Health Communication

ISSN: 1041-0236 (Print) 1532-7027 (Online) Journal homepage: http://www.tandfonline.com/loi/hhth20

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**To cite this article:** Leah M. Omilion-Hodges & Nathan M. Swords (2016) Communication that heals: mindful communication practices from palliative care leaders, Health Communication, 31:3, 328-335, DOI: 10.1080/10410236.2014.953739

**To link to this article:** http://dx.doi.org/10.1080/10410236.2014.953739

Published online: 11 Sep 2015.

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HEALTH COMMUNICATION
2016, VOL. 31, NO. 3, 328–335
http://dx.doi.org/10.1080/10410236.2014.953739

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# Communication that heals: mindful communication practices from palliative care leaders

Leah M. Omilion-Hodges[a] and Nathan M. Swords[b]

[a]School of Communication Western Michigan University; [b]Department of Communication Studies University of Nebraska–Lincoln

**ABSTRACT**

Though research has begun to highlight the centrality of communication in palliative care, studies have yet to focus on the use of mindful communication. Mindful communication is associated with increases in patient care and decreases in physician burnout. Through in-depth, semi-structured interviews the authors sought mindful communication practices from palliative care leaders in American Hospital Association Circle of Life® award-wining units. Four key mindful communication practices emerged: Know your audience, ask questions, discard scripts, and recognize your role. The discussion articulates how key mindful communication practices may be used as a stage model, where key practices may be used individually or in concert, by sole practitioners or within interdisciplinary teams and by new and seasoned clinicians. Theoretical contributions and areas for future inquiry are also discussed.

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While the Accreditation Council for Graduate Medical Education emphasizes communication skills in three of its six general competencies and U.S. medical students are evaluated on these skills in their licensing exam (Accreditation Council for Graduate Medical Education, 2014), ineffective communication may still detract from or jeopardize patient care (Arthur et al., 2013) and may also lead to medicolegal vulnerability (Slocum-Gori, Hemsworth, Chan, Carson, & Kazanjian, 2013). However, adept physician communication improves patient decision making (Tulsky, 2005), increases patient satisfaction and self-management (Levinson, Lesser, & Epstein, 2010), and has been associated with increases in patient psychological functioning (Mahmood-Yousuf, Munday, King, & Dale, 2008). Communication ability may also temper physician burnout (Barth & Lannen, 2011) and assist in dealing with patient loss (Hebblewhite, 2014).

These findings are particularly important in palliative care (PC), as the medical specialty utilizes communication to provide holistic care (i.e., physical, social, psychological, spiritual, etc.) to seriously ill patients and their loved ones (Schut & Stroebe, 2005). Considering the extensiveness and impact of PC services, clinicians not only must be experienced in addressing physical and physiological needs (Gascoigne & Bourke, 2013), but also must demonstrate compassion through their words and actions (e.g., Slocum-Gori et al., 2013). Moreover, communication ability is especially crucial in PC due to the emotional work (Miller, 2007) of caring for seriously ill patients (e.g., Cherlin et al., 2005) and because of its reliance on interdisciplinary teamwork (Mahmood-Yousuf et al., 2008). However, yet to be investigated is how providers view and employ mindful communication within PC.

Mindful communication unites the idea of mindfulness (Langer & Moldoveanu, 2000)—a state characterized by keen situational awareness—with reflective, genuine, and adaptive communication (Burgoon, Berger, & Waldron, 2000). Communicating mindfully is an active process where sensemaking is continuous and participants remain attentive to the timing, nature, and context of the exchange. Additionally, mindful communication is associated with success in communicating across cultures (Ting-Toomey, 1999) and within groups (Gudykunst, 2004), promotes delegation among nurses, and leads to increases in patient safety (Anthony & Vidal, 2010) and decreases in stress and professional isolation among primary care physicians (Beckman et al., 2012). Thus, considering the need for successful communication and the emotional work required in the medical specialty, mindful communication may be a fruitful avenue for PC clinicians.

