



Article

Improved Communication Skills Assisting Cancer Patients Through Counseling Training Palliative Volunteers in Surabaya

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ABSTRACT

Introduction: The prevalence of tumors/cancer in Indonesia is increasing. Many cases of cancer at an advanced stage experience severe symptoms and cause suffering that has not been handled properly. Palliative care helps a cancer survivor and his or her family to live a more comfortable life to have a better quality of life. **Methods:** For this reason, a team that works in an integrated manner includes both medical and non-medical personnel, including volunteers. The role of volunteers in palliative care teams varies according to need and can be involved in hospital care, or at home, expected to bridge between health care institutions and patients. Psychiatrists at Dr. Soetomo General Hospital Surabaya and their residents try to give four sessions of volunteer training to raise awareness, provide health education, or even provide some simple type of medical care and work as counselors. **Results:** After giving four training sessions every week, the ability of palliative teams had increased. **Conclusion:** They have the capability to communicate more effectively and efficiently, which is therapeutic, so it is necessary to provide them with counseling skills to listen to, understand, and respond positively when communicating with cancer patients and their families.

INTRODUCTION

The number of people with cancer tends to increase over time. The World Health Organization (WHO) said that cancer was the number two cause of death, with an estimated 9.6 million people dying from cancer in 2018 [1]. Nearly 70% of cancer deaths occur in low- and moderate-income countries. In Indonesia, based on Riskesdas data, the prevalence of tumors/cancer in Indonesia showed an increase from 1.4 per 1000 population in 2013 to 1.79 per 1000 population in 2018 [2]. Many cases of cancer at an advanced stage experience severe symptoms and cause suffering that has not been handled properly so patients have a poor quality of life, and the family has the difficulties that result. Patients with these conditions experience suffering that requires an integrated approach to various disciplines so that the patient has a good quality of life [2,3] and at the end of his life, he will die with dignity. The challenge for clinicians is to realize such better care of patients with cancer from diagnosis to death, which may occur years after the completion of treatment. Palliative helps a cancer survivor and his family to live a more comfortable life and have a better quality of life. This is an important need for humanity, especially for people with cancer. The philosophy underlying the Implementation of Palliative Care (PkTP Guidelines of the Ministry of Health, 1997) is the right of all patients to get the best care until the end of their lives [4]. Palliative care is a mission to reduce patient suffering and provide support to families experiencing difficulties due to physical symptoms, psychological disorders, social difficulties, and spiritual problems [3, 5].

With the increasing number of cancer patients in Indonesia, the need for palliative care programs is inevitable. The integration of palliative care into integrated cancer management has long been advocated by the WHO, as the number of cancer patients continues to rise because of the increasing

human life expectancy. Implementation of palliative programs in the community and health care facilities is listed in the Palliative Cancer Technical Directive in Adults regarding the principle of being able to be effective, optimal, effective, efficient, and focused on the needs and comfort of patients at an advanced stage [1, 2, 6]. For this reason, the palliative procedures of cancer patients rely on biopsychosocial and spiritual approaches. Palliative team communication with patients and families is important in palliative care. The quality of life of the patient not only depends on the physical aspect, but the psychological aspect also plays a role. Volunteers as part of palliative teams are also required to be able to communicate effectively and efficiently, which is therapeutic [7].

METHODS

The purpose of the Palliative Program is the implementation of a Palliative Program that is integrated in cancer management at every level of health service in Indonesia, has scope in hospitals (hospitals type A, B, C, and D), and Palliative Programs in the community (Health Centers, hospice, home care). For this reason, a team that works in an integrated manner includes both medical and non-medical personnel, including volunteers. A volunteer is someone who sincerely answers the call to serve members of the community by relinquishing time, energy, thoughts, and even material use of their knowledge, skills, and experience. The role of volunteers in palliative care teams varies according to need. Volunteers can be involved in hospital care, or at home. Volunteers come from all sectors of society, expected to bridge between health care institutions and patients. With the right training and support, volunteers can provide direct services to patients and families, assist with administrative tasks, raise funds, and assist with rehabilitation. In addition, it can play a role in helping raise awareness, provide health education,

