ABSTRACT
Objective: to identify the communication strategies that promote the humanization of health care provided to adult/older adult patients hospitalized at the end of life. Method: systematic review carried out with primary studies from EBSCO, PubMed, CINAHL, MEDLINE, LILACS, Web of Knowledge, and B-On databases, and SciELO and Cochrane digital libraries, between November 2012 and January 2013, selected according to the PIOUS method, from the following question: What are the communication strategies that promote the humanization of health care in the interaction between nurses and adult/older adult patients at the end of life? Results: the articles selected demonstrated the urgent need to acquire specific skills in the field of communication, in order to promote a dignified end of life. Conclusion: regardless of experience, or even the ability to deal with the proximity of death, it is extremely important to develop strategies that are not exclusively based on verbal expression, but also on nonverbal signals, in order to promote a positive health care experience.

Descriptors: Communication; Nonverbal Communication; Humanization of Health Care; Terminal Patient.

RESUMO
Objetivo: identificar as estratégias comunicacionais promotoras da humanização do cuidado ao paciente adulto/idoso hospitalizado em fim de vida. Método: revisão sistemática resultante da pesquisa de estudos primários nas bases de dados EBSCO, PubMed, CINAHL, MEDLINE, LILACS, Web of Knowledge, B-On e nas bibliotecas virtuais SciELO e Cochrane, entre novembro de 2012 e janeiro de 2013, selecionados de acordo com o método PIOUS, a partir da seguinte questão: Quais são as estratégias comunicacionais promotoras da humanização dos cuidados na interação enfermeiro-pessoa adulta/idoso em fim de vida? Resultados: os artigos selecionados evidenciam a necessidade premente de adquirir competências específicas na área da comunicação, para que se possa promover um fim de vida digno. Conclusão: independentemente da experiência, ou até mesmo da preparação para lidar com a proximidade da morte, revela-se extremamente importante desenvolver estratégias que não passem exclusivamente pela expressão verbal, mas também pelos sinais não verbais, de forma a promover uma experiência de cuidado positiva.

Descritores: Comunicação; Comunicação Não Verbal; Humanização da Assistência; Paciente Terminal.

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Communication as an expression of humanized...

INTRODUCTION

The end-of-life process is usually associated with feelings of loss, pain, and suffering. In addition to the experience of pain, which is regulated by a set of organic factors, it is known that diseases cause other problems that bring a particular type of suffering to the patients and their families, not just representing something physical, but also implying cognitive, emotional, and even cultural aspects.

In face of this problem, the humanization of health care is a current and growing requirement that emerges from our realities in hospital contexts, in which the requirement for handling high-tech equipment causes some obstacles to the practice of humanized care, therefore affecting the relationship between health professionals, patients, and their families.¹

Health care based on the incessant search for human dignity is essential in the face of a reality that is individual, complex, and unique, representative of suffering. For the sake of health care humanization, communication is an important tool for the sustainability of nursing interventions, since it encompasses all forms of exchange of ideas, feelings, and emotions. In this context, the main challenge will be the personal involvement of nurses with the patients by combining science and humanism. In this way, the patients will be understood as a whole, the bearer of a terminal disease who lacks active and rigorous care.

Even though symptomatic control is strictly recognized in the health care provided to patients at the end of life, our attention must also focus on communication, the strengthening of interpersonal relationships, and the collaboration with the patients in the search of a meaning of life. The integration of the physical, psychological, and spiritual aspects of treatment should be sought so that the patients can adapt themselves to their condition in a complete and constructive way.²³

Communication is always present in the individuals we care for, either by their own glance, face expression, gestures, words, and even the way in which they occupy their environment. In the case of terminal patients, communication codes are different, because we are both in the presence of patients who wait for a sign in our attitude, our form of expression, and who are so weakened that speak little or nothing. In such circumstances, we just count on nonverbal communication, through which we can identify a set of valuable information that confirm the congruence between acting and feeling in the relationship between patients and health professionals and demonstrate interest, empathy, and appreciation of the patients.⁴

Although perceiving and listening to the others is considered important and necessary, we should also learn what happens inside ourselves, being able to identify the emotions and/or reactions that words cause in ourselves. In this context, Phaneuf affirms that "[...] communicating is to be in a relationship with the other, maintaining the relationship with oneself."⁵²² This implies that regardless of the way we communicate, we should consider some elements essential for an efficient communication, such as patience, transparency, security, and even a suitable didactic competence.⁶

Three levels of communication that nurses may develop along the patients on a daily basis are: a) "daily interactions", including conversations that discuss key issues of treatment and the satisfaction of personal care; b) "assessment of treatments", in order to control pain and suffering; and c) the level described as "existential", which occurs in the deepest sense of the patients.⁷ This sensitive and subtle level of communication includes the existential issues of the end of life.

