conversation and their perceptions thereafter. Overall, this conversation tactic was useful in presenting direct, quick information to the patient. By presenting all of the information at once, it allows the patient time to analyze all information at once. Instead of processing information as it is presented, the patients in this case have all of the information. They can then take the time after the physician leaves, or while he is still in the room, to think over what the physician has said.

In the case of physicians that graduate with a Doctor of Osteopathy, the consultation is more informal compared to their counterpart physicians. The physician also enters the room with their healthcare team. Depending on the physician, they will either sit in a chair at the bedside or stand next to the patient. However, in these cases while the physician speaks with the patient, they are more direct. The physician is mandating physical examinations and engaging the patient in the discussion. There is a constant flow of discussion between the patient and physician. This flow of conversation allows the patient the opportunity to voice their opinion and comprehend what is being said. At the same time, the patient needs to also be able to comprehend difficult concepts quicker. Instead of being presented with all of the information at once, the patient is presented with information in small doses. On one hand, this can be beneficial for the patient to slowly cope and manage with information, but at the same time, some patients may wish to have all of the information on their plate so to speak at one time. This tactic is something that was modified

based on patient interaction with these physicians. The physicians would engage with the patient and discuss if they were interested in discussing more information now or at a later time. In doing so, this allows the patient the option. They are in control of their own care.

Patient Oriented Care

Patients continue to play an even greater role in the health care teams and systems around the world. The systems in countries such as America are evolving from a doctor-patient relationship based on paternalistic qualities, to a more ethical model by which patients have more and better information, taking an active role in shaping their own decisions. These changes are reflected in part by recent pushes and reforms for the development of patient-centered medicine²⁴⁻²⁸.

Whereas the emphasis of medical has always been with the intent of providing the best care for the patient, the push for patient-centered medicine implies explicit, and some might even say an urgent, response for direct care. In the last few decades in America, the system has been characterized as having a provider-centered model²⁴⁻²⁸. There has been an emphasis placed on the evaluation and treatment of patients. Compared with traditional clinical medicine, patient-centered medicine has had an overall positive reception.

The concepts of this medicine is to provide tailored, therapeutic approaches to medicine that can be understood by the catch-phrase that “*one size does not fit all;*” every patient is not the same. The same form of treatment will not work for every patient thereafter. Patient-centered medicine aims to provide continued outreach and education in order to better assist the patient²⁴⁻²⁸. This can come in a number of forms of continued education. Most importantly though, this education aims to push for a change in the relationship between a physician and their patient.

The first step in assessing and changing this relationship has been through courses on consultation practices and how best to handle bad news.

(1) I attended a conference on communication that recommended always giving a warning shot prior to giving bad news. I felt this was good advice, so I usually let the patient know I have bad news, give them a minute to let that sink in and then tell them.

(2) I enter the room, sit down, and I ask the patient to sit down with me (if they're not already sitting down or lying in bed). I then tell the patient that I have bad news, and then I explain everything we have done up to this point, just to make sure they did not miss any lab results, etc. Then I break the bad news to them. I try to keep quiet and listen to their questions fully. I have also had to tell pediatric patients that they have cancer, and this is actually much easier than it is with adults, because pediatric patients do not fully understand what cancer is, or how profound the diagnosis can be. I try to explain that they are going to have to take a lot of harsh medicines and they will feel very sick for a long time, but the doctors and nurses will do their best to make them better, and their family loves them very much and will be with them throughout the treatment. I also emphasize that this was not due to anything the patient has done (which can be an assumption that 6- or 7-year old minds can jump to).

(3) I don't bring up death if I don't immediately have to, because I know they may not yet fully comprehend the concept of death. But I try not to shy away from the fact that they are sick, and it is very serious. I have not yet had to divulge cancer

diagnoses/terminal disease diagnoses to older pediatric patients, so I won't speak to that topic. In any case, [a patient] should never have a cancer diagnosis hidden from them.

Through this continued education, physicians were able to better work with and learn from their patients. Navigation of these difficult concepts became easier with courses and continued experiences with their patients. At present, these courses are not required or mandated through medical schools, but within the next decade, individuals believe that there will continue to be a push for these courses²⁴⁻²⁸. However, it should be noted that these courses informed physicians on the necessity to provide each patient with direct, personalized care. In each response above, the physicians were asked how recent communication courses have assisted them in providing direct care. Whereas physicians differ in minute details about engaging conversation, each physician notes above that they wait to provide bad news. Instead, they gauge the situation and responses from the patient. Some patients may wish to hear current news whereas others wish to wait. As noted previously, this calls for patients to be aware of the patient responses before making decisions.

However, current pushes for patient-oriented care and continued education does not revolve only around providing a basis for physicians to improve their care²⁹⁻³⁵. The work and objective of this push in medicine has also been to make the public more aware of current standards and practices. With regards to education and medical legislation, physicians understand that there needs to be a push in educating the public, as well as current and future medical students²⁹⁻³⁵. Further develop can help close the existing gaps between research, clinical practice, and

awareness. Currently, there is a strong misconception of medical practices; palliative medicine is not left behind in this misunderstanding from both the public and medical sphere.

(1) I believe patients may associate palliative care with end of life care. I believe we can remove the stigma. I try to educate my patients whenever I have the chance that palliative care is supporting the patients and families in all aspects of their care. I think educating people is the key.

(2) I do think there is a stigma with the term “palliative care,” and I think it is related to cultural views of death. Very few people plan for the eventuality of their own death in American culture, and to speak of the issue is taboo, especially when the issue begins to become more apparent, i.e. when a beloved family member is intubated in the intensive care unit, and especially so when that family member is a child or infant. This stigma will probably not be changed until the culture as a whole becomes more accepting of death, and this will probably not be in my own lifetime.

The second physician brings up an interesting point that most individuals are reluctant to bring up: cultural views. Cultural views of death can and do drastically shape how individuals perceive medicine in the western world²⁹⁻³⁵. While this is a cited concern in America, America is not the only country that still has a stigma on death. Numerous countries do, but the question comes how best to assess these concerns. The physicians above understand that the only way to combat these beliefs is by providing continued education not only to the physicians, but also the patients and their family members. The education provided to a physician will only go so far. In order to make an impact in the public sphere, education needs to be directed towards the public.

With these pushes for education and legislation, individuals will have a stronger understanding of death and be more open to discussing advanced-directives at an earlier state of prognosis.

Should the First Discussion be the Last?

Palliative care is important to consider throughout the course of serious chronic illnesses as previously mentioned. This means that palliative care does not cease with the first discussion. Initial discussions only aim to introduce patients with physicians in order to begin the building of personalized relationships. However, as patients struggle to find closure in their lives, continued and active listening and empathy is required to provide therapeutic values towards patients and family members. Whereas the initial discussion presents the current prognoses and future recommendations, the later discussions present more trying fields for physicians such as navigating behavioral and decisions changes about their end-of-life care²⁹⁻³⁵.

In a multicultural society, patients and family members have varying attitudes towards discussing current and future care. In particular, some cultures believe that discussion of death hastens its onset²⁹⁻³⁵. Thus, advanced planning in end-of-life care may be inappropriate for some individuals based on backgrounds. In some cases, patients are unfamiliar with their current and future plans because of a hindrance in educational background. On part, this can be due to geographical location²⁹⁻³⁵. Some might even choose to say that this hindrance is due to failure on part by legislation to continue prolonged outreach with the public²⁹⁻³⁵. Despite these varied beliefs, it seems appropriate to say that in America, physicians are recognizing the hardships of continued discussions.

(1) I do have parents and patients of a variety of backgrounds in education and age. If I have parents or patients in denial or not that do not understand [the prognosis], I will

change the way I am explaining until they do understand, spending extra time with them.

(2) I am saddened by patients who do not understand their diagnosis, or those who do not wish to understand their diagnosis. I see them as if they were lost at sea, buffeted by waves, treading water. It's probably a cultural bias, but I think the easiest way to gain control over one's situation in life is to understand it.

As mentioned previously, continued education is a necessity in order to assist and alleviate the concerns of patients that are not familiar with their current welfare. Physicians and legislation can extend their care by acknowledging and exploring psychosocial, existential, and spiritual suffering techniques and research²⁹⁻³⁵. Because people vary widely in terms of culture, knowledge, and beliefs, each patient and family needs to be approached as individual cases. Oftentimes this is not observed among physicians based on a host of factors previously discussed. However, the approaches recommended by these physicians to target the future of palliative care in America will allow patients to drive the discussions, ensuring respect for their values.

The Future of Palliative Care in America

While the use and advantages of palliative care and hospice are gaining momentum at an unprecedented speed in America, there remains a disparity in access to its care geographically across the states. In addition to initial access, the type of care that patients receive in end-of-life care greatly varies according to the location that they receive care, as well as the acute care facility that they are enrolled within. In 2001, a study was produced that discussed dying in a hospital in the United States as depending on, not the preference of the patient or their family

members, but rather on the number of hospital beds or physicians that were available to provide personalized, direct care²⁹⁻³⁵. This statistic was shown to vary differently across the United States, presenting the problem as to why and what can be done in the future.

