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## **Palliative care – the needs of patients with incurable illnesses and their relatives**

### Abstract

Background: Palliative care improves the quality of life of patients facing life-threatening diseases and offers support to their caregivers. It must be delivered depending on individual needs of all involved.

Methods: We have collected data on all the patients with incurable cancer who received help from any service of an Acute palliative care department (APCD) at Oncology institute Ljubljana OIL since its beginnings in 2007 up to 2018, retrospectively. Among all of them, we compared palliative care needs according to their age group based on group discussions and experiences of APCD team members.

Results: Among 2698 patients, there were 94 (3.5 %) young (age 15–40 years), 1086 (40.3 %) middle age (41–64 years), 791 (29.3 %) young old (65–74 years), 615 (22.8 %) middle old (75–84 years) and 112 (4.2 %) very old ( $\geq 85$  years) adults. Palliative care patients have many general needs (physical, psychosocial, spiritual), but in each age-group there can be some additional specific needs according to their diagnosis, concomitant diseases and psychological and social background.

Conclusions: Early identification and assessment of specific age-related palliative care needs are necessary as well as timely and efficient support of them.

### **1. Introduction**

There is a sentence no one wants to hear, »You have cancer«, and we would do anything to avoid it. But the reality is that in 2018 alone, there were more than 18 million new cases of cancer worldwide. With 9.6 million deaths in the same year, it is the second leading cause of death in the world.<sup>1</sup> For all those reasons, cancer represents a physical,

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<sup>1</sup> Freddie Bray, Jacques Ferlay, Isabelle Soerjomataram, Rebecca L. Siegel, Lindsey A.

emotional and financial burden to individuals, families, communities and health systems.

Palliative care is a medical discipline specialised in providing support and care to the seriously ill.<sup>2</sup> According to the WHO definition, it is an approach that improves the quality of life of patients and their families through prevention and relief of suffering by early identification, assessment and treatment of physical, psychosocial and spiritual problems.<sup>3</sup> The multidimensional care of patients' and their relatives' needs can be addressed by good teamwork of interdisciplinary palliative care teams. In oncology, early integrated palliative care (early palliative care) together with other specific therapies (chemotherapy, radiotherapy, surgery) proved to prolong life and positively influence the course of illness.<sup>4</sup>

Palliative care affirms life and accepts dying as a normal and natural process. It intends neither to hasten nor postpone death. It offers a support system to help patients live as actively as possible until death. The main purpose is to preserve the individuals' values and dignity. Access to palliative care is a legal obligation for every country and acknowledged by United Nations conventions as a human right.<sup>5</sup>

There are great disparities between countries in the capacity, resources and infrastructure devoted to the care of people with serious and incurable illnesses.

Annually in Slovenia, we have more than 15,000 new cancer diagnoses, and approximately 6,000 people die from cancer.<sup>6</sup> All aspects of human beings are influenced by the burdens of a cancer diagnosis,

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Torre, Ahmedin Jemal: Global cancer statistics 2018: GLOBOCAN estimates of incidence and mortality worldwide for 36 cancers in 185 countries. In: *CA – A Cancer Journal for Clinicians* 68 (2018), pp. 394–424.

<sup>2</sup> Lukas Radbruch, Liliana De Lima, Felicia Knaul, Roberto Wenk, Zipporah Ali, Sushma Bhatnagar, et al.: Redefining Palliative Care. A New Consensus-Based Definition. In: *Journal of Pain and Symptom Management* 60 (2020), pp. 754–765.

<sup>3</sup> World Health Organization: *National Cancer Control Programmes. Policies and managerial guidelines*. 2nd Edition. Geneva 2002.

<sup>4</sup> Jennifer S. Temel, Joseph A. Greer, Alona Muzikansky, Emily R Gallagher, Sonal Admane, Vicki A. Jackson, Constance M. Dahlin, Craig D. Blinderman, Juliet Jacobsen, William F. Pirl, J. Andrew Billings, Thomas J. Lynch: Early palliative care for patients with metastatic non-small-cell lung cancer. In: *The New England Journal of Medicine* 363 (2010), pp. 733–742.

<sup>5</sup> Frank Brennan: Palliative Care as an International Human Right. In: *Journal of Pain and Symptom Management* 33 (2007), pp. 494–499.