Exploring the role of mindful communication within palliative care extends the field by further highlighting the decisive role of communication within the health setting and through the parceling out of key practices for clinicians. In order to augment our understanding of mindful communication within this rapidly growing medical specialty (Eti, 2011), in-depth, semi-structured interviews were conducted with palliative care providers within units awarded an American Hospital Association Circle of Life designation. The Circle of Life award is designed to "change the way care is provided to the seriously ill" by "providing models from which the field can learn" (American Hospital Association, 2014). Thus, this study draws from the lived experiences (Lindlof & Taylor, 2010) of innovative palliative care providers to understand perceptions and uses of mindful communication. Moreover, there is a dearth of literature exploring PC clinicians' perspectives on their work, as research in this area

**CONTACT:** Leah M. Omilion-Hodges Leah.Omilion-Hodges@wmich.edu School of Communication, Western Michigan University, 1903 W. Michigan Ave. Kalamazoo MI 49008.

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is often collected through intervention-based studies (e.g., Beckman et al., 2012). Considering this, a substantive examination of the nature and role of mindful communication in these nationally recognized units yields (a) concrete communicative actions for PC clinicians from industry exemplars, (b) a nuanced understanding of how clinicians use mindful communication to meet the physical and psychosocial needs of patients and their families, and (c) insight on how the practice of mindful communication may also benefit providers.

## The emotional work of palliative care

Palliative care is patient-centered care, comfort, and support for individuals with chronic and terminal illness (Hughes & Smith, 2014) and is available to people at any age and at any state of illness (Agency for Healthcare Research, 2014). Often delivered by interdisciplinary health teams (i.e., physicians, nurses, social workers, dieticians, chaplains etc.), PC is also inclusive of patients' families and important others explicitly recognizing the stress that ensues when a loved one takes ill (Vedel et al., 2014). Relatedly, PC teams frequently serve as the first point of bereavement to a patient's family in the wake of their death (Cherlin et al., 2007).

Care plans, as opposed to treatment plans, are often used in the delivery of palliative care as a means to offer holistic care: caring for patients' physical, emotional, practical, and spiritual needs. Considering this, PC is frequently linked to a "good death" (e.g., Davis, 2009), suggesting that patients' end-of-life wishes are expressed and honored. This may include preferences for treatment and care plans and also the location of one's passing (Wittenberg-Lyles, 2006). In sum, PC is an expansive medical specialty in that clinical care teams endeavor to care for the whole person (not just a disease), meet patients' physical and psychosocial concerns, and view patients' families as legitimate stakeholders. In light of the scope and nature of PC, providers perform emotional work and are susceptible to compassion fatigue and burnout (Carduff et al., 2014).

In and of itself, the practice and delivery of PC is emotional work (Miller, 2002, 2007). The medical specialty is emotional in nature and involves providers experiencing and demonstrating authentic emotional reactions during interactions with patients (Miller, 2007). Moreover, PC requires job-related emotional work in that clinicians are expected to be demonstrative when engaging with patients and their families. Examples include the delivery of a terminal diagnosis or participation in defining conversations such as when to cease curative treatment (Brown & Bylund, 2008). Other instances of emotional work that are job related may include mediating a patient and loved one's wishes (Feudtner, 2007), assisting in the medical decision-making process (Epstein, 1999), and proving comfort to seriously ill patients and their families (Cherlin et al., 2007). Additionally, social norms dictate that clinicians suppress their feelings in the immediate aftermath of a patient's passing until they are in a nonwork or private setting (Hebblewhite, 2014). Thus, over and above emotion related to the role itself, PC providers engage in individual emotional work as a means to address and regulate their personal feelings (Brotheridge & Grandey, 2002). These feelings may be positive and or negative in nature, where emotional work encompasses myriad reactions from joy to despair.

Specific examination of PC communication needs and challenges yields insight into occurrences that may prompt job and personal emotional reactions. Expert communication skills are crucial, considering that PC providers must engage in audience analysis and in relationship development and maintenance, and initiate conversations regarding physical pain, the meaning of death, family dynamics, last requests, unfinished business, and more (e.g., Sanchez-Reilly, Wittenberg-Lyles, & Villagran, 2007). Family dynamics and competing wishes are additional communication demands placed on care providers (Vedel et al., 2014). Conversations such as these have the propensity to make providers uncertain regarding their role (Considine & Miller, 2010), whereas some clinicians may actively evade frank conversations as some "are afraid that talking about death beckons it" (Kuhl, 2002, p. xv). Relatedly, some patients may also prefer to avoid talking about their illness (Curtis, Patrick, Caldwell, & Collier, 2000). Taken together, palliative care is emotional work that rests on the skillful use of communication; however, communication encounters are ready sites for encountering job- and individual-related emotions. Therefore, while PC centers on communication, the actual act of communicating may result in difficulties for both patients and providers, accentuating the importance of considering alternative approaches that may offer benefits for all.