In the study, it was shown that patients with medical insurance companies in both western and northwestern states have less than a 20% chance of dying in a hospital, whereas the same study showed that patients living in southern and eastern states have a 50% chance of dying in a hospital²⁹⁻³⁵. These findings present different outlooks of death and dying based on geographical location. This research supports the fact that geographical location is still an issue and plays a significant role in end-of-life care²⁹⁻³⁵. Further studies on this issue in America point out that the likelihood that patients will spend their final days in a hospital intensive care unit depends predominately on the geographical location of the patient as well²⁹⁻³⁵. Little evidence was shown as to whether or not patient wishes were followed once within these settings²⁹⁻³⁵. The disparity in where patients go to receive acute, specialized care, as well as the disparity with the level of care that they receive, is an alarming notion.

Despite these alarming results over the past two decades, strides have been made to directly work with the needs of the patients. The Patient Self-Determination Act of 1991 required that all participants of Medicare notify their patients their right to advanced directives in their treatment³²⁻³⁵. The overall goal of these advanced directives when they were first introduced was to allow patients to retain control throughout the course of their care³²⁻³⁵. Current health policies often fail patients in this respect as family members can argue of the choices that the patients make. While the mandate of this federal law was well intended, it resulted in confusion and sporadic compliance from patient and family members with little to no discussion³²⁻³⁵.

At approximately the same time as the passage of the Patient Self-Determination Act in 1991, another paradigm in advanced care was initiated. The goal of this new paradigm was to turn the preferences of patient treatment and advanced directives into medical orders. A new program was thus introduced by the state of Oregon known as the Patient Order for Life Sustaining Care (POLST). The intention was to create and provide a mechanism by which patients can communicate their preferences regarding end-of-life care across various care settings. The document turns the preferences of patients into medical orders that have an overall goal of ensuring the needs of the patients are met.

However, there are still some barriers with this paradigm. The most problematic barrier revolves around statutory state specifications for out of hospital do-not-resuscitate orders³²⁻³⁵. Other potential barriers include forgoing life-sustaining treatment, witness requirements, and medical condition requirements³²⁻³⁵. Despite these state mandates, results of POLST have been well received. Results indicate a strong tie between patients' wishes across multiple care settings³²⁻³⁵. POLST can have a positive impact on the ability of an individual to determine their own end-of-life preferences, as well as where they wish to receive this care.

A tidal wave of social change is headed our way in America. For the first time in history, there will soon be older than young people on the planet³²⁻³⁵. This growing trend of increased age and distance among families is converging on a central idea that personal, professional, and political action is required to combat the needs of patients' end-of-life care wishes.

(1) I see palliative care containing to grow and be a crucial part of oncology. I would love for my patients to meet the palliative care team the same day they meet the oncology team. I think it is so helpful and useful for the family.

(2) I think they will continue to gain mainstream acceptance, especially as the baby boomer generation really hits the end-of-life care situation. I don't know if it will be completely mainstream or not. However, my ultimate hope is that everyone would have a palliative care plan in place by the time of their first hospitalization, and that everybody would view the end of life as precious as the beginning.

Despite the beliefs of these physicians that understand a push in palliative care standards is necessary, not every physician is comfortable about discussing death with family members and patients. All health care professional should strive to create an environment by which the philosophy and original recommendation about palliative care can be understood. In order to meet the recommendations of these physicians and countless others alike, the voice of the public and professional field of medicine needs to be heard. Local, state, and grass-root programs need to continue to be developed, financed, and evaluated. While most financing will need to continue to come from private and grant sources, further allocation of budgets should be implemented by state and federal reserves in order to assess what can be done to promote and enhance current end-of-life care practices.

Simply put, the physicians are correct in their assessment that the patient should have the opportunity to meet with every member of the team at the time of their admittance. In turn, this will lead to higher patient satisfaction, as well as stronger relationships with each team member. We can begin to control the cost of end-of-life care and afford to die with dignity only if further legislation similar to POLST can be mandated across all care continuums in every single state. It is more than possible to imagine that every state can utilize this legislation and have the same, profound effect as observed initially in Oregon. Every individual has a role to play in securing a

better means by which to provide care, and create a nation where quality of life and personal choices are not simply a priority, but a responsibility.

Discussion of American Consultations

While this is not the first ethnographic study to be carried out in an American hospital, I believe that the following study in America presented key findings regarding the use of models in a clinic setting, as well as the variance in training and personal experiences between physicians with an osteopathic background compared to an allopathic background in medicine. Between these two types of physicians, a number of differences and similarities were observed in their daily consultations.

The first finding was the variance in open discussion between patients, family members, and the associated medical team members. Consultation times ranged between the two physicians. Allopathic physicians on average ranged from fifteen minutes to thirty minute visits. The visits by the osteopathic visits were on average longer, ranging from thirty minutes to an hour long. In these cases, longer consultations did not always lead to stronger perception from the patient. Patients still had questions concerning their prognoses. However, patients were more receptive and open to discussing current health care plans. Family members were more open to discussing current plans with the physician depending on the reception of the patient. When patients were not receptive in either case, the parents were more prone to speaking with the physician. No real correlation at this time can be made with respect to family members, but it appears that patients were at least more receptive and open to speaking with the physician under longer consultations. As previous research has shown, longer and consecutive consultations leads to the building of strong relationships. These relationships are important within this field as it

allows physicians and patients to work closely together, ensuring that the needs of the patient are met.

With respect to delivering bad news, both physicians were reluctant to immediately give bad news to their patients. Physicians wait to deliver bad news by delivering social cues. If patients openly respond, then they will begin to give them the bad news. The physician's intention was to wait until the patients can fully grasp the rest of the information that they have received. In some respects this can be a better option than immediately being open with the patient because it allows the patient time to process information. The patient will have a clear mind and idea of what they wish to currently do in their care. However, not informing the patient soon enough can also be a problem because the patient will be expecting one prognosis whereas the physician wishes to pursue another form of treatment. Whether or not to address concerns immediately should be assessed on a case by case basis with the patient.

It should be noted that there are identifiable limitations and issues with this study. The observations during my week stay at the clinic reflect only a brief period of time. The time frame is considerably short to provide an effective outlook on conversation standards at the hospital. These observational differences with American standards could signify the possibility that I was experiencing culture shock. A longer study would rule out this notion though. An extended study would ensure that the tactics described above with the German team were consistent with each member of the team. It would also ensure that I was exposed to new techniques and tactics in communication.

Another important limitation is that the study was conducted only at one institute within America. Whereas previous logs had been analyzed from another hospital in America, this data was not utilized in conjunction with the facility in this study. The study was conducted in a

relatively well known and large medical center within the south west of the United States. The palliative care is not as large as it would be an outpatient clinic. It would be better in this case to analyze additional institutes to ensure that the results from this institution are the same abroad.

Despite the limitations within this study, the information obtained is important for future studies as it denotes the need to study the effectiveness of palliative care team in new ways besides patient satisfaction alone. A more expansive study-design would be the next step. The study would have a qualitative and quantitative study design. In a future study, it would be best to analyze conversations again, but also run a quantitative study that aims to assess patient satisfaction and reception, as well as how doctors handle current models and protocols of discussions with their patients.

GERMAN PORTION OF RESERACH

Previous and Current German State Agendas

As in numerous other countries, Germany has endured an ongoing debate concerning an applicable ethical guideline and care framework for end-of-life practices. The development of palliative care units has had an impressive outlook since its introduction in 1993³⁹. The number of inpatient units and hospices has increased significantly from twenty-one to sixty-five units³⁹. However, no standards have been implemented for inpatient palliative care wards in Germany. This is important to consider given the increase in units⁴⁰.

After 1993, the German Ministry of Health initiated a meeting between physicians across Germany to discuss recommended changes for inpatient units in 1996⁴⁰⁻⁴². In this meeting, physicians and lawmakers analyzed the procedures of the various units across Germany.

Germany began to place emphasis on laws that acknowledged and provided insight into the patient's right of self-determination. These laws also emphasized the obligations of physicians towards their dying patients. In particular, the doctor is supposed to protect the patient from pain as they oversee their care. As long as the doctor keeps the interest of the patient in their mind, according to German literature from the *Indirect Sterbenhilfe*, physicians will be protected even if the patient dies, as long as they provided proper pain management.

At this period, the German perception began to take more notice⁴². It appeared that active mandates were in the process and a step was being taken toward advanced care directives. Physicians were being given more protection under the law in order to meet the requirements of these new mandates. From these units, a draft of core instruments and elements to run these palliative care units was devised⁴⁰⁻⁴². The draft was finished in 1999 and preparations were made

to implement these new standards⁴³. At this time, palliative medicine was still not designated as a specialty.

Specialist palliative care units were then established in 2007 for the local communities⁴⁴. Referred to as SAPV, the reforms mandated the introduction of legal system requirements. These requirements would aid in smooth transitions from primary to specialist units. It appeared that actions were beginning to take place as public awareness increased⁴⁴⁻⁴⁶. These transitions are still in the process of being implemented, but once they finish, specialized palliative care units will become more of a routine.