<sup>6</sup> Institute of Oncology Ljubljana: *Cancer in Slovenia 2017. Epidemiology and Cancer Registry*, Cancer Registry of Republic of Slovenia. Ljubljana 2020.

therefore patients as well as their caregivers have additional physical, psychological, social and spiritual needs. Coping with these new life-situations has to be addressed in all affected. This become even more important when the disease progresses to the incurable state, raising several complex issues around mortality. The comprehensive approach of palliative care intends to support patients in this period and provide alleviation of suffering.

In Slovenia, cancer patients are treated by specific oncology treatment in two major cancers centres and in a few smaller clinics around the country. At the same time, patients with incurable cancer receive palliative care from all health professionals at different levels of the medical system: palliative approach, general palliative and specialised palliative care.<sup>7</sup>

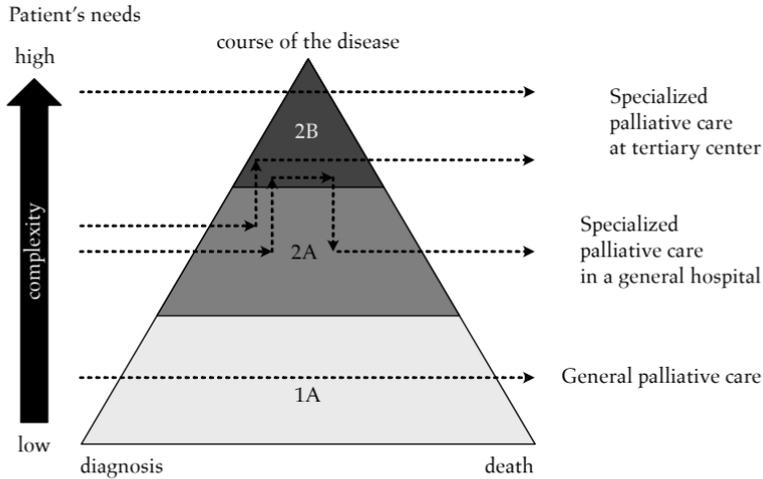


Figure 1: Transition of patients' palliative care needs over period of the progression of a disease

The needs of palliative care patients with cancer change during the course of the disease. They can be simple, where general palliative can handle most of the problems. But sometimes the needs can be extremely complex, where several specialised services and medical professionals need to be included. Most commonly, we see patients

<sup>7</sup> National Cancer Control Programme: The Slovene NCCP. <http://www.dpor.si/eng/#> (accessed 3.10.2020).

traveling through the medical system according to their needs at a certain point in time.

At the Oncology Institute of Ljubljana, we established a specialised unit for palliative care – Acute Palliative Care Department (APCD) – in 2007. At the beginning, it served only as in-hospital care for palliative care patients; today, the range of specialised activities of APCD is much broader and includes inpatient, outpatient and consultation services and an educational and research centre for palliative care.<sup>8</sup>

The team at APCD is made up of physicians and nurses working together with psychologists, physiotherapist, dietitians, social workers and theologians, all with specialised knowledge in palliative care. With an interdisciplinary approach, they support palliative care patients with complex needs. When those patients are discharged from hospital, general teams at the primary level of the health system take over. The general palliative care team consists of a family doctor and community nurse. Cooperation between specialised and general palliative teams is crucial to enable a comprehensive palliative approach.

## 2. Methods

In a retrospective study, we reviewed charts of patients referred by their attending physicians to the specialised palliative care service at APCD at the Oncology Institute of Ljubljana between 2007–2018. The range of services provided were different between distinct periods: between 2007–2012, only in-hospital care, from 2013 on, there were additional services included (outpatient, consultation services).

All data, such as patient demographics (age, gender), type of cancer, palliative care services and clinical course, were obtained from archived patient medical records at the Oncology Institute of Ljubljana and from the Cancer Registry of the Republic of Slovenia. According to their age, we divided them into several cohorts as young (age 15–40 years), middle age (41–64 years) and elderly ( $\geq 65$ ). The last group we further divided into young old (65–74 years), middle old (75–84 years) and very old ( $\geq 85$  years) adults.

Among team members of APCD, we conducted interactive directed discussions and exchange of experiences about age-related differ-

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<sup>8</sup> Onkološki inštitut Ljubljana. <https://www.onko-i.si/eng/> (accessed 3. 10. 2020).

ences in the palliative care needs (physical, psychological, social, spiritual).

