Palliative and end-of-life (EOL) care have not been a priority for Americans until more recent years. The concept of hospice care or referral has often been deemed evidence of failure of the medical system. Americans have recently been more interested in planning for their own EOL care. Advance directives or advance care planning have more meaning and focus for many people. In the past, a will may have been sufficient, but today many Americans have completed living wills, medical directives, living trusts, durable powers of attorney for health care, and/or durable powers of attorney for finances. Completing these legal documents seems to provide some measure of comfort that one’s wishes will be honored to the extent possible. The individual has exercised some control over how she/he will leave this world and how their own property interests will be distributed.

There are several reasons for the increased awareness and interest in EOL care. Certainly the activities of Jack Korvorkian and the assisted suicide law of Oregon have brought the topic of dying in America to the forefront. One cross-sectional, national survey of seriously ill patients, recently bereaved families, physicians, and other care providers concluded that freedom from pain, communication with one’s physician, preparation for death, and the opportunity to achieve a sense of completion are important to most patients (Steinhauser et al., 2000). Other surveys have indicated a preference for dying at home surrounded by loved ones, yet hospitals remain the place of death for a majority of people. However, it is becoming more common for people to request a referral to hospice care. Originating from a mostly volunteer movement in the 1970’s, the Medicare hospice benefit became available for those with a life expectancy of less than 6 months in 1982 (Foley & Gelband, 2001; Zerzan, Stearns, & Hanson, 2000). This was the recognition that palliative and EOL care have a scientific base in the armamentarium, or available resources, for management of acute and chronic disease; they should be made available for all Americans. Hospice has now become a household word in many communities.

Public and Professional Forums

The Open Society Institute, through its Project on Death in America (PDIA), has greatly increased public awareness. The Open Society Institute is a network of foundations created and funded by George Soros. It is active in more than 50 countries around the world (Open Society Institute, 2000). In 1997, a PDIA task force on palliative care developed “The Last Acts,” a very valuable document, addressing care and caring at the end of life – precepts of palliative care. This document, widely endorsed by many organizations including ANNA, is a universal approach to EOL and palliative care across all diseases processes, ages and cultures (see Figure 1). In 2000, public television released “On Our Own Terms,” which is now available in a video series. This documentary, by Bill Moyers, on dying in America has permitted the once uncomfortable discussion of death to enter into our living rooms. (Films for the Humanities & Sciences, 2000).

Nursing has been instrumental in moving the EOL and palliative care agenda forward. In 1999, an agenda for the nursing in EOL care was made available through the Nursing Leadership Consortium on End of Life Care. This effort was funded by The Open Society Institute and the...
Palliative care refers to the comprehensive management of the physical, psychological, social, spiritual and existential needs of patients. It is especially suited to the care of people with incurable, progressive illnesses.

Palliative care affirms life and regards dying as a natural process that is a profoundly personal experience for the individual and family. The goal of palliative care is to achieve the best possible quality of life through relief of suffering, control of symptoms and restoration of functional capacity while remaining sensitive to personal, cultural and religious values, beliefs and practices.

Palliative care can be complementary to other therapies that are available and appropriate to the identified goals of care. The intensity and range of palliative interventions may increase as illness progresses and the complexity of care and needs of the patients and their families increase. The priority of care frequently shifts during this time to focus on the dying process with an emphasis on end-of-life decision making and care that supports physical comfort and a death that is consistent with the values and expressed desires of the patient. Palliative care guides patients and families as they make the transition through the changing goals of care, and helps the dying patient who wishes to address issues of life completion and life closure.

Palliative care has become an area of special expertise within medicine, nursing, social work, pharmacy, chaplaincy and other disciplines. However, advances in palliative care have not yet been integrated effectively into standard clinical practice. The fundamental precepts of palliation should be a basic component of the attitudes, knowledge base and practice skills of all clinicians.

The Last Acts Palliative Care Task Force believes that acknowledgment and incorporation of the following core precepts into all end-of-life care can serve as a starting point for needed reform.