## Mindful communication

Mindful individuals are those who are self-reflective, nonjudgemental, and purposive. Clinicians practicing mindful communication have the ability to observe patients' reactions while also observing their own personal reactions (Epstein, 1999). Mindfulness is promoted through reflection and a heightened state of involvement and engagement and can positively impact health and well-being (e.g., Kasser & Sheldon, 2009). Mindfulness is most often expressed through the thoughtful and intentional use of verbal and nonverbal communication (Anthony & Vidal, 2010).

A burgeoning body of medical research has begun to explore how the practice of mindfulness and mindful communication may spur positive outcomes (e.g., Anthony & Vidal, 2010). In seminal work, Epstein (1999) introduced the benefits of practicing self-awareness and critical self-reflection, specifically demonstrating how mindfulness could accentuate the application of professional knowledge. While Epstein focused on the positive outcomes of mindfulness for practitioners, he also shared an example of how the use of mindful communication could be harnessed to benefit patients.

More recent applications of mindfulness and mindful communication in the clinical setting have continued to reiterate explicit and implicit advantages for both the caregiver and the cared for. Krasner and colleagues (2009) designed a mindful communication seminar to explore how self-reflective and intentional techniques would influence primary care providers' attitudes and propensities to experience burnout. As expected, physicians reported immediate and sustained decreases in emotional exhaustion and depersonalization (Krasner et al., 2009). Similarly, Beckman et al. (2012)

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continued the examination of mindful communication within primary care physicians, noting that those who partook in a mindfulness course reported increased attentiveness and listening ability with patients, decreases in professional isolation, and overall increases in well-being. Anthony and Vidal (2010) found that nurse use of mindful communication improved peer relationships and the exchange of more accurate and relevant information, which led to better decision making and ultimately, increases in patient safety.

In sum, the practice of mindfulness and, more specifically, mindful communication can increase clinician well-being, decrease depersonalization, promote sound decision making, and improve patient safety and care. Review of mindful communication benefits in the clinical setting suggests it may be an efficacious tool for palliative care providers to regulate the emotional work of caring for the terminally ill, while also equipping clinicians to navigate the plethora of communication demands. To that end, the following research question is forwarded:

RQ1: How do clinicians view and employ mindful communication within palliative care?

## Method

Through in-depth, semistructured interviews with 24 palliative care clinicians who have been recognized for their innovation in and dedication to palliative care with a Circle of Life award (American Hospital Association, 2014), the authors gathered data concerning clinician perceptions and uses of mindful communication practices. In line with other palliative care studies exploring clinicians' perspectives on their work (e.g., Luker, Austin, Caress, & Hallett, 2000), an adaptation of the critical incident technique (Norman, Redfern, Tomalin, & Oliver, 1992) was employed. More specifically, participants were asked to recall occasions when they displayed mindful communication in the health care setting with patients, families, and peers. Participants were also asked how they employed the practice of mindful communication for their own benefit in the work setting, allowing participants to consider how they used the technique to help both themselves and others. Respondents were prompted to discuss the reasons why they defined these particular incidents as mindful communication as opposed to simply communication or self-reflection. Follow-up questions were guided by Brown and Ryan's (2003) mindful awareness attention scale. Items were altered to open-ended questions contextualized to patient care. Two sample follow-up questions included "Can you describe some techniques that you use to stay focused on the present while at work?" and "Can you explain some strategies that you use to keep yourself from becoming preoccupied with previous cases or difficult situations while at work?" All questions were asked in regard to patients and their families, peers, and, if applicable, in relation to the providers themselves.

### *Participants and procedure*

Upon securing approval from the institutional review board, 24 individual semistructured telephone interviews were conducted. Interviews were audiotaped and transcribed and lasted between 50 and 75 minutes. Of the participants, 22 were currently practicing palliative care physicians and two were nurse practitioners who held leadership roles within the care unit. Males composed approximately 60% ($n$ = 14) of the sample (females, $n$ = 10), where participants were 53 years old on average. Interestingly, virtually all participants ($n$ = 22) identified as Caucasian, where two participants identified as Black/African-American. Participants worked in palliative care for an average of 18 years ($M$ = 17.56), where tenure ranged from 5 to 35 years.