The major goal of this analysis was to collect general and some specific palliative care needs of patients, as influenced by age. The results were planned to provide the basis and insight into topics that palliative care research needs to focus on in a future.

Categorical data are described using absolute numbers and percentages, continuous by mean, minimum and maximum. The qualitative data analysis was performed using SPSS software, version 22.0.

### 3. Results

In a twelve-year time period, there were 2698 patients with cancer included in any kind of APCD service (in-hospital, outpatient, consultation). Only 94 (3.5 %) patients were younger than 40 years, 1086 (40.3 %) patients belonged to the middle-aged group between 41–64 years and 1518 (56.2 %) belonged to the elderly group of 65 years or more.

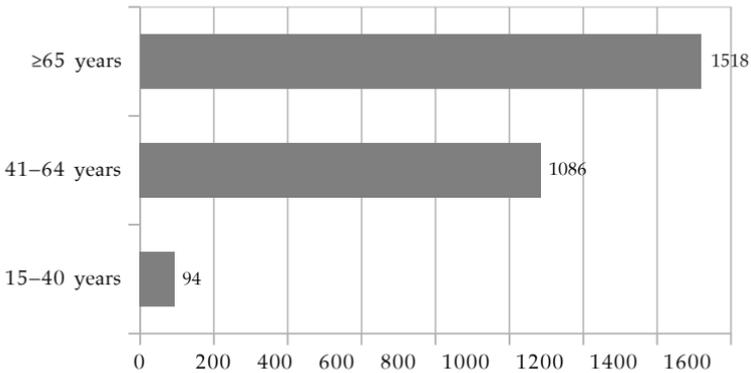


Figure 2: Number of palliative care patients at APCD according to age group between 2007–2018

In a group of elderly there were 791 (29.3 % of all) young old (65–74 years), 615 (22.8 % of all) middle old (75–84 years) and 112 (4.2 % of all) very old ( $\geq 85$  years) adults.

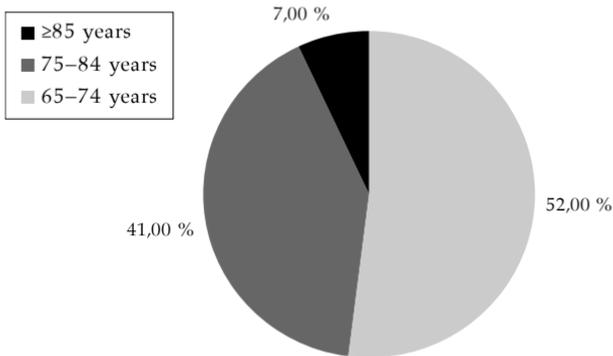


Figure 3: Age distribution only among of elderly APCD patients

The vast majority of all APCD patients were consulted or treated only one time. Regardless of age, the majority were cared for in a hospital department. Compared to others, young patients were more often consulted while being hospitalised in other departments of the Oncology Institute of Ljubljana. Very old patients were more often consulted in an outpatient setting.

With the help of a pre-planned questionnaire and later on in a group discussion of APCD team members, we agreed that all palliative care patients have needs in all four parts of the human being, i. e. physical, psychological, social and spiritual. General needs are common to the majority, but many patients also have some very specific needs. Among them are some age-related, and some depend on other characteristics such as basic diagnosis, concomitant diseases and psychological and social background.

The group of young adults (15–40 years old) generally included patients who were healthy before the diagnosis of incurable cancer. At time of diagnosis, they were usually in good physical condition, with stable nutritional status, that deteriorated only later on during disease progression. Shortly after diagnosis, we could observe psychological problems, some of which can be very individual. A very special characteristic of this group of patients is that they usually have very little experience about death and dying. The most important topics for them are how to cope with insecurity, self-esteem, disruption of body-image, peer-relations, fear and family reactions. Among very special needs are topics of young families, especially those with small children, with questions regarding how to support children and a

spouse. A major influence on the psychological wellbeing of such young families depends on support from the broader structure and caregivers such as grandparents and siblings. In regard to special social needs, there is the situation where young people lack financial independence. In regard to spiritual needs, young patients face the complete spectrum of questions about themselves and their loved ones as well as wishing to have control over their lives.