Observations and Discussion of Key Points of Conducting Consults

Initial observations of patients and healthcare providers began on June 30, 2014 out of the three hundred and ten bed clinic within Germany. The initial interactions were observed and recorded during morning rounds with the ward's team, family consults, and room visits. The notes were then transcribed by me from German to English. The information obtained from these settings suggests the appearance of a keen interpersonal awareness of the concerns and well-being of the patients and their family resulted from the use of humor. The use of humor by the staff was not intended to promote a heightened awareness of the patient's well-being, but rather the imposition of humor through comedic relief promoted a patient-centered atmosphere. The atmosphere allowed for holistic interactions to take place. These interactions were crucial in directing conversations towards understanding and planning end-of-life care, as well as clarifying the concerns of the patient and their family members.

Clinic's Atmosphere

The clinic is a fifteen minute ride on the local tram from the city center. Nestled among small community homes, I entered the institution's clinic. As soon as I entered the front doors, I

understood that this was unlike any facility that I had visited thus far in America. Doctors and patients sat around the commons speaking to patients as they passed them. Everyone was open towards one another with morning greetings. I was immediately greeted at the front door and given directions towards the palliative care unit.

Each individual that I passed greeted me as I had seen them do with the other doctors. Some patients went so far as to shake my hand and thank me. I wondered what I was being thanked for: Was I being thanked because they thought I looked like a physician in my suit and coat? It did not dawn on me at the moment that this was my first glimpse at the atmosphere of this clinic's environment. The patients that were waiting to be seen in the lobby near radiation or radiology were in positive spirits. Individuals conversed with one another and spoke with new arrivals as if they were long acquaintances. I felt a sense of community among the patients and physicians alike as I passed by these conversing individuals each morning. This atmosphere was healthy for providing healing hands to those in need. Each individual understood their role as a health care provider, but they also understood their roles as human beings with the ability to empathize with others.

I was unsure at the time if these were simply cultural markers. Having been prior in Leipzig, Germany for a month, I had become accustomed to the open and warming nature of German citizens. Thus, the cultural markers should not have been a shock. However, as I developed personal relationships with physicians and patients alike, I began to develop a sensitive awareness to the cultural differences.

I learned that this open nature was how the German culture was. Individuals were more prone to stopping and speaking with me as I passed them because I had to wear a medical coat, presenting me as a new physician at the institute. The open-minded atmosphere of the clinic was

something that was implemented during consults. Individuals were more prone to discussing their health because the physicians treated these individuals as more than a disease waiting to be cured, but they were treated as humans. The entire prognosis of the individual was analyzed. Only by analyzing the patient as a sentient being with more than a diagnosis did these patients appear to feel more comfortable speaking about end-of-life care.

Clinic Setting

Research and consultations at the clinic were conducted in three wards of the facility: Station three, five, and NCT Sprechstunde. Station three was for individuals in the palliative care ward. These were individuals that would be there for extended periods of time. Station five was for individuals in the oncology ward. NCT Sprechstunde was a section of the palliative ward that was used solely for individuals that sought out consultation.

The oncology ward was used for various purposes from first visits, to clinical testing, pain management and chemotherapy side effects, to the care of those that were sick and dying. Patients engaged with physicians and nurses in a host of manners. The most typical interactions were during daily rounds in the morning, but the attending physicians I worked under would also do visits at the request of the patients. Visits lasted anywhere from fifteen minutes to over an hour in length. Consults that were scheduled later in the day would last over an hour long. I learned that time was not an issue. Individuals were more focused on providing care to the patient and listening to their concerns than addressing the next concern. Each patient had a place and purpose, and their time was not finished until the patient was satisfied. Even during these consult times, the serenity remains a unit of family and friends. Neighboring patients in adjacent beds in the room were respectful of the health and well-being of their fellow patients. It was not because there was a sense of grief in the air though, but because they understood how important

their time with the physician was to clarify concerns. This does not mean that individuals in the adjacent beds would not communicate with one another. It is quite the opposite actually. Individuals were more prone to speaking with one another as it calmed the tension in the room after these consults. It provided a sense to the patients that they were not alone and others understood what they might be going through.

Station three, or the palliative care ward, was across the grounds from the palliative care ward. Station three was smaller than station five because of the extensive care they must give to each patient. At a time, this ward will only see upwards of twelve patients as opposed to the twenty-eight patients within the oncology ward. There are three floors to this smaller ward. Each floor has a set of rooms on either side with a terrace at the far end. The terrace can be used for sun bathing as it overlooks the entire grounds and pond. Unlike the oncology ward as well, there is one patient per room. This provides security as well as privacy for these patients. Despite these differences, both the palliative care and oncology ward team members act in a cohesive manner. The team members here understand the importance of working as a team and communicating with one another. Despite the nature of this ward, the team is very optimistic. Each patient is greeted during the morning rounds and throughout the day. Consultations also range anywhere from five minutes to over an hour long.

NCT Sprechstunde was specifically for patients that are coming in either for the first time or for an additional meeting to discuss their prognosis and plan of action. Conducted in a separate office, these consults had similar lengths of time as the other two wards. In this setting, the physician would listen intently as the patient discussed their concerns about seeking assistance or on the next treatment step. With patients dominating the conversations, it provided them the act of being in charge of their decisions. This was important as most individuals that

came in for consultation faced prognoses with grim outlooks. NCT Sprechstunde was more formal than station three or station five. Individuals that were coming in needed immediate help in making decisions on future care. This created a sense of urgency in admitting the patients to the institute.

The three wards that I visited were unique in their own ways. The conversations varied between the three settings to fit the needs and atmosphere of the participants of these conversations. NCT Sprechstunde and station 3 were more formal given the atmosphere of the palliative care ward and the consultation room. Individuals in these settings often faced grave results. These individuals needed personalized rooms that were free of a large medical team listening in. This personal undertone allowed conversations to be shorter. Station five, due to the large amount of physicians and nurses that would sit in on the conversations, was more informal. The same serious and comforting undertones observed within station three and NCT Sprechstunde was met by having a large group of individuals sit around the patient. Larger groups were more effective in these settings despite having a second patient in the room. This is noted because it provided these patients that were not yet in advanced stages of their terminal illness the belief that an entire team was there working towards treating the person and not their illness. Overall, these wards provided evidence that conversation tactics diverge in regards to the information that needs to be discussed.

The Gravity of Consultations

A consultation provides a foundation to discuss end-of-life care. Patients and families can speak more openly and feel more trusting of their teams in this setting because the physicians can interact one-on-one and find solace. A caring connection can be made because of the empathy

and compassion of the team. When a team can be open to the stresses and concerns of their patients, they enhance the emotional connections with their patients.

In most terminal illness cases, the prognoses are grim. Curative treatments are no longer the means of care because they have proven to be ineffective⁵. Therefore as the illness progresses, the physician and his team are faced with the challenge of discussing end-of-life care and requests. In this context, most physicians find the challenge in initiating these conversations. Most medical schools do not require continued training in communication skills, and instead, individuals must learn to navigate these conversations from experience as seen in previous research⁴⁵. However, with recent pushes for end-of-life care in Germany, extended communication courses and systems have been implemented such as the SPIKES protocol⁴⁶.

The SPIKES Protocol

SPIKES is a protocol that has become a utilized tool for training new physicians in being able to disclose unfavorable information in the waking of their prognosis. SPIKES is a straightforward and practical method that consists of six steps. SPIKES enables physicians to fulfill their objectives during the care of their patients: gather information pertinent to the care of their patient, transmit medical information to patients and family members alike, provide support to the patient, and develop a collaborative strategy for future care.

Outlined below is the protocol that individuals within the clinic in Germany utilize. Most individuals did not receive specific training during medical school. Instead, these methods were self-taught until continued education courses on communication began to develop in the past decade. Since the introduction of SPIKES, this protocol has become a routine testing procedure within the coursework in medical school in Germany.

STEP 1: P— SETTING UP the Interview

Step one involves preparing yourself for the interview. Mental rehearsal and practice are vital to preparing for end-of-life care conversations. Individuals can accomplish this first step by reviewing how you will tell the patient recent news. Clinicians should prepare by analyzing the potential responses and emotional reactions of their patients. Although bad news can make one feel frustrated and responsible for the outcome, it is important to understand that while bad news is a time of grief and sorrow, the information is important to continue advanced care for the future.

Clinicians should prepare these initial discussions to be in safe, physical settings. These interviews discuss sensitive topics. If the environment is not private, the patient or clinician can become distracted during the discussion, failing to disclose and discuss the goals of the interview.

STEP 2: P—ASSESSING THE PATIENT'S PERCEPTION

Step two is observed during the interview with the patient. At this time, the clinician needs to observe an accurate picture of how the patient perceives their current state. Do they understand the diagnosis? Do they understand why they are here today? These are questions that lend truth to the gravity of this step.

For example, in NCT Sprechstunde, the physician would first review what the patient knows. This gives the clinician the time to assess the views of the patient. They can read into the emotion behind their responses as well. This allows the clinician the time to change their tactics at delivering news if needed.

STEP 3: I—OBTAINING THE PATIENT'S INVITATION

The outcome that most clinicians face is in regards to individuals that express the desire to know all of the information concerning their treatment, and those that do not wish to know about their diagnosis or future plans. Patients that express their willingness to hear information can relieve anxiety and stress from the clinician⁴⁷. However, abstaining from hearing future information is a common psychological mechanism to cope with painful information⁴⁷⁻⁵¹.