In fact, in order to care for each person, it is essential to build a relational process that takes into consideration their experiences, in which sincerity, spontaneity, availability, respect, and unconditional acceptance are the cornerstones for establishing a relationship of trust and the relief of suffering.⁸

Given the above, it is noted that man's end of life has an inestimable value that is no less than any other value in another stage of human life, a reason why a greater humanization of care is crucial. This humanization requires a reflective process regarding the assumptions that guide the professional nursing practice, with respect for the requirements, ethical values, and moral principles, and the relief of pain and suffering, through available technological and psychological resources.

METHOD

In the development of this systematic review, we considered communication, humanization, and patients hospitalized at the end of life as the main issues, in an association from which the following research question emerged: "What are the communication strategies that promote the humanization of health care in the interaction...
between nurses and adult/older adult patients at the end of life?”. This question is particularly related to the need to seek some scientific evidence substantiating all our actions when we are, on a daily basis, confronted with issues and decision making related to effective practices at the end of life.

In this way, the purpose is to answer other questions with regard to end-of-life communication: Is the way we communicate an expression of a more humanized care? What is the meaning attributed by the patient to verbal and nonverbal communication? How does communication reduce the pain and the anguish of the patients at the end of life? Do nurses appreciate the interpersonal communication in the context of health care provided to patients at the end of life?

From these questions and seeking knowledge that justify and organize our actions, we will proceed to present the method used and the results found. In order to acquire the current knowledge about communication strategies, necessary for a more humanized care provided to patients at the end of life, we sought to integrate data and information covered in a set of studies conducted recently.

The main goal was to identify the communication strategies for promoting the humanization of care provided to adults/older adults at the end of life in hospital contexts. The survey was carried out from November 2012 to January 2013 by two reviewers—the authors—using English and Portuguese languages. Initially the date was restricted to 2009; however, due to some difficulties in finding articles that comply with the criteria laid down, the search was extended to 2006.

For the search of the relevant empirical studies, based on the question stated, the following specific keywords were used: communication; nonverbal communication; health care humanization; terminal patient.

The databases used were: EBSCO; PubMed; CINAHL; MEDLINE; LILACS; Web of Knowledge; and B-On, ant the digital libraries were SciELO and Cochrane, after having related the question previously defined in terms of population, interventions, outcomes, and study design. As a complementary source, a manual search of journals was carried out in the Library of the Portuguese Catholic University.

In order to carry out the research and acquire the most appropriate articles/studies to answer the research question and in accordance with the goals of our review, a set of inclusion and exclusion criteria were established, presented in Figure 2.

Figure 1. Protocol of assessment

| Participants | Nurses and other health professionals. Patients hospitalized at the end of life. |
| Interventions | Verbal and nonverbal communication strategies. |
| Comparisons | Does not apply. |
| Outcomes | Communication strategies for promoting the humanization of health care. Needs for professionals' training. |
| Study design | Quantitative and Qualitative. |

Criteria for participants selection

- Adult/older adult patients hospitalized at the end of life.
- Nurses responsible for providing health care.
- Health professionals carrying out activities in hospital institutions.

Intervention

- Importance of communication as expression of a more humanized end-of-life care provided to patients.
- Nurses' communication skills for providing end-of-life care to patients.

Design

- Empiric studies with qualitative or quantitative approach.

Inclusion criteria

- Patients hospitalized in intensive care units and urgent/emergency services, since these are acute care settings with very particular characteristics.
- Studies conducted in Nursing Homes, since there are not such structures in Portugal.
- Pediatric patients.
- Exclusively physicians' perceptions.

Exclusion criteria

- Systematic review of literature, theses and dissertations.

Figure 2. Inclusion and exclusion criteria for empiric studies.
Regarding communication as an intrinsic need to our existence and relationships, it is important to understand it in the light of the interaction between patients and nurses/caregivers. For this reason, we excluded studies in which there was no evidence of interpellation between the caregivers. However, since teamwork is one of the foundations of palliative care, it made sense to consider studies where, in addition to the nurses, there was collaboration on the part of other health professionals (physicians, nutritionists, physiotherapists).

Still, it was considered relevant to exclude the contexts of intensive care and urgency, since they are highly technological services with therapies often aggressive in those situations, which give raise to some ethical questions. In addition, the ability of these patients to communicate may be jeopardized by the need for ventilatory support or even sedation, which would require a different approach.

A significant number of studies were excluded, since, above all, they had been conducted in Nursing Homes, moving away from the Portuguese reality, as well as those very frequently conducted in intensive care units. In addition, a considerable number of studies devoted to pediatrics were excluded, because adult or older adult patients were less mentioned. Studies whose main participants were physicians were also excluded, because these studies are often associated only with the communication of bad news, rather than the communication/relationship with the patient at the end of life.