Participants were selected at random from a complete list of winners and honorees since the commencement of the award. The first author sent e-mail invitations to 35 recognized Circle of Life organizations, where 24 clinicians agreed to participate in the study, resulting in nearly a 70% response rate. Of the 24 organizations represented, 19 were faith-based and all have been designated as Circle of Life Winners or received a Citation of Honor. Receipt of the Circle of Life Award privileges awardees increased opportunity to secure grants and to educate the community, but also demonstrates the program's credibility and devotion to new innovations that may aid in the development or improvement of other PC programs. To that end, participants are innovators in the medical discipline and have been recognized for their contribution to society.

## Analysis

Data were analyzed following the steps of grounded theory research and constant comparative analysis (Strauss & Corbin, 1998). One thousand eight hundred minutes of interview data were transcribed and read in their entirety before being reread and coded for mindful communication practices. In rereading the transcripts, relevant portions of the text were highlighted indicating representative comments. Data were categorized in conceptual theories in an interactive, inductive process, where Strauss and Corbin's procedures for theoretic sensitivity were employed, including questioning and member checks. Moreover, in review of the data the authors reviewed critical incidents and follow-up responses for the presence of selection, active sensemaking, and consideration of multiple perspectives (Burgoon et al., 2000). Corroborating other studies on mindfulness (e.g., Burgoon et al; King & Sawyer, 1998), the authors inspected the data for examples that demonstrated a "willful, conscious process" where participants actively examined and reflected on the situation and carefully selected communicative and behavioral responses (King & Sawyer, 1998, p. 326). Similarly, Krieger's communication categories of shared mindfulness were also employed during analysis to ensure that best practices were in fact examples of mindful communication rather than simply instances of effective communication or self-reflection. Lastly, Owen's (1984) criteria for identifying prevalent themes were utilized. To that end, the authors examined the data for instances of recurrence, repetition, and forcefulness over several meetings to develop inductive categories for the communication practices.

## Findings

Four key practices emerged that center on clinician perceptions of mindful communication on the delivery of PC. Each

key practice highlights how the specific use of mindful communication benefits both patients and providers. Each communication practice was endorsed by a minimum of 80% ($n$ = 20) of participants.

### Key practice: Consider your audience(s)

While audience analysis is taught on the first day of an introductory communication class, as years in the profession mount or as a new clinician with anxieties, it is easy to forget the importance of considering your audience before prescribing a care plan.

> When I first started out, I thought that I knew best. I'd walk up to a patient, I'd already reviewed their chart, and I thought I knew them. I went on like this until my mentor told me, "It's not about you. It's about them. You never even considered how they feel. . . . Just be there with them." It was humbling and at the time, humiliating and infuriating, but the single most important piece of advice I've ever received. It's also the first lesson I teach new residents.

Jennifer, a 63-year-old former practicing palliative care physician and current chief executive officer (CEO) of a hospice and palliative care facility, suggested that a central component of knowing your audience includes considering the tremendous amount of uncertainty and anxiety patients shoulder. Jennifer continued by acknowledging that "we signed up for this, and we know what it's [the dying process] like, but it's vital that we don't take that for granted when interacting with those we serve." Thus, while hospital personnel become acculturated with the daily realities of working in PC (Matsumura et al., 2002), the audience (i.e., patients, families) is likely to be not only less comfortable, but downright anxiety-ridden (McKechnie, MacLeod, & Keeling, 2007).

As a solution, Donald, a registered nurse in a Southern pediatric palliative care program, suggested that he often puts himself in the shoes of his patients and their family members. Admitting that his ability to empathize was both his "strongest trait" and his "kryptonite," Donald acknowledged that he feels most present in patient interactions when he "taps into the shared space" in terms of identifying and embracing the emotions of his patients. When asked how he detects his patients' emotional state, Donald suggested that often he poses questions to himself such as "What would I need?," "How would I feel?," and "What questions would I have?" By reflecting on these questions, palliative care clinicians are provided with a starting point for understanding and empathizing with the audience and a means for learning how to communicate with them in subsequent interactions.