**Precepts of Palliative Care**

**Respecting Patient Goals, Preferences and Choices**

Palliative Care:

- Is an approach to care that is foremost patient-centered and addresses patient needs within the context of family and community.
- Recognizes that the family constellation is defined by the patient and encourages family involvement in planning and providing care to the extent the patient desires.
- Identifies and honors the preferences of the patient and family through careful attention to their values, goals and priorities, as well as their cultural and spiritual perspectives.
- Assists patients in establishing goals of care by facilitating their understanding of their diagnosis and prognosis, clarifying priorities, promoting informed choices and providing an opportunity for negotiating a care plan with providers.
- Strives to meet patients’ preferences about care settings, living situations and services, recognizing the uniqueness of these preferences and the barriers to accomplishing them.
- Encourages advance care planning, including advance directives, through ongoing dialogue among providers, patient and family.
- Recognizes the potential for conflicts among patient, family, providers and payors, and develops processes to work toward resolution.

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Comprehensive Caring

Palliative Care:

- Appreciates that dying, while a normal process, is a critical period in the life of the patient and family, and responds aggressively to the associated human suffering while acknowledging the potential for personal growth.
- Places a high priority on physical comfort and functional capacity, including, but not limited to: expert management of pain and other symptoms, diagnosis and treatment of psychological distress and assistance in remaining as independent as possible or desired.
- Provides physical, psychological, social and spiritual support to help the patient and family adapt to the anticipated decline associated with advanced, progressive, incurable disease.
- Alleviates isolation through a commitment to non-abandonment, ongoing communication and sustaining relationships.
- Assists with issues of life review, life completion and life closure.
- Extends support beyond the lifespan of the patient to assist the family in their bereavement.

Utilizing the Strengths of Interdisciplinary Resources

Palliative Care:

- Requires an interdisciplinary approach drawing on the expertise of, among others, physicians, nurses, psychologists, pharmacists, pastoral caregivers, social workers, ancillary staff, volunteers and family members to address the multidimensional aspects of care.
- Incorporates the full array of inter-institutional and community resources (hospitals, home care, hospice, long-term care, adult day services) and promotes a seamless transition between institutions/settings and services.
- Requires knowledgeable, skilled and experienced clinicians, who are provided the opportunity for ongoing education, professional support and development.
- Includes a clearly identified, accessible and accountable individual or team responsible for coordinating care to assure that changing needs and goals are met and to facilitate communication and continuity of care.

Acknowledging and Addressing Caregiver Concerns

Palliative Care:

- Appreciates the substantial physical, emotional and economic demands placed on families caring for someone at home, as they attempt to fulfill caregiving responsibilities and meet their own personal needs.
- Provides concrete supportive services to caregivers such as respite, round-the-clock availability of expert advice and support by telephone, grief counseling, personal care assistance and referral to community resources.
- Anticipates that some family caregivers may be at high risk for fatigue, physical illness and emotional distress, and considers the special needs of these caregivers in planning and delivering services.
- Recognizes and addresses the economic costs of caregiving, including loss of income and non-reimbursable expenses.

Building Systems and Mechanisms of Support

Palliative Care:

- Requires an environment that supports innovation, research, education and dissemination of best practices and models of care.
- Needs an infrastructure that promotes the philosophy and practice of palliative care.
- Relies on the formulation of responsible policies and regulations by institutions and by state and federal governments.
- Promotes equitable and timely access to the full array of interdisciplinary services necessary to meet the multidimensional needs of patients and caregivers.
- Demands ongoing evaluation, including the development of research-based standards, guidelines and outcome measures.
- Assures that mechanisms are in place at all levels (e.g., systems, direct care services) to guarantee accountability in provision of care.
- Requires appropriate financing, including the development of new methods of reimbursement within the context of a changing health care financing system.
Figure 2
Priority Map for the Nursing Profession’s Agenda for End-of-Life Care