or even provide simple medical care, and work as a counselor. Surabaya palliative volunteers are members of the palliative team of Dr. Soetomo General Hospital under the command of the Palliative & Pain-free Development Center (P3BN). Currently, the number is less than 50 people. Of these active people, there are about 30-40 people. Their age ranges from the average young adult to the elderly. His educational background is quite varied, ranging from high school nurse to undergraduate. Some are still actively working, but most are not working/retiring. Volunteer duties are mostly doing home care. In fact, there were some problems that occurred with volunteer partners, such as the personality and knowledge of palliative volunteers of Dr. Soetomo General Hospital who support their communication skills are not the same and have never received the counseling training needed to carry out their duties as counselors. This communication skill is needed when accompanying patients and families so that their presence can make patients comfortable and their quality of life improved. The method of implementing this community service activity is to map the distribution of the number of cancer patients in the Surabaya area, the process of screening interest, and the location of the domicile of volunteers who are currently registered, then select several people regarding the distribution of the number of regional patients. Training is divided into 2 stages, namely the theory and practice of counseling. Counseling theory: done online by giving pre and post-tests. As for counseling, volunteers are done via offline face-to-face in open spaces by dividing into small groups ranging from 6-8 people. Evaluation is carried out in monthly meetings 3 times through online, the extent to which the skills that have been trained can be applied, evaluation of obstacles and their impact. Volunteers will be taught how to start the counseling for palliative volunteers, complete the orientation counseling, learn counseling techniques, and build re-

lationships with cancer patients. The volunteers are recruited from palliative volunteers scattered in the Surabaya area. They are members of the palliative volunteers of Dr. Soetomo Hospital under the supervision of P3BN Dr. Soetomo General Hospital.

RESULTS

The Community Service Activities of the Fakultas Kedokteran Universitas Airlangga Psychiatry Department Program in 2021 were held at Dr. Soetomo General Hospital, precisely at Jl. Maj. Gen. Prof. Dr. Moestopo No 6-8, Surabaya. This event was held online on Thursday, June 24, 2021, Thursday, July 1, 2021, and Thursday, July 8, 2021, starting at 08.30 GMT+7 and finishing at 12:30 GMT+7. The event was held online using zoom meetings in the form of lectures, discussions, and interactive dialogues. The event was attended by 60 people, consisting of participants, organizers, and several teaching staff members of the Fakultas Kedokteran Universitas Airlangga Psychiatric Department. Counseling training is carried out based on counseling training modules that have been compiled by the Community Service Team of the Department of Psychiatry, Faculty of Medicine, Universitas Airlangga, which consists of 8 hands out materials. Each handout is done with several steps with a predetermined time allocation, namely: Introduction to Counseling, Understanding/Basics/Orientation Counseling, Counseling Ethics, Management/Counseling Techniques, Therapeutic Communication/Communication Skills, Building Relationships, Online Counseling, and Strategy. Increased motivation in pain management/depression Training is done online because it is still in the pandemic period, and prevents exposure to the device screen too long in training so that the training is done in 3 sessions with a distance of 1 week to provide time to carry out homework given by facilitators to improve communication skills. This training was followed by 43

participants who signed up and took part in the training because of the obstacles of various things, not all participants followed the training session in full. Seventeen participants actively participated in 3 training sessions starting from conducting a pretest of 2 sessions and post-tests conducted on June 24, 2021, and July 1, 2021. We see the progress of the participants in each training session via their ability to answer the pretest and posttest questions, and we rank the questions and give feedback to all the participants at the end of this training session. We also conduct a skills assessment

through an objective structured communication skill examination for 21 participants who can attend the third meeting on July 8, 2021, to objectively assess the quantitative and global performance scale of palliative volunteers through 5 different case presentations of palliative patients. We see the progress of the participants in each training session via their ability to answer the pretest and posttest questions, the roleplay score, and the global performance scale, and we ranked the scores and gave feedback to all the participants at the end of this training session.