The middle-aged group (41–64 years old) usually included patients with rare co-morbidities, at the beginning in good physical condition, and only later on with the progression of the disease their nutritional status deteriorates. Among them, we observed diverse individual reactions: some with difficult coping with their diagnosis, denial, others with difficulties accepting the loss of body control, especially when the disease progressed quickly. They usually struggle with questions of how to support their own families, wishing »not to be the burden«, fearing for the future of their children, making plans for them. Some patients can be burdened in regard to their legacies. There are individual attitudes towards death and dying that can sometimes be modest and for that reason also troublesome.

Most people in the elderly group (65 and older) have at least some co-morbidities or at least frailty. Symptoms such as dizziness, imbalance, issues of mobility, deafness and poor vision are common. Already during the diagnosis of incurable cancer in the elderly, some nutrient needs may be reduced, but some requirements of essential nutrients may in fact increase, especially with cancer; later on, we can expect nutritional deterioration. Usually, they are more emotionally stable, focusing on the good things in life but still facing new challenges in life that can also produce more anxiety about their safety, depression, feelings of loneliness and isolation. Issues about death and dying are usually influenced by experiences about death and dying with close friends and family. Also, in this group it is very important to care for not isolating from others, to continue socialising, meeting with peers, give a patient opportunity to tell loved ones what they need without hurting them and strengthening contacts with people they don't know but who can help during this period. An important challenge is also how to arrange the need for basic personal care when there are no healthy family carers. It is very important to respect patient experiences, values, decisions and spiritual support needs (to follow the customs of a patients' religion and beliefs).

A discussion among APCD team members exposed the importance of the individuality of every single patient. We all agreed that every patient is a person with their own history and their own personal experiences, attitudes toward life and wishes, and that we need to consider them as much as possible in preparing a palliative care plan. We anticipate general and specific needs based on our knowledge and experience, but at the same time we need to stay open to some unique and new aspects that can emerge.

#### 4. Discussion

Palliative care needs to address four basic aspects of the human being: physical, psychological, social and spiritual. Every patient has unique palliative care needs, most of them general, but some can be specific, related to age or other patient characteristics. To provide holistic management of all palliative care needs, patients and their caregivers must be offered a range of different interventions such as symptom management, discussion about prognosis, ongoing specific treatments and diagnostic interventions, actively involving them in discharge planning, counselling about goals of care, patient and caregiver support (including spiritual needs) and discussion about patient values and wishes (advance directives: resuscitation status, completion of a living will).

When an individual palliative care plan is being structured, we have to acknowledge personal characteristics, experiences, values and wishes, but at the same time, we have to anticipate patient needs, both general and also some specific. Some anticipated needs can evolve due to specifics of a disease itself, like prevalence and intensity of symptoms (dyspnoea in COPD, lung cancer) and more frequent neuropsychiatric challenges (in elderly), or other characteristics of patients, like social needs (in elderly, young) and distinct spiritual, religious, cultural needs.

Age of a patient strongly influences care decisions and outcomes, in oncology in general as well as in palliative care.<sup>9</sup> Numerous studies

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<sup>9</sup> John D. Parr, Baohui Zhang, Matthew E. Nilsson, Alexi Wright, Tracy Balboni, Edmund Duthie, Elizabeth Paulk, Holly G. Prigerson: The Influence of Age on the Likelihood of Receiving End-of-Life Care Consistent with Patient Treatment Preferences. In: *Journal of Palliative Medicine* 13 (2010), pp. 719–726.

studied age as a covariate among the several palliative care decisions and actions, but many topics are still unanswered. Older patients seem to receive less aggressive care but have more discussions about care decisions. In contrast, younger cancer patients have more aggressive treatments and are less likely to be involved in care decision-making.<sup>10</sup> The study of Rose et al. showed that younger patients had longer stays, higher hospital costs and greater probability of rehospitalisation. Fewer older patients preferred CPR or life-prolonging treatments.<sup>11</sup>

#### 4.1 *Physical symptoms*

A number of studies have shown that there are age-related differences in reporting symptoms such as pain and others among patients with incurable cancer. Some studies noted that older patients were less likely to present with pain.<sup>12</sup> Morita et al.<sup>13</sup> reported that older patients were less likely to present with nausea and vomiting. But Smith et al.<sup>14</sup> and Nugent et al.<sup>15</sup> observed that older lung cancer patients reported more severe dyspnoea than younger patients. Simi-