While a majority of patients express their desires to hear and acquire more information about their current prognosis and treatment options, some patients do not wish to hear these things. This is something that clinicians need to be ready for.

Clinicians can prepare for these events by discussing the format for disclosing information when the patient is admitted. If patients do not want to know details, they can inform their physician. Instead, physicians can offer their service for future questions and answers. This allows patients to understand that the physician is waiting until the patient is ready to discuss these delicate topics.

STEP 4: K—GIVING KNOWLEDGE AND INFORMATION TO THE PATIENT

Warning the patient ahead of time can allow the patient time to process potential information that you will say⁴⁷⁻⁵¹. This will allow them the opportunity to work through the facts. Key examples of bridging this gap could be one of the following: “I am sorry to inform you that...” or “Your test results recently arrived and I was wondering if you were ready to discuss the outcomes?” are feasible ways to communicate this dialogue.

When the prognosis is grim, clinicians were advised to provide information in small doses. Periodically they would check to ensure that the patient is following them. Reinforcing the

notion that the patient understands the physicians is critical to future care. The physician should never state that there is nothing that can be done. The patient may have differing views on what can be accomplished for their care still i.e. pain management, last wishes, etc.

STEP 5: E—ADDRESSING THE PATIENT'S EMOTIONS WITH EMPATHIC RESPONSES

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Responding to the emotional reactions of patients is crucial. This is a difficult task. When patients hear emotional news and react accordingly, individuals can present a host of emotional responses. In these situations, clinicians can provide empathic responses and lighten the mode. Oftentimes during initial news of cancer and further chemotherapy in station five, physicians and patients might engage in light humor. The following is an example of an interaction with a physician and their patient in during a round:

Physician: *I am sorry to say that the x-ray tests performed indicate that the cancer is not responding to the chemotherapy [pause].*

Patient: *[Silence] I was afraid of this.*

Physician: *[Physician moves chair closer and they reach across the table to hold patient's hand]. I understand that these are not the results yourself or your family were expecting. I wish that I could be giving you positive news instead.*

In the above dialogue, the physician observed the patient having an emotional reaction to grim news. The patient was having trouble processing the information. Immediately the physician offered their support to the patient by reaching across the table. Initiating physical contact can be comforting at this time as it acknowledges the gravity of the situation.

STEP 6: S—STRATEGY AND SUMMARY

Patients that have a future plan for their care are less likely to experience anxiety when discussing future care. Before discussing treatment plans, it is important to ask if individuals are ready for these discussions. This establishes the perception that the physician understands the wishes of the patient. Once these bonds are formed, effective care can be sought.

Initiating the Conversation

As mentioned in the SPIKES protocol⁴⁶, the process of working with terminally ill patients begins with the entire team getting involved in the care of their patient. Early discussions can provide their patients the opportunity to elicit their general thoughts and concerns about end-of-life care. Conversations began by asking permission from the patient and their present family members how they were feeling. Instead of immediately asking the patient if they were ready to discuss advanced directives, they learned how the patient was doing. This established a comfortable setting. Once this setting was established, an assessment could be made if the time was right. Oftentimes we would come back on rounds once we knew everyone was present that wished to be a part of the decision making.

Enabling the patient to make decisions on their care is essential to palliative care. Each patient is unique in that they need to choose their own pathway. Patients diverge in regards to the paths they wish to take when faced with death. These paths are unique and can only be determined by themselves on what they want to manage (i.e. pain relief, the appearance of wounds and bandages, conversations about anxieties, etc.). Thus, it is essential that the patient initiate these processes and discussions once they are ready. In some respect, it is only the task of

the professional to provide the proper setting and listen to these discussions, acting more as a guide when needed.

(1) Der Patient soll vor allem die Information bekommen, die er haben will. Es soll aber auch die Information bekommen, die er braucht um eine freie Entscheidung treffen zu können. Das Ziel ist eine präferenzsensitive Therapieentscheidung. Die Autonomie des Patienten muss unterstützt werden.

English Translation: *The patient should especially receive [what] they desire. This information needs to allow the patient to make free decisions. Thus, it must be informative enough for them to make these decisions. The goal is that the decisions these patients make about their treatment plans are preference-sensitive.*

(2) Mein Ziel ist immer, das medizinisch Notwendige mit den Wünschen des Patienten zu verbinden. Die höhere Priorität haben aber die Wünsche des Patienten, ich passe gegeben falls die medizinische Intervention daran an. Ich versuche immer, den ganzen Menschen zu sehen und zu verstehen, nicht nur den Mensch als Patient.

English Translation: *My goal is to connect what is medically necessary with the wishes of the patient. However, the highest priority is with the patient's wishes because adjustments can be made to medical interventions. I try to see and understand the person not only as a patient, but as a whole person.*

The commonality with these physicians is the idea of what the patient means. The patient is a human being. This is the first concept that needs to be understood when beginning a consultation. When you understand that you are treating the whole person, you can begin to

understand that each patient has preferences for how to be treated. Informing yourself of their wishes allows the patient the opportunity to make free decisions. Each case is sensitive to that specific patient. Thus, treatment plans and discussions will differ slightly between each patient. However, the idea behind treatment and how to initiate these discussions stays the same.

The nature of how the team initiates these discussions is important to note because it is in line with the atmosphere of the clinic. The physicians are somewhat informal with their patients. They do not attempt to tower over them as they deliver news. Instead, they take a more informal route by sitting on the bedside or inviting them to sit with them. Oftentimes you would even see the team of care providers sitting on the windowsill next to the patient. The purpose was maintaining direct contact with the patient as it instilled within the patients the notion that they were there. They were not hiding behind a computer screen taking notes. Instead, they sat there speaking softly with the attending members of the consult and wrote notes as they discussed the agendas of their patients.

The loss of a formal consultation provides even footing for patients and family members to communicate with their physicians. As a physician would sit alongside the bed of their patients or gather on the windowsill to look out the window at the gleaming sun, they began to humanize themselves. They no longer felt like doctors in a white coat. They were not in control. Instead, it put the patient in control. The doctor was a friend that was there to care and place a helping hand on their shoulder. In this light, the roles are distinguished and it becomes obvious that this is not simply a career for these individuals; it is their duty to help people.

Patient Oriented Care

End-of-life conversations are supported not only by palliative care, but also by other medical practices that are oriented around maintaining patient livelihood⁵⁵⁻⁶³. Patient-oriented

care revolves around effective interpersonal care that can identify and characterize relationships that encourage informed choice and autonomy⁵⁵⁻⁶³. The focus of interpersonal care, regardless of cultural disparities, is the need to understand the ailment of the patient. Once this is understood, then adequate care can be given³⁷.

The medical professionals at the clinic see patient-oriented medicine in a new, broadened manner. Instead of focusing solely on the diagnosis and treatment plan, they attempt to take a wide encompassing approach by analyzing the patient as a whole. They see the patient as more than a diagnosis waiting to be cured. Instead, they attempt to “see through the patient’s eyes⁶³⁻⁶⁵.” This means that they want to understand the viewpoint of the patient with respect to doctor-patient relationships, as well as the context of their suffering^{62, 64-66}. This approach towards medicine places the patient in charge of their treatment. The patient ultimately determines the outcome of his or her life by making the decisions for treatment and care. Empowering the patient with these decision making capabilities endows them with dignity and respect. Despite the prognosis of their condition, the sense of being in charge gives them hope. They can have respect for themselves, and their body, as well as their care providers. This creates a healthy environment to care for the patient because all care providers are on the same page. There is no ethical disparity between doctor and patient roles⁵⁹. Each individual is in the room so to speak for one goal: to care for the patient.

The other key value to recognize with empowering the patient is that they can make choices that reflect their ideals. Each patient has varied values and needs. Some patients might wish to forgo treatment because of the consequences that treatment can have on the body. Individuals may feel weak or debilitated after extensive chemotherapy treatments, making further care harder on the patient and care providers. As the treatments continue, the drugs take a

toll on the body and mind. Individuals may lose the drive to continue. This issue is even more so prominent in younger patients whose treatments are often far more intense because it is believed that their bodies can fight off the effects of the drugs. Therefore it is important that an individual patient can make these decisions according to their needs and values. If an individual patient feels that they cannot sustain such a life, it is important that they are given these choices and the power to make these decisions. In the end, this will lead to a stronger quality of life at the end of the patient's life because they had made the decisions.

The key to patient-oriented care is for care providers to respond in a way that individuals understand that they are in control. Patients need to be able to sense that their “ideas, feelings, expectations, and fears are understood⁶¹— essential elements of end-of-life care⁶³.” Patient-oriented communication skills are essential to health care providers in this setting⁶⁶. These skills enable these individuals to form lasting relationships with their patients. When care providers can build emotional connections with their patients, a physician can more effectively care for a patient. The care for the patient becomes more than a routine. When asked their opinion on these relationships in the clinical setting, several team members agreed with the importance of forming these interpersonal relationships. Team members stressed the importance of making sure the patients understand the severity of their conditions. Open communication allows for the patient to make their decisions during their period of care, as well as for death to eventually be confronted openly by all parties^{60, 62, 64-66}.

(1) Wichtig ist, den Patienten zum Gespräch einzuladen, ihn zu fragen, was er wissen will.