- Establish an ongoing network to build consensus among nursing organizations that EOL issues are high priority and need to be addressed.
- Develop nationally recognized nursing standards and practice guidelines with application between settings of care.
- Encourage professional nursing organizations, including specialty organizations to establish EOL care as a strategic priority.
- Ensure EOL content in undergraduate/graduate education by including such content in NCLEX and all certification exams and changing accreditation standards.
- Create a mechanism/strategy for collaboration among nursing organizations to inform and influence public policy in EOL care.
- Develop strategies to implement and support nursing research on EOL care.
- Contribute to efforts to remove regulatory and financial barriers to access for comprehensive palliative services including hospice.
- Establish effective pain management as a standard reimbursable practice through traditional and complimentary modalities.
- Develop a national long-range plan designed to effectively deal with social and professional forces (e.g., the aging population, projected nursing shortage) to prepare for EOL care in the future.
- Create interdisciplinary models for teaching professionals effective communication, decision making, and conflict resolution techniques in EOL care.
- Establish an appropriate umbrella organization as a nursing resource center/clearinghouse for existing EOL resources.
- Establish a research agenda for EOL issues for nurses and specialty groups.
- Disseminate national nursing standards and guidelines for EOL care to include educational programs, professional organizations, and certification and regulatory bodies.
- Develop appropriate outcomes criteria for EOL/palliative care.
- Create a national campaign for patient education and rights; target schools, places of worship, and the workplace.
- Establish system to disseminate EOL information to the public.

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PDIA and organized by the American Association of Critical Care Nurses (AACN). A work group of 23 specialty nursing organizations, the National Institutes of Health, the PDIA, the Robert Wood Johnson Foundation and other institutions met to share a variety of perspectives on EOL care (Rushton, Scanlon & Ferrell, 1999). The priority map for nursing actions is illustrated in Figure 2.

In 2000, the Nursing Leadership Academy for EOL Care was created by the Institute for Johns Hopkins Nursing and funded by the Open Society Institute’s PDIA. ANNA was one of 22 national nursing organizations to be represented (Rushton, Williams & Sabatier, 2002). One of the beginning accomplishments of the academy was a statement of commitment to EOL and palliative care that ANNA readily endorsed (see Table 1). The work of the academy is ongoing with an Internet resource at www.palliativecarenursing.net. ANNA has established a direct link to this website on its home page (www.anmanurse.org).

Several specialty nursing organizations have position statements that address quality of care at EOL. The ANNA Ethics Committee is in the initial stages of writing a position statement that addresses the care of renal patients. The ANA Code of Ethics for Nurses with Interpretive Statements includes considerations for the nurse’s role in EOL care. The American Association of Colleges of Nursing (AACN) has recommendations for achieving a peaceful death through outlined nursing competencies and nursing curricular guidelines. Our colleagues in medicine,
through the American Medical Association (AMA), have issued a report on good care of the dying patient through the AMA Council on Scientific Affairs with recommendations for research, education and clinical management of the dying process. The Renal Physicians Association and the American Society of Nephrology (RPA/ASN) issued a position paper on the quality of care at the EOL. In 1999, the RPA/ASN released the Clinical Practice Guideline for Shared Decision Making in the Appropriate Initiation of and Withdrawal from Dialysis (RPA/ASN, 2000). This comprehensive document includes considerations for planning palliative and EOL care for patients with either acute renal failure (ARF) or ESRD. ANNA was represented on this impressive work group which tackled the difficult issues surrounding forgoing or withdrawing dialytic therapy. The full document is available through RPA/ASN and ANNA national offices. A summary of the committee recommendations is outlined in Table 2. Finally, in 2002, under the Robert Wood Johnson Foundation national program for Promoting Excellence in EOL care, an ESRD workgroup was created which included nephrologists, nephrology nurses, social workers, renal administrators, and patients. The final report of this workgroup, containing recommendations to the field, is now available (Moss, 2003; Robert Wood Johnson Foundation, 2003).