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<sup>10</sup> Julia Hunnum Rose, Elizabeth E. O'Toole, Neal V. Dawson, Charles Thomas, Alfred F. Connors, Neil S. Wenger, Russell S. Phillips, Mary B. Hamel, Harvey J. Cohen, Joanne Lynn: Age differences in care practices and outcomes for hospitalized patients with cancer. In: *Journal of the American Geriatrics Society* 48 Suppl. 5 (2000), pp. 25–32.

<sup>11</sup> Julia Hunnum Rose, Elizabeth E. O'Toole, Neal V. Dawson, Renee Lawrence, Diana Gurley, Charles Thomas, Mary B. Hamel, Harvey J. Cohen: Perspectives, Preferences, Care Practices, and Outcomes Among Older and Middle-Aged Patients With Late-Stage Cancer. In: *Journal of Clinical Oncology* 22 (2004), pp. 4907–4917.

<sup>12</sup> Sebastiano Mercadante, Gabriella Dardanoni, Leonardo Salvaggio, Maria G. Armeta, Antonio Agnello: Monitoring of opioid therapy in advanced cancer pain patients. In: *Journal of Pain and Symptom Management* 13 (1997), pp. 204–212.

<sup>13</sup> Tatsuya Morita, Junichi Tsunoda, Satoshi Inoue, Satoshi Chihara, Toshihiro Ichiki: Symptom prevalence and risk factors in terminally ill cancer patients. In: *Japan Journal of Cancer Clinics* 44 (1998), pp. 879–884.

<sup>14</sup> Ellen L. Smith, Danette M. Hann, Tim A. Ahles, Charlotte T. Furstenberg, Tara A. Mitchell, Louise Meyer, L. Herbert Maurer, James Rigas, Susan Hammond: Dyspnea, anxiety, body consciousness, and quality of life in patients with lung cancer. In: *Journal of Pain and Symptom Management* 21 (2001), pp. 323–329.

<sup>15</sup> William C. Nugent, Mark T. Edney, Paul G. Hammerness, Bradley J. Dain, L. Herbert Maurer, James R. Rigas: Non-small cell lung cancer at the extremes of age: impact on diagnosis and treatment. In: *The Annals of Thoracic Surgery* 63 (1997), pp. 193–197.

lar results were collected in a study by Evers et al.<sup>16</sup> where patients older than 80 needed fewer interventions for pain, nausea, anxiety and other symptoms than younger patients, but more interventions for dyspnoea. But not all of the studies are uniform. As an example, the Hirakawa et al.<sup>17</sup> study, where researchers also compared younger and elderly patients, reported no difference between symptom experience and care receipt.

## 4.2 *Psychological symptoms*

The psychological implications of incurable cancer result in a range of challenges for both the patient and the caregivers. Patients and caregivers may experience feelings of fear, being a burden to others, loss of control, anger, loss of sense of dignity and uncertainty, or they present with symptoms such as an anxiety, distress and depressive episodes. Uncontrollable pain and intense unrelieved physical symptoms can sometimes even deepen the feelings of helplessness and hopelessness. Caregivers have an important and challenging role in this matter, providing emotional and social support for the patient, helping with medical needs and meeting increasingly complex instrumental needs such as running the household and work.<sup>18</sup>

There are some obvious differences in psychological needs between certain age groups.<sup>19</sup> Younger patients with incurable cancer have unique psychosocial needs that besides coping with this serious

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<sup>16</sup> Martin M. Evers, Diane E. Meier, R. Sean Morrison: Assessing Differences in Care Needs and Service Utilization in Geriatric Palliative Care Patients. In: *Journal of Pain and Symptom Management* 23 (2002), pp. 424–432.

<sup>17</sup> Yoshihisa Hirakawa, Yuichiro Masuda, Masafumi Kuzuya, Akihisa Iguchi, Kazumasa Uemura: Age-related differences in care receipt and symptom experience of elderly cancer patients dying at home: Lessons from the DEATH project. In: *Geriatrics and Gerontology International* 7 (2007), pp. 34–40.

