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ESSAYS/PERSONAL REFLECTIONS

Personal reflections on compassionate practice toward relatives

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Showing compassion to patients and their relatives is a fundamental component of the palliative and end-of-life care provided by multidisciplinary teams. Patients can clearly describe when compassion was present in or absent from their care (Bramley & Matiti, 2014), and patients and their families say that how they are listened to and cared for matters just as much as the quality of the healthcare they receive (Bray et al., 2014; Lown et al., 2011; Schout et al., 2009). "Compassion" has been defined as "a virtuous response that seeks to address the suffering and needs of a person through relational understanding and action" (Sinclair et al., 2016, p. 193). The focus on taking action is what differentiates compassion from empathy, sympathy, and other virtues (Papadopoulos & Ali, 2016; Sinclair et al., 2016). As practitioners of palliative care, we understand that compassion is not just about caring; it is also about acting to relieve the suffering of others. In this essay, we reflect on the skills needed to show more compassion to relatives. We draw on our personal experiences and offer insights into our clinical practice. We describe our experience of caring compassionately and with intention for family members who seek meaning at the time of their relative's death. We have a responsibility to listen and understand that families' personal beliefs and practices shape and form their search for meaning at such times (Saunders, 1988).

Palliative care revolves around nonjudgmental, compassionate care. Recently, I (SL) delivered end-of-life care that focused on a grieving family's comfort and concern. I first met Mary, an elderly African-American woman, and her family as the weekend hospice triage nurse. Shortly after I arrived, I stood with her family as Mary took her last breath. Tears, as an expected reaction to passing, expressed the family's intense grief. Initially, it seemed they didn't even notice my presence. After some time, I encouraged them to share some cherished memories about Mary. They were quiet at first, but I said that I was interested, and then they smiled and began to tell stories, laughing through their tears. This seemed to give them comfort, and they seemed more accepting of Mary's death. Then they handed me about a dozen cell phones and asked if I would take pictures of each of them with Mary. In turn, each family member posed on the bed with Mary, placing their arms around her while smiling and/or waving at the camera. Some of the children were also included in the photos. For me, this was an unusual request, and I was initially unsure as to how to respond, but I realized it was not my place to judge family traditions or customs. No one explained the desire to take photos, but it seemed natural to the family. Compassionate care required me to respond to their needs at the time and do whatever they needed to assist with their grieving process, so I accepted the role as photographer. I felt honored that they asked me to be the photographer, as they could have taken the snapshots themselves and dismissed me as an outsider. Including me affirmed that my actions had contributed to a valued relationship—I was no longer merely a professional but someone who shared their grief. After seeing how important the photos were to the family as they recorded the last time they would see their loved one, it was obvious this was an integral part of their grieving. By taking photos for each family member, I supported how they needed to say goodbye to their

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relative. After the photo session, and once I had completed my routine tasks, I asked them if there was anything more I could do. They had called their clergyperson and asked me to stay for a service. It touched my heart to be included in such a personal moment. Nothing else mattered at that time. That they included me caused me to pause and reflect on how I had contributed at this special time as they said their goodbyes. As a hospice nurse, it reinforced my role to set aside personal beliefs and respond to families with an open mind and heart, a sign of compassion. This was a compelling personal growth experience that enhanced my understanding of the meaning of compassion and quality care for patients and their relatives.

On occasion, we are challenged or surprised by the behavior of patients or relatives and need to be prepared to respond intentionally with compassion, insight, and courage. Annie had been admitted to the hospice several times recently for management of worsening chronic obstructive pulmonary disease. On the day I (AH) relate here, she lay back in the comfort of many pillows, eyes closed, breathless, exhausted, and holding her rosary beads. Over the months, I had met many of her relatives and heard how she and her husband had emigrated from Italy several decades ago. Cooking wonderful food was an example of her maintaining traditions and expressing love for her family. Not surprisingly, her daughters continued this tradition and believed that she would keep up her strength if she kept eating. However, even the smell of food now nauseated Annie. Her daughters interpreted her rejection of food as a rejection of them and so were upset when untouched meals were returned to the kitchen. It was important to encourage them to express how the rejection of their food contributed to their distress about their mother's impending death. Later that night, Annie died without warning. She was still resting against the pillows, eyes closed, and holding her rosary. Family members were shocked, upset, and unwilling to believe that she had passed. One of the daughters, sitting next to her, tried to get a spoonful of food into her mouth. The crying and wailing from other family members filled the room. The other nurses were horrified and demanded I stop the feeding, but I deliberately chose to do nothing. The significance of the food to them and disbelief that their mother had died was all that mattered at that moment. I validated their right to express their grief by not intervening. As I expected, other members of the family soon acted to stop the daughter and supported her in acknowledging that her mother had died. Later, the other daughters thanked me for not intervening. For them, it was important that I hadn't stopped what was happening or judged their sister's peculiar behavior, and my compassionate response had diffused the tension in the room. One of the daughters explained, "Nothing prepares you for the moment when your parent dies; it is unchartered territory." Intentionally not intervening created the space for the daughters to focus on their grief and do what needed to be done at that time. They had needed palliative care practitioners present, reaching out in compassionate ways to alleviate their suffering and acting with the courage and insight to witness the expression of their grief. As Currow (2016, p. 72) confirmed, "Compassion is the courage to be there."

Caring for patients and their families at the end of life can be surprising and challenging for multidisciplinary teams. As we are reminded by Saunders (1988, p. 1), "We have to be aware of the whole group and the understanding and support they need if they are to find and use their own resources and strengths." In this paper, we have reflected on how we intentionally practiced compassion to facilitate a meaningful experience for two families when their relative died. Our compassionate response as palliative care practitioners validated and supported the two families' expressions of grief at the profound time of a relative's death. These reflections confirm the importance and illustrate the impact of compassionately listening, understanding what matters, and intentionally supporting relatives in their expression of grief and their search for meaning at the time of their relative's death. These skills are essential for every team member to ensure that support is offered to help the family members cope during a patient's illness and in their own bereavement (World Health Organization, 2002).

CONFLICTS OF INTEREST

The authors hereby state that they have no conflicts of interest to declare related to this article.

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