### Key practice: ask questions. listen. repeat

"She asked me to lean in, she looked me in the eye, held my arm and said, 'I appreciate your asking, but I'm most grateful that you listened,'" recounted a 56-year-old palliative care physician from an expansive hospital system located on the East Coast. "It was then that I realized that as much as I am a physician, I am also a communicator. I couldn't, we [the unit] couldn't, provide care like this without being mindful and intentional with our communication."

While there is no "cookie-cutter" approach to navigating end-of-life conversations (Considine & Miller, 2010, p. 173), physicians can increase patient engagement and initiate rapport building simply by asking questions and by remaining engaged in patient interactions. For example, Bill, a hospice and palliative care physician and medical director of a 450-bed facility located in the Midwest, suggested:

> The first thing I teach new residents is mindfulness and intention. I tell them to be authentic even if they are authentically awkward or shy or quiet. Whatever it is, as long as it is them and they are fully present in the conversation.

Bill then expounded on this key practice by likening authenticity to a "relational slingshot," suggesting that in his 35 years of experience, when he interacted with patients as his authentic self, he more quickly developed rapport and "mutual and trusting relationships" with them. Bill and 18 other participants all acknowledged that initial meetings with patients and their families should not commence with a medical history or even inquiries about palliative care goals. Instead, it is recommended that physicians should ask patients about themselves, inquiring about their likes or their dislikes, even their favorite sports team, movie, or hobby. Such innocuous questions build connections and can establish a baseline for the physician to begin to understand the patient personally, allowing the clinician to tailor communication in a manner that behooves the patient.

Linda, a 49-year-old palliative care physician from a large West Coast health system, acknowledged that she "scrutinizes" initial patient responses to learn how to best communicate with them. Linda suggested that if a patient replies matter-of-factly to a series of questions, she may infer that a patient prefers a straightforward communicative approach. But if a patient responds to her inquiries with jokes or in a jovial manner, then she is likely to use humor as "we walk this path together." It is important to note that nearly half of the study's participants acknowledged that clinicians should never underestimate the power of utilizing a simple direct request: "Do you enjoy humor?" "What can I do to communicate most effectively with you?" "How would you like me to communicate with your family?"

Participants also acknowledged that the crux of this mindful communication practice lies in the sincerity of the inquiry and in the genuine demonstration of listening behavior. Ken, the youngest participant at 36 years of age, reiterated that "Even though it can be tempting to multi-task when rounding, we [palliative care physicians] can do a lot of damage if the patient thinks we're more interested in the computer or our PDA." Therefore, should the patient perceive that the clinician is merely regurgitating a list of suggested ice-breaker questions or that he or she is more interested in the electronic medical record or other devices, this key practice will fall short.

### Key practice: discard scripts

"We call them courageous conversations. They're not easy, but they are crucial to what we do, to the care that we provide," explained a Jim, a physician from a 530-bed hospital within a national health care system. He continued, "We encourage our physicians to run to conflict, not away from it, so we even provide 'bad death stories' so they can learn. But

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we never provide a script. Even if it's not perfect, people can tell they're trying."

Though scripts can help train new clinicians or those who experience heightened levels of anxiety when conveying bad news, it is not recommended that a care provider attempt to memorize a narrative. Without exception, every participant suggested that while his or her organization or health system employed standard tools (e.g., shadowing, role playing, case studies, etc.), the participant would never encourage a peer to utilize a blanket statement with every patient. "It's messy, it's sad, it's a heartbreakingly real time for our patients," remarked Faith, a director of palliative care at a Southern faith-based hospital. "We can't appear, even for a moment, that we don't care, that we're not standing right there beside them."

Reflection on the initial audience analysis and subsequent communication exchanges may help specify how a palliative care clinician initiates and engages in conversation with a patient and his or her family. Moreover, while it is likely that the care provider experiences discomfort in these situations, considering his or her audience(s) means that the needs and expectations of the patient are paramount. Thus, while a script may help a clinician to feel more at ease, he or she should remember that in that moment, the audience comes first and expects and deserves authenticity. In this vein, several participants acknowledged that specific moments call for them to be a "person" before a "medical provider," such as at the time of delivering a terminal prognosis. In these encounters, some participants acknowledged feeling "whole" when they were able to honestly express or display their own emotions, such as genuine disappointment and sadness when a patient exhausts treatment plans or when patients incur other difficulties. For example, John, a palliative care provider in a faith-based health system shared the following:

> I feel much closer to my patient and fuller as a person when they expresses their frustration, disappointment or fear and I'm able to look them in the eye and tell them "I'm scared too or I'm sad too." They know that I'm there with them and I'm honoring myself too instead of pretending it's all okay or business as usual.