<sup>18</sup> Louise Burzotta, Helen Noble: Providing psychological support for adults living with cancer. In: *End of Life Journal* 4 (2010), pp. 9–16; Amy S. Kelley, R. Sean Morrison: Palliative Care for the Seriously Ill. In: *The New England Journal of Medicine* 373 (2015), pp. 747–755; Betty R. Ferrell, Martha L. Twaddle, Amy Melnick, Diane E. Meier: National consensus project clinical practice guidelines for quality palliative care guidelines. In: *Journal of Palliative Medicine* 21 (2018), pp. 1684–1689.

<sup>19</sup> Sharyl J. Nass, Lynda K. Beupin, Wendy Demark-Wahnefried, Karen Fasciano, Patricia A. Ganz, Brandon Hayes-Lattin, Melissa M. Hudson, Brenda Nevidjon, Kevin C. Oeffinger, Ruth Rechis, Lisa C. Richardson, Nita L. Seibel, Ashley W. Smith: Identifying and addressing the needs of adolescents and young adults with cancer:

disease, encompass turning points in their physical and mental development such as changes in identity, body image, sexuality, professional and personal goals, obstacles in relationships with others and sometimes also with young parenthood.<sup>20</sup> Feelings such as uncertainty, vulnerability, loss of control, anger and isolation are common. Some patients and relatives may even hesitate to talk openly about the incurable state of disease and death, but experience tells us that in the young group of patients, there is need for discussion about those topics.<sup>21</sup> Addressing their fears, preferences and wishes usually relieves the stress and helps them in coping with the situation. Some evidence even suggests that in this group »(...) palliative care is not only needed, but it is critically beneficial to patients, families, and healthcare professionals alike.«<sup>22</sup>

In the older group, psychological needs are a bit different. We observe emotional symptoms, such as anxiety, loneliness, depression and anger, that someone might acknowledge as a normal reaction. But in the holistic approach of palliative care, psychological symptoms need to be addressed, because that improves the quality of life of patients and helps them in coping with a situation. In a Reynolds et al. study, patients over 55 years of age experienced depression and anxiety in 11.4 % and 6.8 % respectively.<sup>23</sup> Delirium is also extremely prevalent in hospitalised older patients, with an estimated 8–15 % of palliative care patients affected.<sup>24</sup>

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Summary of an Institute of Medicine workshop. In: *The Oncologist* 20 (2015), pp. 186–195.

<sup>20</sup> Abby R. Rosenberg, Joanne Wolfe: Palliative care for adolescents and young adults with cancer. In: *Cancer* 117 Suppl. 10 (2011), pp. 2323–2328.

<sup>21</sup> Rosenberg, Wolfe: Palliative care for adolescents (Note 0).

<sup>22</sup> Rosenberg, Wolfe: Palliative care for adolescents (Note 0).

<sup>23</sup> Kristin Reynolds, Robert H. Pietrzak, Renée El-Gabalawy, Corey S. Mackenzie, Jitender Sareen: Prevalence of psychiatric disorders in U.S. older adults: findings from a nationally representative survey. In: *World Psychiatry* 14 (2015), pp. 74–81.

<sup>24</sup> Julia Barnes, Suzanne Kite, Manoj Kumar: The recognition and documentation of delirium in hospital palliative care inpatients. In: *Palliative and Supportive Care* 8 (2010), pp. 133–136.

### 4.3 *Social issues*

Care for social issues is part of the everyday tasks of any interdisciplinary palliative care team, but specialised interventions often fall to specific professionals like social workers. The goal of social care interventions is to improve social support, which benefits patients in a variety of ways. Better social engagement in any age group is associated with better subjective wellbeing<sup>25</sup>, quality of life<sup>26</sup> and better physical function.<sup>27</sup> In a study by Holt Lunstad et al., older patients who experience subjective social isolation had higher mortality,<sup>28</sup> more depressive symptoms and increased psychosocial distress.<sup>29</sup>

A key feature of family care is support during bereavement adapted to the age-group of a patient. In a young patient, we usually need to support the parents, partners, siblings or sometimes also very young children.

### 4.4 *Spiritual support*

Spiritual and religious health is an important factor in overall health. There are many proven positive effects of spirituality on a patient's quality of life, no matter the patient's age.<sup>30</sup> For these reasons, it re-

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<sup>25</sup> Xingmin Wang: Subjective well-being associated with size of social network and social support of elderly. In: *Journal of Health Psychology* 21 (2016), pp. 1037–1042.