These position statements and reports provide excellent indepth discussion and recommendations for improving patient care. They are available through the respective national offices of ANA, AACN, AMA, RPA, ASN, and ANNA.

The Nephrology Nurse Role

Nephrology nurses have these exceptional resources available from which they can devise a plan of care for a patient with ARF, chronic renal insufficiency, or ESRD. The approach to palliative and EOL care will vary depending on the patient’s circumstances, but the principles and precepts are the same. The health care team must respect the patient’s goals, preferences, and choices; a comprehensive plan of care must be developed with the patient/family participation; the expertise of individual providers must be engaged; caregiver concerns must be included in the plan; and an environment of support must be philosophically and financially available.

Incorporating the precepts of palliative and EOL care into the Shared Decision Making Guideline for Initiation of or Withdrawal from Dialysis provides systematic direction for the nephrology nurse and other members of the renal care team. It is particularly important that nephrology nurse practitioners incorporate these principles and guideline into their practice because it is becoming more evident that nurse practitioners are often the primary care providers working in collaboration with the physician in the care of nephrology patients. The individual and shared clinical roles of nurse practitioners and nephrologists has been agreed upon and addressed in the joint RPA/ASN/ANNA position statement on collaborative practice. Moreover, nurse practitioners work very closely with the clinical nephrol-

### Table 1

**Nursing’s Commitment to Palliative Care**

We, the undersigned, come together to express our commitment to the advancement of palliative care across the life span, and in all settings. We commit that our organization will seek opportunities to collaborate within an effort to ensure the quality of care rendered to individuals, families, and communities. We have endorsed the *Precepts of Palliative Care*, developed by the Last Acts Palliative Care Task Force (December, 1997), and we commit to participate in the translation and application of these *Precepts* for the area of nursing in which our membership is engaged.

**Note:** Statement endorsed by nursing organizations participating in the Nursing Leadership Academy for End of Life Care (September, 2000).

### Table 2

**Summary of RPA/ASN Shared Decision Making Guideline for the Appropriate Initiation of and Withdrawal from Dialysis**

**Recommendations**

1. **Shared decision making:** Involves the renal care team, to include the nurses and patient and family in health care decisions.
2. **Informed consent or refusal:** Legal documentation and understanding of personal decision regarding health care.
3. **Estimating prognosis:** Evidence-based morbidity and mortality data explained to patient to assist with decision making.
4. **Conflict resolution:** Involves effective communication between physicians, nurses, or other health care providers and/or patients and families.
5. **Advance Directives:** Prior documented patient decisions about health care which should be honored.
6. **Withholding or withdrawing dialysis:** Describes situations where forgoing or withdrawing dialysis is appropriate.
7. **Special patient groups:** Addresses patients with terminal illness or conditions which make the provision of dialysis very difficult.
8. **Time-limited trials:** Provision of dialysis when the patient or family is uncertain about their wishes, and/or medical prognosis is uncertain.
9. **Palliative care:** End-of-life care with referrals to professionals with expertise in palliative care when decision is to forgo or withdrawal dialysis.
ogy nurses and other renal staff in the hospitals and dialysis facilities. In situations where a nephrology nurse practitioner is not available, a nephrology clinical nurse specialist may be an available resource, otherwise the responsibility for assuring palliative and EOL care may fall to the primary nephrologist.

Shared Decision Making

Shared decision making is a relatively new concept in healthcare. In 1999, Dartmouth-Hitchcock Medical Center in Lebanon, New Hampshire established the first full service center for shared decision making within their hospital. A very attractive sign announces the service available for patients and families (see Figure 3). The services provided at Dartmouth incorporate a broad spectrum of patient advocacy services, including palliative and EOL care, to which patients can be referred or patients may self refer. The center stresses that for all health care decisions, there is more than one choice and no “correct” choice, in that personal value and circumstances must be taken into consideration. The emphasis is on the patient and family being involved in all health care decisions. This center has the RPA/ASN guideline as one of its resources. It would be an excellent step forward for all hospitals to establish a department of Shared Decision Making. Certainly, nephrology practices and renal patients and families would benefit from such a service, a service where patients and families are encouraged and expected to get involved.