Dann gibt es keinen falschen Zeitpunkt um über Sterben und Tod zu sprechen. Das ist

folglich auch früh im Krankheitsverlauf möglich. Andererseits gibt es Patienten, die bis zum Tod darüber nicht reden wollen. Auch das muss man akzeptieren und respektieren

English Translation: *It is important to invite the patient to talk, to ask him what he wants to know. There is no wrong time to talk about dying and death. This is therefore also possible early in the disease. On the other hand, there are patients who do not want to talk to death about it. You have to accept and respect [this decision].*

(2) *Ich nähere mich immer vorsichtig der Wahrheit an und versuche langsam herauszufinden, wieviel der Patient oder die Angehörigen wissen wollen und vertragen können. Letztlich finde ich es aber auch wichtig, dass jeder die Chance hat, auf das Wissen um das baldige Ende zu reagieren.*

English Translation: *I will approach the situation carefully towards the truth. I want to find out exactly how much the patient or relatives want to know or can tolerate. Ultimately, I think it is important that everyone has the opportunity to respond to the knowledge of the imminent end.*

The team of this cancer unit understands that the beliefs their patients have about their condition are inherent in making critical determinants of goals. The patient must be in control of their life. Interventions in these clinical settings are tied into the self-efficacy of the patient⁶³⁻⁷³. Patients with advanced illnesses pursue these strategies in order to maintain and assess adverse effects from treatment plans, maintaining a positive outlook on the condition, and clarity of overall treatment. Sometimes it is not even the treatment that needs clarity, but the words that are used. Even though Germany's culture has a more positive outlook on death than America, there are still uncertainties regarding the term 'palliative care.' Individuals have stricken this word

with a stigma revolved around death. This is due on part to palliative care still being new to Germany. However, physicians at the clinic noted that common issues with the term were because their patients had heard of this specialty only when hearing about cancer, despite the fact that palliative care is sought even with individuals with heart ailments such as heart attacks.

(1) *Ich glaube, dass der Begriff Palliativmedizin weiterhin stigmatisiert ist, denn er wird direkt mit Sterben und Tod assoziiert und deshalb negativ besetzt. Es ist nicht bekannt, dass Palliativmedizin mehr ist als nur Sterbebegleitung.*

English Translation: *I believe that the term palliative care continues to be stigmatized because it is directly associated with dying and death, and therefore [this creates] a negative connotation. It is not known that palliative care is more than just the dying.*

(2) *Ja, das ist ein großes Problem, dass die meisten Menschen Palliativmedizin mit Sterben gleich setzen.*

English Translation: Yes, this is a big problem that most people connect palliative care and dying together.

Patients often struggle with other factors such as finding a purpose in death, medical costs, family impacts, etc ⁷⁰⁻⁷⁵. Targeting these factors allows for patients and doctors to work cohesively together. Overlooking these factors can lead to further distress. Thus, it is important to target these factors at the beginning of treatment.

(1) *Wir können es schaffen, an dem Stigma zu arbeiten, wenn wir aktiv über die Möglichkeiten der Palliativmedizin aufklären und auch als Ärzte uns trauen über Sterben und Tod zu sprechen.*

English Translation: *We can work on the stigma when we actively educate about the possibilities of palliative care, and as doctors we [must be able] to talk about dying and death*

(2) *Da ist sehr viel Aufklärung notwendig. Ich denke aber, dass sich das in Zukunft ändern wird. Das ist ein Prozess, der lange dauert.*

English Translation: *More education on palliative care is [currently] necessary for the public, but I think that this [problem] will change in the future. This is a process that takes a long time.*

Awareness of these factors and continued education to the public can create a prolonged effort to enhance interpersonal care between patients and care providers, essentially shaping how end-of-life conversations should be handled for now on.

Humor in Consults

Humor can be a therapeutic procedure for both patients and physicians alike. Therapeutic humor was first introduced in 2004 by the Association for Applied Therapeutic Humor as a viable means of therapy⁷⁶. Oftentimes society attributes the hospital as a place of grim despair. Individuals do not willingly choose to visit the hospital for enjoyment. There is always a reason for visiting the hospital. It seems strange to believe that humor and jokes can be an active form of therapy within the hospital setting.

(1) Humor hilft, erzeugt positive Gefühle. Manchmal erzählen mir auch die Patienten einen Witz. Es ist etwas sehr Menschliches.

English Translation: *Humor helps generate positive feelings. Sometimes I tell the patient a joke. There is something very human [about making jokes].*

Individuals denote therapy as a form of intervention that promotes health and wellness⁷⁶⁻⁷⁹. With this in mind, who is to say that humor cannot be employed as a routine therapy? Jokes and laughter help stimulate a healthy lifestyle because they can reduce stress. People feel better about themselves and their situations when they can share a laugh with other individuals. Laughing creates an experience. These experiences result in friendship or a sense of feeling human again. Individuals with terminal illnesses that must stay in hospital settings for longer periods may feel distant from the rest of humanity.

In these situations, it is imperative that healthcare teams pay attention to these signs. Nurses generally spend more time than other healthcare workers with their patients⁷⁶⁻⁸⁰. Humor can be an effective mechanism to bridge relationships with their patients, but only if jokes are made in conjunction with the respect of the patient kept in mind. Healthcare workers want to ensure that their patient's wishes are kept in mind, lest they offend them.

The contrary was true with the team in the three hundred and ten bed unit in Germany. Oftentimes, it was the patient and physician that engaged in humorous banter. This playful exchange of humor created new levels of friendship and trust. This is not the first time that this has been seen. Recently, there has been an increase in quantitative studies from ethnographers to study the use of tactical humor in palliative consults^{24, 76-80}. The individuals in these setting

understand that humor is important to cope with their crisis. Patients are not the only individuals to benefit. Both parties can benefit from finding humor in the situation.

(1) Ich habe von meinen Patienten gelernt, dass man je nach der Situation, sogar über den Tod lachen kann.

English Translation: *I have learned from my patients that, depending on the situation, you may even laugh at death.*

(2) Humor spielt eine große Rolle. Wir lachen viel mit unseren Patienten, es kann sehr erleichternd sein, wenn man einen Witz machen kann.

English Translation: *Humor plays a big roll. We laugh a lot with our patients and it can be quite a relief when you can make a joke and laugh [in these settings].*

Despite the cultural differences regarding death between America and Germany, individuals still fear death. It is the final chapter of our lives. By being able to take a moment to laugh, individuals can take a breather. They can relax before having to discuss their end-of-life plans. With individuals that are still planning these steps, this factor is important to note. Patients and physicians can take a moment to regain their footing before continuing the discussion. This allows individuals to adjust to what they just heard. Physicians and patients alike should feel more comfortable thereafter in these settings. Physicians need to trust their instincts about the appropriate time to engage in humorous banter. Combined with recent scientific studies and

continued education in communication, humor can become a more routine facet of healthcare. Only then will individuals begin to see the humanizing nature of laughter.

Whereas there was some humor observed in the American consultations, it was not often seen compared to the consultation in Germany. The humor in America was not well received. On part this can be due to the fact that there was a wider range of age with the patients in America. The patients in Germany were predominately older in age. The jokes were potentially better received by the older patients because they could fully comprehend the jokes. They had a more positive outlook on their situation. The children were unsure often what was going on. However, both physicians in America and Germany remarked about the importance of humor in consultations being that it allows individuals to laugh about their predicaments and realize that death is merely another step in life.

Should the First Discussion be the Last?

Consultations can assess general thoughts and concerns of patients, but several factors make it impossible in this initial discussion for end-of-life decisions to be made⁵³⁻⁵⁸. Patients and their family members often require additional communication in order to understand the extent of their medical prognosis. Repetition ensures that individual have a full comprehension. As in most medical settings, it is best to use simple discussions when dealing with delicate topics. The avoidance of technical wording can ensure that patients understand the wording of the discussion. If the wording is too complicated, patients and family members may become lost in the discussion. During times of high anxiety, comprehension is crucial. Anything that can further limit comprehension can become dangerous to helping the patient.

The staff of the three hundred and ten bed unit in Germany ensured that these conditions were met by not waiting to discuss hypothetical scenarios. Hypothetical scenarios can hamper

the nature of the discussion. While it is impossible to anticipate the outcome, an individual should maintain honesty with their patient. The physician can address these uncertainties by going over the facts of the current prognosis and results. In doing so, he can learn of patients' preferences to care, as well as their beliefs and values.

Besides becoming acquainted with the patient and their history, initial discussions would last longer in order to answer questions and clarify terms. As mentioned previously, key terms such as 'palliative medicine' often go unknown to patients. The team prides itself in ensuring that patients comprehend their discussions. When asked if patients ever leave consultations not knowing of their prognoses, the staff members had similar comments.

(1) Dass Patienten über ihre Krankheit nicht Bescheid wissen, passiert in Deutschland selten, denn es wird grundsätzlich sehr offen aufgeklärt.

English Translation: *The fact that patients do not know about their disease notification, rarely happens in Germany, because it is basically solved very open.*

(2) Das kommt vor, ist aber eher selten. Vielleicht 10-20% der Patienten.