<sup>26</sup> Fatemeh Bahramnezhad, Raheleh Chalik, Farideh Bastani, Masoumeh Taherpour, Elham Navab: The social network among the elderly and its relationship with quality of life. In: *Electron Physician* 9 (2017), pp. 4306–4311; Paolo Scocco, Mario Nassuato: The role of social relationships among elderly community-dwelling and nursing-home residents: findings from a quality of life study. In: *Psychogeriatrics* 17 (2017), pp. 231–237.

<sup>27</sup> Andrew D. Beswick, Karen Rees, Paul Dieppe, Salma Ayis, Rachael Gooberman-Hill, Jeremy Horwood, Shah Ebrahim: Complex interventions to improve physical function and maintain independent living in elderly people: a systematic review and meta-analysis. In: *Lancet* 371 (2008), pp. 725–735.

<sup>28</sup> Julianne Holt-Lunstad, Timothy B. Smith, Mark Baker, Tyler Harris, David Stephenson: Loneliness and social isolation as risk factors for mortality: a meta-analytic review. In: *Perspectives on Psychological Science* 10 (2015), pp. 227–237.

<sup>29</sup> Harry O. Taylor, Robert J. Taylor, Ann W. Nguyen, Linda Chatters: Social isolation, depression, and psychological distress among older adults. In: *Journal of Aging and Health* 30 (2018), pp. 229–246.

<sup>30</sup> Marie-José Gijssberts, Anke I. Liefbroer, René Otten, Erik Olsman: Spiritual Care in

presents an intrinsic and essential component of palliative care.<sup>31</sup> Delivery of spiritual care is a key role of the interdisciplinary palliative care team.<sup>32</sup>

Spiritual care is an especially important component in the group of elderly patients,<sup>33</sup> where it predicts social support, physical functioning and fewer depressive symptoms, better cognitive function and improved cooperativeness.<sup>34</sup>

## 5. Conclusion

Today, we document disparities in many areas of healthcare, also in the field of palliative care. Palliative care consists of the active total care of patients with a serious and life-threatening illness and support to their caregivers. It involves an interdisciplinary approach to symptom management, preservation of function and quality of life. Every patient at any stage of serious, especially incurable, disease should receive palliative care, regardless of age, sex, race or other characteristics. No matter when and where we treat such patients, we need to approach them holistically and offer general support for all aspects of the human being (physical, psychological, social, spiritual). Still, we must be aware that some distinct groups of patients at a certain point in time or in a specific situation may require different approaches. Each patient has their own personality, with their own values, beliefs and wishes, and we need to respect that. Only in this way palliative

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Palliative Care: A Systematic Review of the Recent European Literature. In: *Medical Sciences* 7 (2019), <https://doi.org/10.3390/medsci7020025>.

<sup>31</sup> Tracy A. Balboni, Mary E. Paulk, Michael J. Balboni, Andrea C. Phelps, Elizabeth T. Loggers, Alexi A. Wright, Susan D. Block, Eldrin F. Lewis, John R. Peteet, Holly G. Prigerson: Provision of spiritual care to patients with advanced cancer: Associations with medical care and Quality of Life near death. In: *Journal of Clinical Oncology* 28 (2010), pp. 445–452; Rosa Lee Kamper, Lois Van Cleve, Marilyn Savedra: Children with advanced cancer: Responses to a spiritual Quality of Life interview. In: *Journal for Specialists in Pediatric Nursing* 15 (2010), pp. 301–306.

<sup>32</sup> Ferrell, Twaddle, Melnick, Meier: National consensus project (Note 8).

<sup>33</sup> Christina M. Puchalski: Spirituality in geriatric palliative care. In: *Clinics in Geriatric Medicine* 31 (2015), pp. 245–252.

<sup>34</sup> Harold G. Koenig, Linda K. George, Patricia Titus: Religion, spirituality, and health in medically ill hospitalized older patients. In: *Journal of the American Geriatrics Society* 52 (2004), pp. 554–562.

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care can provide the best quality of life and the dignity of dying for all patients, independent of their characteristics, and sufficient attention to caregiver needs during all phases of a disease, even in the phase of grieving.

