Summary

SUMMARY The question of terminal prognosis disclosure represents a controversial problem and is largely determined by the philosophyof healthcare: Western medical philosophy favors open disclosure, while in Eastern medicine physicians would rather concealing information on terminal diagnosis from a patient or reveal it only partially. The discussion on this ethical and procedural medical dilemma is heated with the fact that research conducted among terminally ill patients indicates that patients' awareness of their terminal diagnosis and their understanding of imminent death impact positively patients' quality of life. Pery and Wein (2008) advocating the full disclosure of terminal diagnosis indicate that " good death" occurs when the subjective (patient) and the objective (society, family) appear to blend seamlessly - before, during, and afterward (p. 400). Simultaneously, Chochinov et al (2000) concludes that what patients are told, how they are told t and the manner in which they are able to integrate and cope with such information remains an important issue for clinicians attending to patients facing imminent death (p. 505). Finally, Field and Copp (1999) emphasize that full disclosure approach to communication of terminal diagnosis is mandatory and results in positive outcomes for patients, their families and medical personnel. More specifically, Field and Copp (1999) indicate the following outcomes: (1) better information and communication from medical personnel, including nurses, (2) patient's participation in decisions about care, (3) psychological support from family members, (4) palliative care, (5) self-esteem, (6) autonomy and decreased anxiety, (7) preparation for death and acceptance. Because there is emerging empirical evidence on improvements of patients' quality of life occurring after terminal diagnosis is communicated to them, a need for change in practice is mandatory.

According to Rosswurm and Larrabee (1999), improvements in medical care are made through the emphasis on solid scientific evidence and innovation (p. 317). Design for change in practice is conducted through protocols, procedures and standards (Rossuwurm and Larrabee, 1999). In order to implement mandatory communication of terminal diagnosis to patients as a change in practice, mechanism of protocols and their subsequent distribution to medical personnel is necessary. Protocol for change in practice consists of four parts and contains well-structured and detailed information regarding terminal diagnosis disclosure practice and follow up procedures aimed to improve patients' quality of life. This is done to eliminate complexity of design and increase the likelihood of change acceptance (Rossuwurm and Larrabee, 1999, p. 320). The first part of protocol emphasizes the benefits of communicating terminal diagnosis to patients. Simultaneously, protocol encourages physicians and nurses to seek individualized approaches to disclose terminal diagnosis and communicate diagnosis abruptly or in stages, carefully considering such factors as patient's emotional state, characteristics of diagnosis and disease. The second part of protocol is designed to eliminate avoidance practices among medical personnel involved in communication with terminally ill patients. This element of design is done to prevent unsatisfactory communication avoidance practice that can lead to process of social dying among terminally ill patients. Research evidence suggests feelings of abandonment and isolation tend to increase as patients get closer to death (Dow, 1990), therefore physician and medical personnel should interact with terminally ill patients. The third part of protocol includes the discussion of directness communicating terminal diagnosis. Practically, it means that medical personnel should provide direct

and honest answers to topics of unique concern for terminal patients, avoiding the utilization of complex terminology and jargon. The final fourth part of protocol emphasizes the need for non-verbal communication with terminal patients. Research indicates that touch, in particular, is critical in conveying care, positive attention, and improving terminal patients' quality of life. For instance, Routasalo (1996) reports that patient attitudes towards nurses become more positive after non-necessary touch.

REFERENCES

Chochinov H. M, Tataryn D., Wilson K., Enns M., Lander S. (2008). Prognostic Awareness
and the Terminally Ill. Psychosomatics; Nov/Dec; 41, 6, pp. 500-505

Dow, K. H. (1990). The enduring season in survival, Oncology Nursing Forum, 17(4), pp. 511
516.

Field D., Copp G. (1999). Communication and awareness about dying in the 1990s. Palliative
Medicine, 13, pp. 459-468

Pery S., Wein S. (2008). The dying patient: The right to know versus the duty to be aware.
Palliative and Supportive Care, 6, pp. 397-401

Rosswurm, M. A., Larrabee, J. H. (1999). A Model for Change to Evidence-Based Practice.
Journal of Nursing Scholarship, 31(4), pp. 317-333

Routasalo, P. (1996). Non-necessary touch in the nursing care of elderly people. Journal of
Advanced Nursing, 23, pp. 904-911.