Table 1. Evaluation Score of Each Participant

No	Name	Gender	Pretest 1	Pretest 2	Posttest	Roleplay Score	Global Performance
1	AY	F	35 / 100	55 / 100	Not doing	Not assessed	Not assessed
2	AL	F	45 / 100	Not doing	70 / 100	Not assessed	Not assessed
3	Y	F	50 / 100	55 / 100	95 / 100	81,14	Very Competent
4	BA	M	Not doing	Not doing	Not doing	Not doing	Not assessed
5	BU	M	Not doing	Not doing	Not doing	Not assessed	Not assessed
6	GR	F	55 / 100	Not doing	Not doing	Not assessed	Not assessed
7	RO	F	60 / 100	90 / 100	100 / 100	96,43	Very Competent
8	YS	F	45 / 100	55 / 100	75 / 100	71,43	Fairly Competent
9	AN	F	35 / 100	Not doing	Not doing	Not assessed	Not assessed
10	AR	F	55 / 100	75 / 100	95 / 100	96,86	Very Competent
11	TT	F	60 / 100	75 / 100	85 / 100	Not assessed	Not assessed
12	DW	F	30 / 100	70 / 100	Not doing	71,43	Fairly Competent
13	ED	F	Not doing	65 / 100	Not doing	Not assessed	Not assessed
14	EY	F	Not doing	Not doing	90 / 100	71,43	Fairly Competent
15	EA	F	45 / 100	65 / 100	65 / 100	64,29	Fairly Competent
16	HP	F	35 / 100	90 / 100	75 / 100	78,57	Fairly Competent
17	TN	F	35 / 100	95 / 100	Not doing	Not assessed	Not assessed
18	RA	F	55 / 100	75 / 100	80 / 100	60,71	Fairly Competent
19	NYS	F	60 / 100	Not doing	65 / 100	71,43	Fairly Competent
20	LM	F	55 / 100	60 / 100	Not doing	Not assessed	Not assessed
21	LK	F	50 / 100	40 / 100	Not doing	57,14	Fairly Competent

22	MN	F	45 / 100	70 / 100	95 / 100	71,43	Fairly Competent
23	JN	F	55 / 100	75 / 100	Not doing	Not assessed	Not assessed
24	NK	F	35 / 100	80 / 100	Not doing	53,57	Fairly Competent
25	ND	F	60 / 100	80 / 100	95 / 100	53,57	Fairly Competent
26	NR	F	45 / 100	55 / 100	Not doing	28,57	Fairly Competent
27	CH	F	55 / 100	Not doing	Not doing	Not assessed	Not assessed
28	IBB	F	55 / 100	40 / 100	70 / 100	Not assessed	Not assessed
29	YL	F	35 / 100	Not doing	Not doing	60,71	Fairly Competent
30	RN	F	Not doing	60 / 100	90 / 100	57,14	Fairly Competent
31	RD	M	50 / 100	70 / 100	95 / 100	82,14	Very Competent
32	WN	F	45 / 100	80 / 100	90 / 100	Not assessed	Not assessed
33	MR	F	40 / 100	45 / 100	50 / 100	60,71	Fairly Competent
34	ZBD	F	45 / 100	55 / 100	85 / 100	Not assessed	Not assessed
35	YY	F	60 / 100	70 / 100	85 / 100	Not assessed	Not assessed
36	SN	F	Not doing	Not doing	Not doing	Not assessed	Not assessed
37	ST	F	Not doing	Not doing	Not doing	Not assessed	Not assessed
38	NI	F	65 / 100	Not doing	45 / 100	35,71	Fairly Competent
39	TE	F	40 / 100	Not doing	Not doing	Not assessed	Not assessed
40	TR	F	Not doing	Not doing	Not doing	Not assessed	Not assessed
41	VT	F	55 / 100	65 / 100	80 / 100	Not assessed	Not assessed
42	WE	F	Not doing	50 / 100	95 / 100	71,43	Fairly Competent
43	YL	F	Not doing	70 / 100	85 / 100	Not assessed	Not assessed