English Translation: *This happens, but it is rare. You [may] see this in 10-20% of patients.*

Taking the time to discuss and clarify each word ensures that the patient leaves feeling comfortable. This is important in end-of-life care because it promotes the beginning of a healthy relationship between the caring physician and the patient. However, this does not mean that this is the final discussion. The team remarks that even though an extensive amount of time is placed on initial discussions, it is not the last. Individuals can still leave the consults confused after

hearing news of their prognosis. This is to be expected though and the sole reason why extensive discussions are necessary.

The prognosis of a patient can change in an instant. Although the uncertainty complicates making decisions for the patient, family members, and physicians, continued discussions can provide reassurance to the patient. A patient will become worried over the facts of their latest results just as much as hypothetical scenarios. By honestly acknowledging these uncertainties in a prognosis, a team can build trust.

The Future of Palliative Care in Germany

In recent years, delivering adequate care for individuals that face incurable terminal illnesses has come to attention. The public, politicians, and professionals have begun to make demands for changes. Palliative care is beginning to have the chance to flourish. Currently, individuals measure the extent of palliative care's outreach through the number of units, hospices, outpatient care services, specialist palliative care, etc. However, these estimates are still considerably low⁷⁶⁻⁸⁰.

In Germany, legislators have begun to establish specialist palliative care units in the local communities, commonly referred to as *specialisierte ambulante Palliativversorgung* (SAPV)⁷⁶⁻⁸⁰. As recent as 2007, health care reforms for the introduction of SAPV have taken notice⁷⁶⁻⁷⁸. The degree of support varies. Some areas range from specialist support to off-clinic consultations to full palliative care units. The end of 2009 marked the implementation of fifty new SAPV contracts between service providers nationwide in Germany.

This movement for the introduction of SAPVs, while sluggish, was a step in the right direction. The delay is due to extensive requirements, structural designs, and an efficient distribution of resources to both local and urban areas⁷⁶⁻⁷⁸. These issues with the implantation of

SAPV should not detract from its effect. SAPV has a promising future for extensive palliative care in local communities.

Despite recent interest in the field of palliative medicine and research with SAPV, they are still at an insufficient level⁷⁶⁻⁷⁸. In terms of research, more networking is necessary. Funding towards education is the main problem. The funding that these services have received is not enough. Services are still separated in Germany between rural and urban areas. Even with cooperation and sharing between these areas, the reach cannot be sustained. This break in communication hinders the advancement of palliative medicine across Germany. Without effective communication, public awareness will continue to drop. Ultimately, these issues and more revolve around the lack of funding that only recently began to flow towards the field of palliative medicine.

Individuals across Germany feel the effects of the low funding. With less funding, there exists a lack of education and training in palliative care for medical, nursing, and other health related professions. Palliative care is still not an obligatory track for German medical students⁷⁶⁻⁸². Despite the introduction of more communication based training, individuals leave medical school with a lack of knowledge at handling end-of-life conversations⁶¹⁻⁶². Senior individuals have begun to take notice though of these adverse effects.

(1) Die Palliativmedizin muss wachsen, denn jeder Patient mit einer fortgeschrittenen, unheilbaren Erkrankung hat Anspruch. Wir konzentrieren uns in Deutschland weiterhin fast nur auf die Krebspatienten. Wir müssen mehr den nicht-onkologischen Bereich ausbauen. Wir müssen weiterhin hierfür viel Aufklärungsarbeit bei Patienten und auch Ärzten leisten.

English Translation: *Palliative care needs to grow because each patient with an advanced, incurable disease [should be] entitled to advanced end-of-life care. We focus in Germany still almost exclusively on cancer patients. We need to remove the non-oncology more. We must continue to provide this much educational work among patients and doctors alike.*

(2) *Die Palliativmedizin muss noch viel mehr in den Fokus aller Kollegen rücken. Sie muss früher einsetzen, nämlich bereits mit der Diagnosestellung einer unheilbaren Erkrankung beginnen. Davon sind wir noch weit entfernt, aber ich bin zuversichtlich, dass das so kommen wird.*

English Translation: *The palliative care field still needs to become more of a focus with all of our colleagues [in the medical field]. We need to begin sooner with the diagnosis of an incurable disease. We are still far away, but I am confident that this will happen.*

As public awareness increases, so will the demand for outreach. It is hopeful with an increased surge in education and public awareness that charities will become well-versed with this topic. This private money is necessary to initiate the upkeep of palliative care programs across Germany. Further refinement of standards will continue to bring notice to palliative care and such programs as SAPV. Refinement needs to include more than the government funding. Academic and conceptual development in this field will be necessary in order to better determine how to effectively mandate education requirements and provide for the community.

Discussion of German Consultations

It is my belief that this is the first ethnographic study with a German hospital to present direct observations and responses from physicians and nurses regarding end-of-life care

communication within inpatient palliative care, oncology, and consultation wards. During data collection at the clinic, there were four key findings that were of particular interest for clinical research and training purposes.

The first finding was that the prognosis of each patient was openly discussed and clarified for patients, family members, and medical team members alike. These consultations on end-of-directives showed that longer consultations, which range from thirty to sixty minutes, led to significantly more receptive and accurate perceptions. Patients and family members consecutively left each consult with fewer questions. In addition to more positive perceptions, patients were more easily readily to communicate treatment options. Longer and consecutive consultations allowed the team to form strong relationships. These relationships allowed the medical team to quickly coordinate and establish the needs of the patients. This lends support to the need for longer consultations within consultations that promote building relationships with your patients.

It was further observed that the palliative care team, patients, and family members established conversations in more optimistic, yet realistic, terms. This is a noticeable difference compared to currently observed practices in America that abstain from delivering bad news. Delivering clarified and realistic prognoses provides patients the capability to come to terms with their diagnosis. This does not mean that the physicians state that nothing can be done. This is actually quite the contrary to what was observed. Providing realistic and clarified outlooks allowed patients to be more open about their daily conditions and beliefs. Physicians engaged patients with subtle voice tone changes to fit the information that was being given. This shift in tone could be linked with Step Two in SPIKES to assess the patient's moods before delivering bad news. On the other hand, the shift of the conversations to discussions on daily conditions and

beliefs (pain, outlook on life, etc.) might be made on an assessment basis. Individual patients assess the information and outlook, switching discussions accordingly. Once individuals understand their condition, they begin to make a balance between treatment and making their symptoms more manageable to enjoy their remaining time. A more in-depth analysis or questionnaire would be needed to assess if this switch in discussion topics can be measured and applied to other cases. This would allow clinicians to more readily observe when the conversations needs to change.

The third finding was the importance of humor between the three areas of the hospital that observations were recorded. Physicians and patients engaged in humorous banter on a regular basis (predominately observed in Station Five). Humor generally began with the patient responding to a question from the attending physician. Humor was generally utilized by acknowledging grim states of condition (i.e. being unable to eat, walking to the bathroom, etc). Physicians often took a second to respond to these humorous outbursts. The use of humor brings individuals back to the present. As expressed above, the physicians even admit that laughing about death or a condition can be healing to the patient and physician. It can relieve tension within the room. Oftentimes individuals lose track of their setting when grim situations are being discussed. One gets lost in the context of these words. However, by introducing comedic moments, individuals can slowly come to terms with their onset. Individuals can become more relaxed with the physicians that are attempting to care for them.

The fourth finding was the variance between Station Three, Station Five, and NCT Sprechstunde. Deliverance of information differed in the three areas based on the clinical setting of the rooms, family members and other patients within the room, as well as the physicians delivering the news. Station Three in the palliative care ward engaged in conversations with

more serious undertones. Despite the emotional setting, these conversations were on average briefer and more soothing. Individuals spoke quietly with one another. When patients were not active participants, this was predominately in Station Three, often due to patients being sicker or asleep. Instead, family members took a more active role in the care of the patient. Family members asked more questions with the physician. Discussions were more frequent instead of being longer. This allowed family members to discuss with the patient the information that they received from their physician when they were unresponsive. Station Three's conversations were mixed between the patients, family members, and physicians being involved. The divvying of conversation time during discussions allowed each individual the chance to voice their concerns and questions. This showed that the patients and family members had an active role in controlling their treatment options. NCT Sprechstunde and Station Five were conducted to allow for longer discussions. Longer discussions in these areas were more necessary because key points on treatment and option plans were necessary to discuss. Physicians needed to ensure that the patient left with full comprehension. This means that conversations were predominately dominated by the physician. The physician would allow the patient time to comprehend what was previously said. The physician would then ask the patients if they have further questions about what was previously said. If there were no questions that needed to be addressed, then further clarification was provided about the context of the test results or treatment plans. Despite variances among physicians between the three areas of the facility, it was impossible to conclude how much training each individual gained in conducting end-of-life care conversations. This is something that should have been collected among each individual present.

It should be noted that there are identifiable limitations and issues with this study. The observations during my week stay at the clinic reflect only a brief period of time. The time frame

is considerably short to provide an effective outlook on conversation standards at the hospital. These observational differences with American standards could signify the possibility that I was experiencing culture shock. A longer study would rule out this notion though. An extended study would ensure that the tactics described above with the German team were consistent with each member of the team. It would also ensure that I was exposed to new techniques and tactics in communication.