RPA/ASN Guideline with Nephrology Community Involvement

The RPA/ASN Shared Decision Making for the Appropriate Initiation and Withdrawal of Dialysis Guideline (See Table 2) should be a readily available resource as a reference in all patient discussions. This guideline is formatted with nine recommendations and a last section on considerations for dealing with difficult patients. The remainder of this article will address this guideline as a whole, but particularly it will highlight the nephrology nurse’s role in implementing the recommendations regarding advance directives and palliative care (Recommendations # 5 and 9).

Recommendation #1. This valuable document starts by explaining the necessity of a shared decision making environment. The first recommendation from the RPA/ASN guideline addresses shared decision making by the renal care team. The patient and family should play a pivotal role in the discussions about health and illness and potential treatments. Where the patient lacks decision-making capacity, a legal agent should be appointed. With the increased emphasis on early intervention and education, nurse practitioners are often involved simultaneously with the nephrologists in educating and in monitoring renal patients’ progression of disease. Clinical nephrology nurses are more involved in the ongoing education of these patients generally after dialysis is initiated.

Recommendation #2. The second recommendation is to assure that the patient is indeed making an informed decision about her/his health care. Most often, the initial discussion regarding dialysis is between the patient and the physician, but increasingly these discussions are with the nephrology nurse practitioner. However, once dialysis has been initiated, very often the clinical nurse is the first to learn of a patient’s wish to discontinue dialysis. In either situation, the entire renal care team should ensure that the patient or legal agent understands the consequences of the decision.

Recommendation #3. The third recommendation addresses estimating the patient’s prognosis with either acute or chronic renal failure. This recommendation of the guideline is evidenced based and the primary nephrologist, primary care physician and/or the nephrology nurse practitioner is responsible for assisting the patient to interpret the data specific to
her/his health care status and likely morbidity and mortality.

Recommendation #4. The fourth recommendation addresses conflict resolution between the patient and the providers, and also between providers, which are not an uncommon occurrence when life-sustaining treatments are involved. Conflict resolution is a science unto itself and a necessity whenever a shared opinion does not exist amongst providers. Nurses and physicians have to master the process of overcoming interpersonal and intrapersonal issues in pursuit of quality patient care.

Recommendation #5. The fifth recommendation on advance directives will be discussed at length later in this article.

Recommendation #6. The sixth recommendation addresses the appropriateness of withholding or withdrawing dialysis in certain clinical situations. When a competent patient wishes to forgo dialysis or discontinue dialysis, as long as the patient is well informed of the consequences, the patient’s decision must be honored. A patient not deemed competent, who when competent made her/his wishes against dialysis clearly known, should not receive dialysis. An appointed legal guardian may also make the decision to withhold or withdraw dialysis if the patient is no longer able to make decisions, as long as the patient’s wishes are well known to the legal guardian. Finally, patients with irreversible, profound neurological impairment should appropriately not be dialyzed.

The nephrology nurses’ role in these situations with a likely shortened life expectancy for the patient varies between being a patient advocate and/or family supporter. With the emphasis on chronic disease management, nurse practitioners and clinical nurses may be more involved in these patient situations and they must work to safeguard patient autonomy.

Recommendation #7. Recommendation seven addresses patients with either ARF or ESRD who have a diagnosis of a terminal nonrenal disease, who are clinically unstable, or who cannot cooperate with or withstand the dialysis treatment secondary to a medical or physical condition that cannot be altered. Some patients just should not or cannot be offered dialysis. In some situations, the burden of dialysis outweighs any benefit of pursuing aggressive therapy. Nurses comprehend the nature of the health status of these patients, for example, severe hypotension, unmanageable mental or emotional disability without pharmacological restraints, and exhausted vascular access sites.