DISCUSSION

Palliative cancer care plays a role in improving the quality of life in patients with advanced cancer by controlling symptoms and relieving pain. It is widely found that patients receiving palliative therapy generally have misconceptions about their prognosis, the intention of such treatments, and they have unrealistic expectations of their cancer being cured. For patients with advanced cancer, access to palliative care was found to improve patients' mood, their quality of life, and reduce the risk of longer hospitalizations, aggressive anti-cancer treatment, and lower hospital mortality [8–10]. Often, cancer patients are not

prepared to face the fact that they must coexist with chronic diseases in their bodies, plus also when there are symptoms of depression and anxiety, fatigue, cognitive problems, and pain. Do not rule out the possibility that cancer patients can experience sequelae that, according to research, will cause the onset of symptoms such as depression, fatigue, and excessive pain. There are some challenges for patients and caregivers when revealing a terminal prognosis. These challenges include considering their obligations to patient autonomy while deciding how much information needs to be provided, and how much patients want to know from the caregivers. In

addition, caregivers sometimes find it difficult to convey such information in a realistic way, but also keep the patient hopeful [8, 11]. In an Australian study involving 126 patients diagnosed with incurable cancer, 59% were curious about the expected survival when first diagnosed; 34 and 40% wanted to be asked about when they would rather discuss expected survival and death, respectively. Also, 45% of these patients want specialists to be the ones who initiate such discussions. Only 11% said they never wanted to discuss dying/palliative care and 10% were unsure. Communication styles play a major role in the patient experience. Sensitive and supportive information given by the caregivers makes them able to provide hope by helping patients develop coping strategies and focus their goals on achieving a comfortable and meaningful end-of-life period. Palliative care is provided by an interdisciplinary team consisting of doctors, nurses, and social workers that work together to provide extra support and improve the quality of life for the patient and their family [8, 12]. By giving palliative care, the volunteers could help manage the difficult-to-treat symptoms of cancer or treatment side effects such as pain, constipation, and shortness of breath. Also, they could assist and guide patients through the course of their disease, and provide practical, emotional, and spiritual support for the patient and their families [13]. From the results of the research conducted by Lingens et al., mentioned above, psychosocial cancer service support plays a role in improving patient welfare and successfully overcoming the bad psychosocial problems of cancer patients and their families. These cancer support services could reach a higher number of patients with cancer faster and thus gain an interest in cancer care [14, 15]. Pain management in cancer patients can be provided with two techniques, namely pharmacological and non-pharmacological management. Some of the non-pharmacological management techniques used are EBT (Emotive Behavioral Therapy),

SEFT (Spiritual Emotional Freedom Technique), relaxation techniques, breathing techniques, reflexology, music playing, flexibility exercises, heat or cold therapy, hypnobirthing, and TENS (Transcutaneous Electrical Nerve Stimulation) [7, 16]. Cancer patients always need support from volunteers to coexist with cancer throughout the course of their disease. From the results of research that has been done, it was found that cancer patients who coexisted with the volunteer group showed higher self-efficacy compared to those who lived unaccompanied. Social support, coping skills, and life optimism are some of the points expected from palliative volunteer assistance. Self-efficacy has been shown to affect the feelings, thoughts, self-motivation, and behavior of patients with chronic diseases. These patients have high resilience by the time they get stressors, so they will be easier to adjust to in a better way, enjoy a better quality of life, and live longer. The thing that palliative volunteers can do is psychoeducation therapy that will have a combination of supportive conversations, learning about relaxation techniques, applying positive imagination and a healthy lifestyle holistically by practicing healthy communication by not focusing on stress and negative emotions that are being faced [15, 17]. In addition to providing psychoeducation to cancer patients, volunteers can conduct group discussions by presenting several people with the same condition to sit together to discuss complaints and problems. By doing this for several sessions, it was proven that patients with chronic disease experienced decreased levels of anxiety, depression, and stress. This therapy also helped reduce negative emotions and thoughts, anxiety, fatigue, and hopelessness. It was found that this therapy can improve the mood, self-efficacy, quality of life, purpose of life, and spiritual needs of patients or those with other chronic diseases [16]. The provision of practical information for patients with chronic diseases or terminal conditions in a support-

ive environment can foster encouragement and hope for them. Please note that to be able to provide information about the condition of a person's disease is timely and in accordance with the attention to individual autonomy because each patient has the right to reject this information. For the volunteers, the first thing to do when talking about the state of an illness was to commit to the patient to have a conversation about logistics and plans; talk about their fears, emotions, and coping when facing a problem, talk about the impact on the family when they are gone. All this can be done if there is a good rapport first between volunteers and patients. Volunteers should respect the patient's preferences and could strengthen at some time when the patient is in a mood swing. If the volunteer has had difficulty in establishing a relationship with the patient, it is emphasized that it is necessary to report the type of difficulty to the team of psychiatrists who have accompanied the patient as well as the volunteers on duty [16, 18].