Another important limitation is that the study was conducted only at one institute within Germany. The study was conducted in a relatively well known and large medical center within Germany. The palliative care and emphasis on communication within this institute, while relatively newer than other institutes, is a program that is still maturing. The institute is still working out what is best for their patients and the institute. This means that even their current way of handling these conversations might not be the preferred route. Establishing myself at an institute that has a mature palliative care team and advanced communication program would establish context for a future study. From a mature program, I could compare the advanced program to new programs. This comparison among a wider selection of hospitals would provide important data on what the preferred practice techniques should be in hospitals. For that reason, it is hard to say how much the observations collected within this unit relate to other institutes and wards within Germany. Conversations can differ drastically based on the ward that the patient is seeing (as observed within Station Three, Station Five, and NCT Sprechstunde).

Despite the various limitations within this study, the information obtained from these wards signifies the need for more research. A more expansive study-design within palliative care wards across Germany would be the first step, followed by expanding past oncology and palliative care wards to other practices. Expanding to other practices would show the need for

continued education in communication skills. However, as of now, this study shows that the team members utilize continue communication, clarified discussions, and humor to promote strong relationships with their patients. This study also identifies how conversations vary based on settings and individuals under the institute, despite discussing end-of-life care.

CONCLUSION

The capability to provide proper end-of-life care requires the heightened ability to understand how patients and family members experience the process of dying. Individuals in the medical field must be able to empathize with their patients. This can only occur with effective communication skills. These discussions occur on part to forming relationships based on trust. Physicians that can conduct effective and thoughtful discussions about a patient's care, whether it is end-of-life care or not, will do so comfortably with little no confusion or conflicts.

Physicians need to understand the dilemma that comes from ineffective communication. Many physicians desire the skills that are required to address the needs of their patients and family members⁶⁰⁻⁶⁴. As mentioned by individuals at the facility, ongoing professional training is a necessity. There must be a commitment to learning new communication skills as well as new regiments for care. Every physician benefits by observing their experienced, superior physicians that can address these issues with patients. End-of-life care is a demanding field that can lead to personal discomfort or fears. Only through working on these skills can one's own skills and comfort levels increase. This requires repetition and practice that can only be obtained with ongoing training.

Ongoing training is not the only method that should be employed across healthcare settings. Physicians must be open to receiving feedback from a wide range of sources. These sources can be individuals such as mentors, patients, family members, as well as other fields of study that work directly with patients. The ability to accept criticism allows us to grow and expand our viewpoints. Medicine is just as much about healing as it is about learning and exposing yourself to new views.

Overall, the biggest concept that must be addressed is the stigma around death around the globe. As mentioned previously, the team at this clinic has demonstrated how Germany has begun to move away from this stigma on death and palliative medicine. Europe is beginning to take a more progressive approach as they begin their reforms to increase awareness on death and this field of medicine⁶⁴. Individuals need to reshape their views and acknowledge that death is a natural step in life. It is the last step in our progression through life in terms of aging as well as a disease⁴⁰. Acknowledging that death is a foreseeable outcome allows individuals to prepare themselves both physically and mentally.

Providing care for any patient can be challenging, especially when they are dying. However, the most gratifying experiences for a physician are when they can effectively provide for their patient's needs. Death should be peaceful and dignified, as it should reflect back on the life the individual had⁶⁰⁻⁶⁴. The act of being able to assist someone acquiring such a death is a gift to the patient just as much to those that helped bring that care forward. Death can be a beautiful concept again if we only take the time to see how other individuals are handling this difficult concept and time.

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REFERENCES

1. Hill Pt. Treating the dying patient: the challenge for medical education. *Arch Intern Med.* 1995; 155:1265-9.
2. Mermann AC, Gunn DB, Dickinson GE. Learning to care for the dying. *Acad Med.* 1991;66:32-5.
3. Callahan D. Pursuing a peaceful death. *Hastings Cent Rep.* 1993; 23:33-8.
4. Brennan F. Palliative care as an international human right. *Journal of Pain and Symptom Management.* 2007;33(5):494–499.
5. Miles SH, Koepp R, Weber EP. Advance end-of-life treatment planning; a research review. *Arch Intern Med.* 1996;156:1062-8.
6. Street RL, Gordon HS, Ward MM, *et al.* Patient participation in medical consultations: why some patients are more involved than others. *Med Care* 2005;43:960–9.
7. Reill BM, Magnussen CR, Ross J, Ash J, Papa L, Wagner M. Can we talk? Inpatient discussions about advanced directives in a community hospital. *Arch Intern Med.* 1994; 154:2299-308.
8. Butow PN, Maclean M, Dunn SM, *et al.* The dynamics of change: cancer patients' preferences for information, involvement and support. *Ann Oncol* 1997; 8:857–63.
9. Billings JA. What is palliative care? *J Palliat Med* 1998; 1:73-81.
10. Billings JA. *Recent Advances* Palliative care? *BMJ* 2000;321:555–8
11. Simon ST, Ramsenthaler C, Bausewein C, Krischke N, Geiss G. Core attitudes of professionals in palliative care: a qualitative study. *Int J Palliat Nurs.* 2009;15(8):405-11.
12. Evans N, Bausewein C, Menaca A, *et al.* A critical review of advance directives in Germany: attitudes, use and healthcare professionals' compliance. *Patient Educ Couns.*2012;87:277–288.
13. Schmitten J, Lex KM, Mellert C, Rothärmel S, Wegscheider K, Marckmann G. Implementing an advance care planning program in German nursing homes: results of an inter-regionally controlled intervention trial. *Dtsch Arztebl Int.* 2014;111(4):50–57.
14. Ernst, E. The role of complementary and alternative medicine. *BMJ* 2000;321:1133

15. "Palliative Care Is an Essential Part of Cancer Control." *WHO*. World Health Organization, n.d. Web. 13 Jan. 2015.
16. *Approaching Death: Improving Care at the End of Life*. Committee on Care at the End of Life. Division of Health Care Services, Institute of Medicine. In: Field MJ, Cassel CK, eds. Washington, DC: National Academy Press; 1997.
17. Council of Europe Parliamentary Assembly. Recommendation 1418: protection of the human rights and dignity of the terminally ill and the dying. Official Gazette of the Council of Europe, June 1999
18. Billings AJ, Block S. Palliative care in undergraduate medical education: status reports and future directions. *JAMA* 1997;278: 733-8
19. Goldsmith, B., Dietrich, J., Qingling, D., & Morrison, S. (2008). Variability in access to hospital palliative care in the United States. *Journal of Palliative Medicine*, 11(8), 1094-1102.
20. Connor, S. (2007). Development of hospice and palliative care in the United States. *Journal of Death & Dying*, 56(1), 89-99
21. Cerminara, K. (2011). Health care reform at the end of life: Giving with one hand but taking with the other. Retrieved from http://www.aslme.org/print_article.php?aid=460404&bt=ss
22. Brody, J. (2011, January 17). Keep your voice, even at the end of life. *The New York Times*. Retrieved from <http://www.nytimes.com/2011/01/18/health/18brody.html>
23. American Nurses Association. (1991). ANA position statement: Nursing and the patient self-determination acts. Washington, DC: Author Tang S.T., Hung Y.N., Liu T.W., Lin D.T., Chen Y.C., Wu S.C. Pediatric end of life care for Taiwanese children who died as a result of cancer from 2001 through 2006. *J. Clin. Oncol.*2011;29(7):890–894.
24. Arnold RM. Clinical practice guidelines for quality palliative care. Brooklyn, NY: National Consensus Project for Quality Palliative Care; 2004.
25. Field MJ, Cassel CK. *Approaching death: improving care at the end of life*. Washington, DC: National Academy Press; 1997.

26. Truog RD, Meyer EC, Burns JP. Toward interventions to improve end-of-life care in the pediatric intensive care unit. *Crit Care Med.* 2006;34(11 Suppl):S373–9.
27. Browning DM, Solomon MZ. The initiative for pediatric palliative care: an interdisciplinary educational approach for healthcare professionals. *J Pediatr Nurs.* 2005;20:326–34.
28. Hickman, S.E., Nelson, C.A., Perrin, N.A., Moss, A., Hammes, B.J., & Tolle, S. (2010). A comparison of methods to communicate treatment preferences in nursing facilities: Traditional practices versus the physician orders for life sustaining treatment program. *Journal of American Geriatric Society*, 58(7), 1241- 1248.
29. Hickman, S.E., Nelson, C.A., Moss, A., Hammes, B.J., Terwilliger, A., Jackson, A., & Tolle, S. (2009). Use of the physician orders for life sustaining treatment (POLST) paradigm program in the hospice setting. *Journal of Palliative Medicine*, 12(2), 133-140.
30. Hickman, S., Sabatino, C., Moss, A., & Nester, J. (2008). The POLST paradigm to improve end of life care: Potential state legal barriers to implementation. *Journal of Law, Medicine and Ethics*, 36(1), 119-124
31. Hogan, C., Lunney, J., Gabel, J., & Lynn, J. (2001). Medicare beneficiaries' costs in the last years of life. *Health Affairs*, 20(4), 188-195
32. Sabatowski R, Radbruch L, Nauck F, et al. Über die Entwicklung palliativmedizinischer Einrichtungen in Deutschland. *Zeitschrift für Palliativmedizin.* 2000;1:40–46
33. Sabatowski R, Radbruch L, Nauck F, et al. Entwicklung und Stand der stationären palliativmedizinischen Einrichtungen in Deutschland. *Schmerz.* 2001;15:312–319
34. Radbruch, L., Nauck, F., Fuchs, M., Neuwohner, K., Schulenberg, D., and Lindena, G. 2002. What is palliative care in Germany? Results from a representative survey. *J Pain Symptom Manage.* Jun., vol. 23(6):471-83
35. Tuffs, A. 1996. Germany drafts guidelines for care of the dying. *Lancet*, May 4, vol. 347(9010):1256
36. Brueckner T, Schumacher M, Schneider N: Palliative care for older people -exploring the views of doctors and nurses from different fields in Germany. *BMC Palliative Care* 2009, 8:7.