### *Key practice: recognize your role*

"Whether you like it or not, or whether you're conscious of it or not, you're part of their [the patient and their family's] story," revealed Lynn, the medical director of a palliative care unit in a large faith-based national system. The notion of the palliative care team as an integral partner in a patient's treatment was a resounding theme. Moreover, terms such as ally, teammate, friend, counselor, and collaborator were used repeatedly in describing the relationship of the PC clinician, the patient, and the patient's family.

This final key communication practice blends each of the previous: Consider your audience(s), ask questions, listen, repeat, and discard the scripts. Hospitals or long-term care facilities are virtually never frequented by choice. So while PC clinicians are committed to serving in this regard and assimilate to the profession and to a particular organization, patients involuntarily find themselves in these locations. Therefore, what is a routine day for a clinician is likely to be one that family members of a patient do not forget. The death and dying process is "a chapter in any individual's story," as one participant remarked. While 17 participants explicitly acknowledged that increased needs of financial and human resources and time devoted to educating others about the ethical obligation of palliative care were key stressors that could detract from their practice of mindful communication, Lynn shared a perspective to remain mindful at work. She suggested that as clinicians complete their professional tasks, they never forget that they are simultaneously "a main character" in a patient's story and the patient's family's life.

Several participants revealed that they follow a routine before beginning a shift that helped to put them in the "right" mind set. One participant affixed a three-by-five card to his rearview mirror that reads "I serve body, mind and spirit," serving as a reminder to treat the whole patient, not only his or her physical needs. Another participant wears a religious pin on her lab coat that she holds between her thumb and forefinger in trying moments as a means to stay "in the present and attend fully to the patient." Journaling or blogging was another mindful practice that several participants expressed partaking in, where 13 of the 18 participants who maintain a journal or a blog routinely end each shift with an entry as a means of "reflecting on the sanctity of my job," "to process the emotions of the day," and to "ensure that I'm always learning." Nearly as prevalent as journaling, more than half of the participants acknowledged that they either began or ended their shifts with meditation to ensure that they were intentional, mindful, present, and/or completely engaged while caring for patients, and then also took the time to reflect on the day and address their emotions after shifts. Each of these mindful routines positions PC providers to deliver exemplary care, but also "helps keep our heads on straight" and "reminds us why we do this [PC]," reiterating that use of mindful communication is not only fundamental in the delivery of patient care, but also in provider well-being.

## Discussion

Palliative care is a cutting-edge sector of health care (Eti, 2011) at a pivotal position where attention to mindful communication practices is warranted. Establishing practices at present that revolve around mindful communication will better prepare palliative care providers for the demand that lies ahead, such as the aging baby-boomer generation (King, Matheson, Chirina, Shankar, & Broman-Fulks, 2013; U.S. Bureau of the Census, 2006) and in helping to protect clinicians from the burnout of the emotional work (Beckman et al., 2012) associated with the medical specialty. The emergence of key mindful communication practices may also be particularly well-timed because of the current and anticipated future shortage of PC physicians, suggesting that clinicians may endure yet another source of job-related stress (Lupu, 2010).

The data demonstrate award-wining clinicians' perceptions of the vast benefits of mindful communication in the palliative care medical specialty. This research answers calls to design palliative care research that increases knowledge surrounding the efficacious use of communication (e.g., Considine & Miller, 2010) and centers on the needs of patients (Arthur et al., 2013). Similarly, the data corroborate extant scholarship (e.g., Beckman et al., 2012) reiterating that in attending fully

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to messages and engaging in thoughtful contemplation during verbal and nonverbal responses, clinicians' sense of meaning with their work is enhanced. Moreover, this scholarship takes the unique approach of exploring clinicians' perceptions of their work, rather than a quantitative or other intervention-based study. Pragmatic and theoretical implications are parceled out and couched within extant literature.