The approach taken by volunteers should center on patient complaints that identify and negotiate various communication styles, decision-making styles, family roles, and issues of distrust, prejudice, among other factors. It is hoped that with increased ability, volunteers will be able to develop their skills as the closest companions of patients in overcoming situations that change according to the circumstances of their disease or when facing rejection, lack of acceptance of their diagnosis, poor prognosis, news of death and sadness, lack of knowledge of medical science, distrust, and family-related resistance to open communication about cancer diagnosis and prognosis [17,18]. So it is expected that volunteers when meeting with patients are expected to be able to conduct motivational interviews and integrative therapy while using communication strategies such as empathic listening, being an active listener, normalizing, refraining, reflecting, validating, using hopeful language, and other

therapeutic techniques including breathing exercises, behavioral interventions, decision balance, existential strategies, here-and-now, relaxation, visual techniques, written techniques, and psychoeducation when treating cancer patients [11, 16, 19]. Palliative care can offer high-value alternatives in care of advanced cancer patients. This not only decreases costs, but more importantly, it could improve patients' quality of care during a serious illness. By increasing access to palliative care through sustained investment in physician training and current models of collaborative palliative care, and focusing on what is important to the patient, this service could improve end-of-life care [12, 20].

CONCLUSION

The integration of palliative care into integrated cancer management has been implemented into palliative programs in communities and healthcare facilities by providing training and skills to volunteers in serving cancer survivors by undergoing trials online. This is because pandemic conditions still have high effectiveness by seeing an increase in the understanding of trainees from their pre and post-test results. With the increasing understanding of volunteers, it is expected that palliative services conducted by Dr. Soetomo's General Hospital team in Surabaya can help cancer survivors and their families to live more comfortably and have a better quality of life.

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CONFLICT OF INTEREST

The authors have declared that they have no conflict of interest.