In the selection of articles, we sought to assess: whether the inclusion and exclusion criteria were appropriate; the quality of the studies included; whether the results had been systematically combined; and whether the conclusions were substantiated by data.

Therefore, the studies considered were those that complied with the inclusion criteria. Of a total of 182 articles, 19 were considered relevant to our study. After reading the abstract and complying with the relevant criteria, 11 articles were excluded. With the integral reading, eight articles were accepted (primary sources), which are presented in Figure 3.

The selection of articles was carried out in accordance with the assessment matrix proposed by a recent publication, which ranks the quality of evidence into seven levels: I - the evidence is derived from systematic review or meta-analysis of controlled randomized clinical trials or from clinical guidelines based on systematic reviews of controlled randomized clinical trials; II - evidence derived from at least one well delineated controlled randomized clinical trial; III - evidence obtained from well delineated non-randomized clinical trials; IV - evidence from cohort studies and well delineated case-control studies; V - evidence from systematic review of descriptive and qualitative studies; VI - evidence from a single descriptive or qualitative study; and VII - evidence from authorities' opinion and/or reports of committees of experts. Regarding the methodological design, three studies were descriptive non-experimental quantitative, four were qualitative, and one had a mixture of methods, with evidence level 6, not reaching the highest level of qualification.
Table 1. General characteristics of the studies composing the literature sample.

<table>
<thead>
<tr>
<th>Primary studies</th>
<th>Participants</th>
<th>Objectives</th>
<th>Intervention and method of analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liu Jun-E, Mok Esther, Wong Thomas. (2006) China</td>
<td>Convenience sample: 20 oncology patients selected from two hospitals of Beijing that met some inclusion criteria: being aware of cancer diagnosis; having been hospitalized for at least two weeks; and who had no difficulty in verbal communication.</td>
<td>To understand patients’ perceptions and experiences related to communication as an attitude composing nursing care.</td>
<td>Qualitative study (content analysis). Semi-structured interviews.</td>
</tr>
<tr>
<td>Araújo M, Silva M. (2007) Brazil</td>
<td>39 oncology patients with no cure prognosis, submitted to palliative chemotherapy, hospitalized at a private hospital institution.</td>
<td>To know patients’ expectations regarding the communication with the nursing team.</td>
<td>Qualitative study (exploratory and descriptive). Semi-structured interviews.</td>
</tr>
<tr>
<td>Afonso H, Lourenco S. (2011) Portugal</td>
<td>11 nurses (seven females and four males) having provided care to patients at the end of life for more than a year.</td>
<td>To assess the strategies used to humanize health care provided to terminal patients.</td>
<td>Qualitative study (exploratory). Semi-structured interviews.</td>
</tr>
<tr>
<td>Boyd Denise et al. (2011) United States</td>
<td>31 oncology nurses.</td>
<td>To characterize nurses’ attitudes in the final three months of patients’ lives.</td>
<td>Quantitative study (descriptive and correlational). Application of a questionnaire with close and open questions.</td>
</tr>
<tr>
<td>Kozlowska L, Doboszynska A. (2012) Poland</td>
<td>95 nurses working at five hospices in Poland aged between 21 and 65 years old, and 21% had specific training in palliative care.</td>
<td>To assess the communication strategies most used by nurses in the interaction with the patients at the end of life.</td>
<td>Quantitative study (descriptive statistic). Application of questionnaires.</td>
</tr>
<tr>
<td>Reynke LF, et al. (2012) United States</td>
<td>717 nurses from four U.S. states (working in hospitals or that had already worked for more than 19 years).</td>
<td>To know nurses’ perspectives regarding important nursing knowledge, though underused for end-of-life care.</td>
<td>Qualitative and quantitative study. Assessment of interviews and questionnaires.</td>
</tr>
</tbody>
</table>

Figure 3. General characteristics of the studies composing the literature sample.

ANALYSIS OF THE RESULTS

Through the literature review, we assessed and reflected on the articles selected on the basis of the research question and the goals of the study. Eight articles were assessed, of which four were qualitative, three quantitative, and one integrated both types of approaches (Figure 4).
Communication emerges as one of the central objectives of end-of-life care, in order to achieve a quality and humanized service. However, a need clearly evidenced by scientific studies—although still poorly carried out in palliative care units—is training/education of communicational attitudes. It is extremely important to sensitize professionals who deal with these patients to the need to establish authentic and sincere relationships, full of meaning and human warmth. It is an easy task and involves availability and attention, and ability to correctly interpret the message, in order to achieve the intended impact. Proper training of these skills produces effective and lasting changes in the professional performance, increasing the satisfaction of patients and their adherence to treatments.