37. Determann MM, Rzehak P, Küchler T, et al. Qualitätssicherung in der Palliativmedizin. *Forum Deutsche Krebsgesellschaft*.2000;15(2):10–13
38. Schneider N, Mitchell GK, Murray SA. Palliative care in urgent need of recognition and development in general practice: the example of Germany. *BMC Fam Pract*. 2010;14:66. doi: 10.1186/1471-2296-11-66.
39. Schindler T: Palliative Care in Germany. *Bundesgesundheitsblatt* 2006,49:1077-1086.
40. Sahn, S.W. 2000. Palliative care versus euthanasia. The German position: the German General Medical Council's principles for medical care of the terminally ill. *J. Med. Philos. Apr.*, vol. 25(2):195-219
41. Gramling, D., and Gramling, R. (2012). Laughing at the Dark: Tactical Humor for Autonomous Decision Making in Serious Illnesses". *Journal of Palliative Medicine*. 15: 1170-1172.
42. Baile, W. et al. SPIKES – A six step protocol for delivering bad news: application to the patient with cancer. *The Oncologist* 2000; 5:302-311
43. Conlee MC, Tesser A. The effects of recipient desire to hear on news transmission. *Sociometry* 1973;36:588-599.
44. Gattellari M, Butow PN, Tattersall MH et al. Misunderstanding in cancer patients: why shoot the messenger. *Ann Oncol* 1999;10:39-46.
45. Miller SM. Monitoring versus blunting styles of coping with cancer influence the information patients want and need about their disease. Implications for cancer screening and management. *Cancer*1995;76:167-177.
46. Butow PN, Maclean M, Dunn SM et al. The dynamics of change: cancer patients' preferences for information, involvement and support. *Ann Oncol* 1997;8:857-863.
47. D Weissman DE. Consultation in Palliative Medicine. *Arch Int Med*. 1997; 157:733-737.
48. Lipp, Volker (2005): Patientenautonomie und Lebensschutz. Zur Diskussion um eine gesetzliche Regelung der „Sterbehilfe“, Universitätsverlag: Göttingen.
49. Jaspers, B., and Schindler, T. 2004. Stand der Palliativmedizin und Hospizarbeit in Deutschland

und im Vergleich zu ausgewählten Staaten. Enquete-Kommission des Bundestages. Ethik und Recht der modernen Medizin, Section 3, Deutschland.

50. Johnstone MJ, Kanitsaki O. Ethics and advance care planning in a culturally diverse society. *Journal of Transcultural Nursing*. 2009;20(4):405–416. Laine C, Davidoff F. Patient-centered medicine: a professional evolution. *JAMA*. 1996;275:152-156.
51. Curtis JR, Vincent JL. Ethics and end-of-life care for adults in the intensive care unit. *Lancet*. 2010;11:1347–1353.
52. Gerteis M, Edgman-Levitan S, Daley J, Delbanco TL. Medicine and health from the patient's perspective. In: Gerteis M, Edgman-Levitan S, Daley J, Delbanco TL, eds. *Through the Patient's Eyes*. San Francisco, Calif: Jossey-Bass Inc; 1993:1-15.
53. Epstein RM, Campbell TL, Cohen-Cole SA, McWhinney IR, Smilkstein G. Perspectives on patient-doctor communication. *J Fam Pract*. 1993;37:377-388.
54. Teno JM, Clarridge B, Casey V, et al. (2001) *Validation of Toolkit After-Death Bereaved Family Member Interview*. *J Pain Symptom Manage* 22:752–758.
55. Larson DG, Tobin DR. End-of-life conversations: Evolving practice and theory. *JAMA*. 2000;284:1573-8.
56. von Gunten CF, Ferris FD, Emanuel LL. The patient-physician relationship. Ensuring competency in end of-life care: communication and relational skills. *JAMA*. 2000;14:3051–3057.
57. Curtis JR. Communicating about end-of-life care with patients and families in the intensive care unit. *Crit Care Clin*. 2004;11:363–380.
58. Mack, J.W., Wolfe, J., Grier, H.E. et al. (2006). Communication about prognosis between parents and physicians of children with cancer: parent preferences and the impact of prognostic information. *Journal of Clinical Oncology*, 24(33), 5265–70.
59. Brown M. Participating in end of life decisions: The role of general practitioners. *Aust Fam Physician*. 2002;31:60–2.
60. Bandura A. *Self-efficacy: The Exercise of Control*. New York, NY: WH Freeman; 1997.

61. Merluzzi TV, Sanchez MAM. Assessment of self-efficacy and coping with cancer: development and validation of the cancer behavior inventory. *Health Psychol.* 1997;16:163-170.
62. Merluzzi TV, Nairn RC, Hegde K, Martinez Sanchez MA, Dunn L (2001) Self-efficacy for coping with cancer: revision of the Cancer Behavior Inventory (version 2.0). *Psychooncology* 10: 206–217
63. Parle M, Maguire P, Heaven C. The development of a training model to improve health professionals' skills, self-efficacy and outcome expectancies when communicating with cancer patients. *Soc Sci Med* 1997;44:231- 240
64. Beckham JC, Burker EJ, Lytle BL, Feldman ME, Costakis MJ. Self-efficacy and adjustment in cancer patients: a preliminary report. *Behav Med.* 1997;23:138-142.
65. Mezey MD, Leitman R, Mitty EL, Bottrell MM, Ramsey GC. Why hospital patients do and do not execute an advance directive. *Nursing Outlook.* 2000;48(4):165–171.
66. Danis M, Mutran E, Garrett JM, et al. A prospective study of the impact of patient preferences on life sustaining treatment and hospital cost. *Critical Care Medicine.*1996;24(11):1811–1817.
67. Danis M, Patrick DL, Southerland LI, et al. Patients' and families' preferences for medical intensive care. *JAMA*1988;260(6):797-802.
68. Goodman J, Fry WF Jr. Toward optimal health: the experts discuss therapeutic humor. Interview by Jodi R. Godfrey. *J Womens Health (Larchmt)* 2004;13:474–479.
69. Hased C. How humor keeps you well. *Aust Fam Physician*2001;30:25–28.
70. Buxman K. Humor in therapy for the mentally ill. *J Psychosoc Nurs Ment Health Serv* 1991;29:15–18.
71. Duffield C, Diers D, O'Brien-Pallas L, Aisbett C, Roche M, King M, Aisbett K: Nursing, the work environment and patient outcomes. *App Nurs Res* 2011, in press.
72. Arbeitsgemeinschaft Spezialisierte Ambulante Palliativversorgung: Verzeichnis der SAPV Einrichtungen.
73. World Health Organization Regional Office for Europe: *Palliative Care, the solid facts.*Copenhagen; 2004.

74. Deutscher Bundestag : Zwischenbericht der Enquete-Kommission Ethik und Recht der modernen Medizin. Verbesserung der Versorgung Schwerstkranker und Sterbender in Deutschland durch Palliativmedizin und Hospizarbeit.
75. Lindena G, Woskanjan S: Hospiz- und Palliativversorgung HOPE.
76. Murray SA, Kendall M, Boyd K, Sheikh A: Illness trajectories and palliative care. *Clinical Review. BMJ* 2005, 330:1007-11.
77. Laske A, Dietz L, Ilse B, Nauck F, Elsner F. Undergraduate medical education in palliative medicine in Germany. Report of 2009. *Z Palliativmed.* 2010;11:18–25.
78. Elsner F. Das neue DGP-Curriculum für Studierende. *Z Palliativmed.* 2009. p. 182.
79. Ostgathe C, Voltz R, Nauck F, Klaschik E. Undergraduate training in palliative medicine in Germany: what effect does a curriculum without compulsory palliative care have on medical students' knowledge, skills and attitudes? *Palliat Med.*2007;21:155–156.
80. J. Schildmann, J. Hoetzel, C. Mueller-Busch, J. Vollmann. End-of-life practices in palliative care: a cross sectional survey of physician members of the German Society for Palliative Medicine. *Palliative Medicine*, 2010; DOI: [10.1177/0269216310381663](https://doi.org/10.1177/0269216310381663)
81. Klaschik, E, Nauck, F, Radbruch, L, Sabatowski, R. Palliativmedizin—Definitionen und Grundzüge. *Internist.*2000;41:606–611.
82. Sabatowski, R, Radbruch, L, Nauck, F et al, Entwicklung und Stand der stationären palliativmedizinischen Einrichtungen in Deutschland. *Schmerz.* 2001;15:312–319.