REFERENCES

- [1] World Health Organization, "Cancer," 2018. <https://www.who.int/news-room/fact-sheets/detail/cancer>
- [2] D. P. D. P. T. Menular, "Pedoman Nasional Program Paliatif Kanker," Jakarta: Kementerian Kesehatan Republik Indonesia, 2018. <http://p2ptm.kemkes.go.id>
- [3] S. Hojjat-Assari, M. Rassouli, M. Madani, and H. Heydari, "Developing an integrated model of community-based palliative care into the primary health care (PHC) for terminally ill cancer patients in Iran.," *BMC Palliat. Care*, vol. 20, no. 1, p. 100, Jun. 2021, doi: [10.1186/s12904-021-00795-2](https://doi.org/10.1186/s12904-021-00795-2).
- [4] D. K. RI, *Pedoman PKTP*. Jakarta, 1997.
- [5] R. A. Chowdhury, F. P. Brennan, and M. D. Gardiner, "Cancer Rehabilitation and Palliative Care-Exploring the Synergies.," *J. Pain Symptom Manage.*, vol. 60, no. 6, pp. 1239–1252, Dec. 2020, doi: [10.1016/j.jpainsymman.2020.07.030](https://doi.org/10.1016/j.jpainsymman.2020.07.030).
- [6] K. K. RI, *RISKESDAS 2018*. Jakarta: Badan Penelitian dan Pengembangan Kesehatan, 2019.
- [7] S. D. Gede Sunardianta I, Sri R, Pujiastuti E, Indrati D, "Emotive Behavior Therapy and Flexibility Activities on Pain Level among Breast Cancer Patients," *Int. J. Nurs. Heal. Serv.*, vol. 4, no. 1, pp. 52–8, 2020, [Online]. Available: <http://ijnhs.net/index.php/ijnhs/homehttp://doi.org/10.35654/ijnhs.v4i1.388>
- [8] W. A. Ghandourh, "Palliative care in cancer: managing patients' expectations.," *J. Med. Radiat. Sci.*, vol. 63, no. 4, pp. 242–257, Dec. 2016, doi: [10.1002/jmrs.188](https://doi.org/10.1002/jmrs.188).
- [9] C. L. Craigs, R. M. West, A. Hurlow, M. I. Bennett, and L. E. Ziegler, "Access to hospital and community palliative care for patients with advanced cancer: A longitudinal population analysis.," *PLoS One*, vol. 13, no. 8, p. e0200071, 2018, doi: [10.1371/journal.pone.0200071](https://doi.org/10.1371/journal.pone.0200071).
- [10] D. R. Sullivan et al., "Association of Early Palliative Care Use With Survival and Place of Death Among Patients With Advanced Lung Cancer Receiving Care in the Veterans Health Administration.," *JAMA Oncol.*, vol. 5, no. 12, pp. 1702–1709, Dec. 2019, doi: [10.1001/jamaoncol.2019.3105](https://doi.org/10.1001/jamaoncol.2019.3105).
- [11] J. Dekker et al., "Clinical management of emotions in patients with cancer: introducing the approach 'emotional support and case finding'.," *Transl. Behav. Med.*, vol. 10, no. 6, pp. 1399–1405, Dec. 2020, doi: [10.1093/tbm/ibaa115](https://doi.org/10.1093/tbm/ibaa115).
- [12] A. J. Zarrabi, R. Huo, and D. E. Meier, "High-Value Palliative Care for Cancer Patients.," *AMA J. ethics*, vol. 17, no. 11, pp. 1064–1072, Nov. 2015, doi: [10.1001/journalofethics.2015.17.11.pfor3-1511](https://doi.org/10.1001/journalofethics.2015.17.11.pfor3-1511).
- [13] T. J. Brown, T. J. Smith, and A. Gupta, "Palliative Care.," *JAMA Oncol.*, vol. 5, no. 1, p. 126, Jan. 2019, doi: [10.1001/jamaoncol.2018.4962](https://doi.org/10.1001/jamaoncol.2018.4962).
- [14] S. P. Lingens, H. Schulz, and C. Bleich, "Evaluations of psychosocial cancer support services: A scoping review.," *PLoS One*, vol. 16, no. 5, p. e0251126, 2021, doi: [10.1371/journal.pone.0251126](https://doi.org/10.1371/journal.pone.0251126).
- [15] H. Irawati, Y. Afiyanti, and M. Sudaryo, "Effects of a support group to self efficacy of breast cancer patients that receiving chemotherapy," *J. Kedokt. dan Kesehat. Indones.*, vol. 10, pp. 246–254, Dec. 2019, doi: [10.20885/JKKI.Vol10.Iss3.art7](https://doi.org/10.20885/JKKI.Vol10.Iss3.art7).
- [16] N. Chong Guan, S. Mohamed, L. Kian Tiah, T. Kar Mun, A. H. Sulaiman, and N. Z. Zainal, "Psychotherapy for cancer patients.," *Int. J. Psychiatry Med.*, vol. 51, no. 5, pp. 414–430, Jul. 2016, doi: [10.1177/0091217416680197](https://doi.org/10.1177/0091217416680197).
- [17] A. L. Stanton, J. H. Rowland, and P. A. Ganz, "Life after diagnosis and treatment of cancer in adulthood: contributions from psychosocial oncology research.," *Am. Psychol.*, vol. 70, no. 2, pp. 159–174, 2015, doi: [10.1037/a0037875](https://doi.org/10.1037/a0037875).
- [18] R. Costas-Muñiz, O. Garduño-Ortega, N. Torres-Blasco, E. Castro-Figueroa, and

F. Gany, “‘Maintaining hope:’ challenges in counseling latino patients with advanced cancer,” *J. Psychosoc. Oncol. Res. Pract.*, vol. 2, no. 3, p. e028, Oct. 2020, doi: [10.1097/OR9.000000000000028](https://doi.org/10.1097/OR9.000000000000028).

[19] H. X. Fan Z, Lin J, Chen X, “Application of Palliative Care in Improving the Quality of Life of Patients with Cancer Pain,” *Open J. Nurs.*, vol. 7, no. 4, pp. 473–

480, 2017, doi: <https://doi.org/10.4236/ojn.2017.74036>.

[20] K. L. Quinn et al., “Association between palliative care and healthcare outcomes among adults with terminal non-cancer illness: population based matched cohort study,” *BMJ*, vol. 370, p. m2257, Jul. 2020, doi: [10.1136/bmj.m2257](https://doi.org/10.1136/bmj.m2257).