Some barriers pointed out with respect to the ineffectiveness of communication are justified by the environment and organizational issues. These obstacles refer to lack of time and privacy, some reluctance to start the topic due to medical hierarchy, or little knowledge about issues related to the end of life and the lack of skills for communicating these topics.

To overcome these difficulties, building an empathic relationship, with emphasis on communication, emerges as the main strategy to humanize nursing care. This relationship should be characterized by an interactive and...
customized process, which includes affinity, understanding, and acceptance between nurses and patients.

Studies show that nurses, by being empathetic, allow the patients to express their stress and satisfy their psychological needs, in addition to recognizing the impact that the compassionate attitude of nurses has on most depressed patients. These studies also affirm that the concern with communication extends to the information given and to careful listening, that gives us the conviction that the message is received.

Therefore, active listening is considered one of the main work instruments for palliative care, because through it we can identify the needs in the different dimensions of those who experience this process. Active listening includes: the use of silence; conscious facial signals, that show interest in what is being said; and assuming an attitude of solidarity and responsibility, taking into account the physical approach and the position of the body (trunk turned toward the patient). In addition, the use of short verbal expressions should be taken into account, such as 'I'm listening', 'go on', 'and so', as well as performing important caring actions: active greeting; friendly attitude; affection; understanding; talking face-to-face and with a soft voice; and smiling, in order to give them the strength to fight.

Cheerful verbal communication that focuses on optimism and good mood is chosen as an important strategy to relieve the tension in a context of pain and suffering. Other aspects still valued are: providing information to the patients at the end of life, so that they can understand their disease process; talking with honesty and directly; showing availability and sensitivity when these patients address the issue of death, exploring with them the things they want to do before dying and collaborating in the achievement of their goals.

Since one of the purposes of communication is to reduce uncertainty and improve the relationships, it is also relevant to appreciate the nonverbal aspects of communication, namely: serenity or anxiety; facial expression; eye contact; smiles; and touching, through which the sense of isolation can be reduced.

Silence is another fruitful moment of the relationship, and never a synonym of emptiness. In most cases, difficult moments have to be faced; however, for patients at the end of life, communication performed through the presence and silence acquires a special significance, since it may be interpreted as a sign of a true company full of deep respect.

Most nurses emphasizes that holding hands is a way to express emotions and smiling is a form of tension relief in difficult moments, this way facilitating dialogue and making patients more satisfied. In fact, patients were very sensitive to nonverbal communication, recognizing that it significantly influenced their mood. On the other hand, nurses, by being empathetic, allowed them to express their stress and satisfy their psychological needs.

Several studies emphasize distinctly nurses' profiles to provide quality care, making them responsible for applying knowledge and skills of nonverbal communication, which enable them to decode the essential information and thereby lessen the anxiety of the patients at the end of life. Sometimes, these patients request things or actions hard to be understood, hence the desire to establish an interpersonal interaction through gestures, attitudes, facial expression, bodily movements, among other particularities that meet their needs.

In addition, they consider important to make the patients feel that in the proximity of death they will not be alone. However, to that end, there must be an effective communication between the multidisciplinary team for the patients' quality of life. Undoubtedly, the use of communicative strategies constitutes the center of emotional support in the end-of-life care, such as presented in Figure 5.
Skills such as listening, questioning, exploring feelings, and feedback are essential and necessary tools to provide emotional comfort and positively influence the patient’s psychological adjustment to their new situation, losses, and uncertainty, which are characteristic aspects in an end-of-life context.

Corroborating with the various studies, communication emerges as a basic tool in the construction of strategies that promote the humanization of care and that assumes respect for silence, the use of plain language, a smile that expresses confidence, a reassuring glance, warm touch that provides support and comfort, and a word of encouragement, able to raise the self-esteem of the patients.

**CONCLUSION**

By assessing these articles, we found that all of them highlighted communication as a pressing need at the end of life. We believe that the dimension of terminal patients’ suffering demonstrates the need to develop a scientific and humanized care, able to allow the institutions and health professionals to give an efficient response to these patients, because among the most important tools in palliative care are words and listening. Moreover, given that the establishment of a positive relationship with patients only becomes possible through effective communication, it is essential to take into account some criteria that can jeopardize the communication, and also consider the need for specific training.

Nurses stay longer with the patients and have greater proximity and availability regarding the needs expressed by these patients at the end of life. Therefore, investing in the field of communication, rather than a challenge, is a current requirement of our care process. Communication between patients at the end of life and their care providers is a priority. Caring for patients with advanced diseases is an integral part of nursing practice and requires a certain level of interpersonal involvement. Thereby, nurses are continually challenged to reflect not only on their experiences with patients, but also on their own actions, behaviors, values, and beliefs. This reflective process, supported by scientific evidence, will help us develop abilities to communicate with these patients and look at them as humans, allowing them to feel valued, at the same time that we provide a more humanized care to them.

**REFERENCES**


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