Recommendation #8. The guideline committee recognized that in some situations a patient’s prognosis is unclear as is the patient’s likely response to treatment, or that the patient and/or family are uncertain in their decision making. In these situations, dialysis should be considered for a time-limited trial, which is addressed in the eight recommendation. This approach provides time for all involved parties to secure more information on which to base a decision about long-term treatment. Physicians and nurses need to support the patient/family through this process avoiding conflicting personal opinions, but rather creating an environment that allows the patient/family to be comfortable with their ultimate decision.

Advance Directives and Palliative Care

Recommendation #5. The fifth recommendation addresses the universal need for all patients to have written advance directives, or at least have the opportunity to consider such advance care planning. The renal care team should attempt to establish advance directives with all dialysis patients. Equally important, these advance directives should be honored. The format or forms vary considerably for advance directives, but the central theme is the same. Some patients will seek the assistance of their personal attorneys for establishing their end of life conditions and durable powers of attorney for health and financial concerns. State-approved forms are generally available, and they may not require the assistance and expense of an attorney to complete them. Often hospitals, dialysis units, and nursing care facilities have advance directive forms and offer the personnel to assist with completing these forms. Patients should be allowed their right to have their advances directives honored, including no cardiopulmonary resuscitation during the dialysis treatment. There have been anecdotal reports across the United States of dialysis centers that do not honor patients’ wishes during the dialysis treatment. This is absolutely contrary to the Shared Decision Making guideline and may also be against state and federal laws.

Nephrology nurses often are confronted with patients with ARF or ESRD who have not completed advance care planning. These patients present to the hospital or dialysis clinic filled with anxieties and fears, and although their desires need to be known, the first dialysis treatment probably is not the best time for the discussion to take place. If timing and circumstances permit, the nephrologist, nephrology nurse practitioner, the primary care physician, or another health care team member should attempt to have this discussion with the patient and family prior to the initiation of dialysis.

Once dialysis has been initiated, and assuming the patient is clinically stable, the topic of advance directives can be approached within the first couple of weeks of starting treatment. The nephrology clinical nurses certainly have a role in bringing this discussion to the forefront. If the facility has a standard form, the nurse can use the outline of this form to clarify the patient’s wishes. Once the form is signed, a copy should be maintained in the patient’s chart. There also must be a means or chart identification whereby all members of the renal care team know the patient’s wishes. Advance directives should be reviewed at least annually with the patient and anytime a significant change in the patient’s clinical status occurs, such as, after a myocardial
infection, cerebral vascular accident, extremity amputation, or serious infection.

**Recommendation #9.** Referral for palliative and EOL care is the ninth recommendation. Palliative care should enter into the conversation for all patients who decide to forgo dialysis or transplantation, and for all patients who chose to discontinue treatment. Depending on the percent of renal dysfunction or creatinine clearance of chronic kidney disease, a formal hospice referral may not be appropriate. A Medicare referral requires a life expectancy of less than 6 months. The ESRD benefits for hospice will be covered when a patient withdraws from dialysis or when a patient has a terminal disease unrelated to renal failure and this disease process is estimated to result in death in less than 6 months (Medicare Reference Guide for Hospice Agencies, 1999). In the latter situation, the patient may continue dialysis and receive hospice benefits, if the patient and family prefer treatment.

Under the current chronic disease management strategy, patients who decide to forgo dialysis may be followed in a renal clinic and by their primary care provider. As the kidney disease progresses to the point of inevitable short life expectancy, professionals with the expertise in EOL care should become involved in the care of the patient. This does not indicate that nephrology professionals should halt their involvement in the patient’s care. However, the hospice staff members become the primary providers to ensure a peaceful death with dignity at home or in a care center. Palliative care and symptom management become a shared responsibility between nephrology and hospice. It is critical for nephrologists, nephrology nurse practitioners, and nephrology clinical nurses to promote and arrange for a seamless transition of care such that the patient receives all EOL benefits and services. Unlike most nephrology practices, generally hospice programs also include bereavement support for the families for a period of time after the death of the patient. This is an additional reason why referral for palliative and EOL care is imperative.