### Practical implications

The key mindful communication practices were garnered from discipline exemplars and may provide foundational communication training to new palliative care professionals or serve as a reminder for more established practitioners. Those new to palliative care or those who experience anxiety in broaching difficult conversations may look at the key practices as a sequential guide for developing rapport with and meeting the needs of the patient. Even seasoned providers can struggle with end-of-life care conversations with patients and their families (Lo et al., 1999); thus, experienced clinicians may wish to keep these practices as a reference to supplement their own negotiated and successful communication repertoire. Regardless, a clinician could remind him- or herself to (a) get to know the audience, (b) ask questions and listen, and (c) discard any predefined scripts to instead focus on mindful, authentic communication, while (d) remaining cognizant of the role that the clinician plays in each patient's life. Moreover, caregivers may not move through each key practice in succession, and may spend more time on a certain phase while bypassing others, remaining mindful of the relational dynamics at play.

Group settings as well as interdisciplinary contexts can benefit tremendously from the key practices. This is important for a number of reasons. First, teamwork is a central component of palliative care (Jünger, Pestinger, Elsner, Krumm, & Radbruch, 2007), and second, conversation about individual patients promotes not only increases in patient care, but also increases in collegial relationships (Barth & Lannen, 2011). In conjunction with the key practices, palliative care units could hold training sessions or team huddles at the beginning and conclusion of shifts where members can dialogue about patients' physical and communicative needs. Palliative care units may also create communication files or add a component to the electronic medical record (EMR) system where providers can note patient communication likes/dislikes. Not only would these sources of information be valuable for palliative care professionals to prepare and improve their communicative behaviors with patients, but these could also serve as a constant team reminder of the sanctity of the job.

### Theoretical implications

Theoretically, this study corroborates recent others (e.g., Anthony & Vidal, 2010; Beckman et al., 2012; Krasner et al., 2009) in demonstrating the utility of mindfulness and mindful communication (Langer & Moldoveanu, 2000). In addition to demonstrating the usefulness of mindful communication in a medical specialty that has enjoyed a marked growth—hospitals with a PC team have increased 138% from 2000 to 2009 (Palliative care, Eti, 2011)—the results open up additional doors for communication-centered research.

The constant and nonjudgmental sensemaking that defines mindful communication (Burgoon et al., 2000) makes a ready partner for other areas of communication such as compassion and empathy (Way & Tracy, 2012). That said, demonstrating empathy through compassionate communication may be a useful vehicle for audience analysis (Miller, 2007). Miller (2007) posits that compassionate communication is composed of noticing, connecting and responding, whereas Way and Tracy (2012) underscore the importance of context, suggesting that compassionate communication concerns both what is exchanged and what is withheld, substantive relations, and intentional behaviors (communicative and otherwise) that can be seen as compassionate by all interactants. Taken together, compassionate communication rests on purposeful, sincere and empathic nonverbal and verbal exchanges that oscillate around astute audience analysis (Miller; Way & Tracy), corroborating the key communication practices that emerged.

Similarly, as the data demonstrate, mindful communication can be a useful tool for those who engage in emotional work offering tangible tools to assuage the real and frequent hardships associated with certain professions. In particular, the fourth key practice centers around personal approaches to mindful communication that helped to remind clinicians of the "profound honor" of their work. In recalling the basic mission of palliative care, providers are likely to be better poised to serve as a positive, heroic main character in a patient's story, rather than one perceived by the patient or their family to be more concerned with administrative tasks or organizational politics (Madsen & Uhrenfeldt, 2014) of health care.

### Limitations and future research

While this study offers numerous theoretical and pragmatic findings, it is not without limitations. Data were purposively collected from palliative care leaders as a means to offer key practices; however, in doing so the communication practices may not currently be used widely within the medical specialty. Moreover, clinicians in award-winning units were chosen because of the recognition they earned for exemplary care. In this regard, the practices that emerged were from the provider perspective, where participants relayed their encounters with patients, often parlaying the patient's words verbatim. Again, while this was a conscious choice in order to establish a theoretical foundation for mindful communication in palliative care, it privileges the physician perspective. Subsequent studies should also include patients and their important others to explore these perspectives directly.

In terms of future research, there are numerous avenues for scholars to explore. While this particular study sought to capture the rich lived experience of palliative care providers through in-depth qualitative interviews, future researchers could conduct observations or administer a quantitative survey to further measure mindful communication. Scholars may also explore factors that may either facilitate or impede the practice of mindful communication such as time pressures, repetition, or the degree of familiarity with the patient and or

family. While the current study asked palliative care providers how they practiced mindful communication going forward, researchers may seek to teach patients and families basic principles of mindful communication.

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