As stated earlier, nephrology clinical nurses are often the first to become aware of a patient’s decision to discontinue treatment, either immediately or with a planned date in the future. This information should be given to the primary nephrologist so a renal team approach can be instigated to ascertain if there are any clinical problems that are amenable to correction and that might alter the patient’s decision to withdraw care. Emotional and physical pain or discomfort should be addressed. However, sometimes patients have just “had enough” and they desire to take control for a perceived good death. These patients should be referred for palliative and EOL care. Under these circumstances, a patient may receive dialysis for ultrafiltration only for symptom management, if dyspnea secondary to fluid overload occurs after dialysis is discontinued.

A patient with ESRD may have another terminal disease, such as cancer, which will lead to a life expectancy of less than 6 months. Under this circumstance, a patient may continue routine dialysis and receive a Medicare benefit for ESRD and for hospice care. Collaboration between the hospice care team and the renal care team is important to ensure the maximum benefit for the patient and family. The dialysis treatment must be safe and effective, but it should be modified to provide the most comfort and quality of life for the patient. Adequacy of dialysis may need to be sacrificed if clinical stability can be achieved with less treatment time. The dialysis prescription will need to be adjusted as the patient’s appetite becomes suppressed. The need for heparin administration during dialysis must be evaluated as malignancy consumes the patient’s other body systems. Dialysis at this point is palliative care, and the prescribing physician or nurse practitioner must customize every treatment. The clinical nurses have the responsibility of keeping everyone informed of their nursing assessment and the patient’s response to therapy.

**Conclusion**

The premise of shared decision making should guide the care of dying patients. Nephrology health care providers have many available resources to assist with palliative and EOL care for patients with ARF or ESRD. When a hospital has a department for shared decision making, the patient and family should be referred early in the process. All providers should become familiar with the Medicare and other insurance regulations for providing palliative, EOL and hospice care. The goal should be assisting every patient to achieve quality of remaining life, symptom management and a good death, as defined by the patient and family.

**References**


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Books Reviewed in This Issue:
High Blood Pressure: The Black Man and Woman's Guide to Living with Hypertension
James W. Reed and Hilton M. Hudson
First edition, 2002
Hilton Publishing

High Blood Pressure: The Black Man and Woman's Guide to Living with Hypertension
James W. Reed and Hilton M. Hudson
First edition, 2002
Hilton Publishing, P.O. Box 737, Roscoe, IL 61073
soft cover, 147 pages, $16.95

Here is a factual, straightforward, and compassionate book about hypertension, one of the most prevalent health problems in the African American community. The book is full of useful information — what is hypertension, what causes it, what are the consequences, and most importantly, what can patients do about it?

The authors, both physicians, write in layman's terms but do not minimize any important information. They even include a list of questions to ask one's physician. They explain the role and importance of regular health care, but the real emphasis is on how patients can make meaningful changes to improve their health no matter what their age or medical condition. The chapters, which cover stress, weight control, alcohol, diet, exercise, meditation and spirituality, are full of realistic suggestions and timelines. For example, if it seems infeasible to eliminate sweets, start by cutting out the afternoon cookies but keep eating the after-dinner pie. Once the cookies are gone, then start to decrease dinner desserts until they too are gone (p. 105). Another chapter discusses antihypertension medications, their actions and how to handle potential side effects. Another chapter deals with the role of stress, aspects unique to the African American community, and how to recognize even subtle forms and modify one's reactions for improved health outcomes. Two chapters examine psychological and spiritual aspects and the vital role these play in hypertension.

I finished this book wishing I had a stack of books that I could distribute to patients and their families. Although written for the African American community, the information is useful for anyone with hypertension and accompanying risk factors. While clearly outlining the consequences of not changing, this book emphasizes that one does not have to be wealthy, well educated or even well employed to make significant life changes with far-reaching health benefits.

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Fatigue Among Caregivers
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