COMMENTARY

The Healing Hand: The Essential Role of Nurses in Palliative Cancer Care

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ABSTRACT

Palliative care is the mainstay treatment paradigm among patients with advanced cancer, with its focus on symptom relief, dignity, and quality of life when the possibility of cure has ended. As the most visible members of the palliative multidisciplinary care team, nurses play a pivotal role in biophysical, psychosocial, spiritual, and ethical interventions. This commentary explores the role of palliative nursing in a case study grounded in clinical practice, with particular emphasis on evidence-based symptom management practices, ethical considerations in prognosis disclosure, and targeted nursing interventions to promote patient-centered end-of-life care.

Keywords: *Palliative nursing, end-stage cancer, symptom management, patient autonomy, multimodal analgesia, spiritual care, ethical decision-making.*

INTRODUCTION

When the prospect of a cure is lost, the priorities of cancer care transform to focus on comfort, preservation of function, and quality of life [1]. Palliative care meets this need by adopting a multi-dimensional model of care to reduce suffering (physical, emotional, and spiritual) [2]. Among all professions involved in palliative care, nurses are the direct providers of care who are by far the most present at the bedside and play a pivotal role in symptom assessment and mitigation, therapeutic communication, and the development of therapeutic rapport [3]. Specialist palliative nursing has been rigorously shown to improve quality of life and reduce avoidable acute care visits [4].

The challenges are considerable. Palliative nurses navigate the challenges of managing intractable physical symptoms simultaneously, the intricacies of emotional turmoil, and the ethical complexities of autonomy and disclosure [5]. Clinical communication is central to this effort as patients commonly communicate their concerns about untreated pain and loss of autonomy—concerns that demand competency and compassion simultaneously [6]. It is through the juggling of these responsibilities that nursing practice impacts the moment this commentary describes as taking people from pain to peace.

SCENARIO: ETHICS OF THE ADVANCED MALIGNANCY

A 68-year-old woman with metastatic breast cancer, a history of cerebrovascular accident, and poorly controlled type 2 diabetes mellitus was being cared for palliatively. The medical team had been instructed at the request of the family not to disclose the full prognosis for fear of upsetting her. As time went on and her condition worsened, she became increasingly agitated, asking the nursing team point-blank about her prognosis. When later informed, she indicated her care choices would have been different had she been so informed earlier. Her progress was further complicated by the development of chemotherapy-related sepsis, leading to ICU admission—where decisions no longer mattered.

This case highlights, in palliative oncology, a conflict not uncommon between autonomy and protectiveness, even so-called "familism." The available evidence, mostly derived from studies of adult cancer patients, shows that most prefer to receive honest information about their prognoses and, when delivered correctly, disclosure does not lead to patients' psychological implosion but adaptive coping and patient autonomy in decision-making [5]. Nurses are patient advocates within the multidisciplinary team, speaking out about infringements of autonomy and practicing graduated, compassionate disclosure: roles that might be "deviant" forms of harm if they are not delivered [3].

PHYSICAL SYMPTOM MANAGEMENT

Pain Management: More than 70% of advanced cancer patients experience uncontrolled pain, and pain is cited as the "dominant" quality-of-life symptom [1]. Palliative nurses administer the World Health Organization analgesic ladder under the direction of the prescribing clinician and have primary nursing accountability for patient-specific pain management, opioid side-effect surveillance, and patient education [1, 2]. Importantly, exclusive opioid pharmacotherapy has proven clinically ineffective and entails established risks of tolerance,

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dependence, and opioid-induced hyperalgesia—risks that are not eradicated by palliative care. Multimodal models that incorporate adjunctive interventions such as therapeutic massage, acupuncture, and transcutaneous electrical nerve stimulation have shown effectiveness in decreasing the opioid workload while addressing the emotional components of pain not addressed by pharmacotherapy [7].

Dyspnea, Fatigue, and Gastrointestinal Symptoms: Management of dyspnea requires opioid and anxiolytic relief measures, optimization of body position, and—when research demonstrates positive effects—handheld fan therapy. Fatigue, which affects most patients with advanced cancer, is treated with energy-conservation strategies, nutrition maximization, and tailored physical activity [8]. Gastrointestinal issues, such as nausea and emesis, alongside opioid-induced pagination, also must be managed by the nurse, in anticipation, rather than reactively; preventive bowel care, commenced concurrently with opioid administration, is one such example of an anticipatory nursing assessment, with profound implications for the patient's comfort level [2].

PSYCHOSOCIAL AND SPIRITUAL CARE

Emotional Support: Existential distress—fear of death, loss of meaning, and anticipatory grief—impacts large numbers of palliative care patients, regardless of psychiatric illness [9]. Nursing management is based on specific, evidence-based communication skills: non-reassuring active listening, open-ended questioning, and emotional validation—the non-judgmental acceptance of the patient's affective experience as real—independently reduce distress at the end of life [9]. Evidence-based protocols like Dignity Therapy, which encourage patients to identify sources of meaning and create a legacy document, are another tool in the nurse's arsenal, provided they have suitable training. For interventions outside the nursing scope, referrals to clinical psychology and/or specialist palliative counselors are an important nursing responsibility.

Spiritual Care: Spiritual quality of life is an empirically separable construct at the end of life, and unmet spiritual needs are associated with greater distress and a preference for more intensive life-prolonging measures [10]. Spiritual care encompasses more than the facilitation of religious practice: for growing numbers of patients with no formal association with religious practice, evidence-based secular approaches such as life review, legacy building, and mindfulness-based practice help reduce anxiety and promote acceptance [9, 10]. Nurses are well placed to deliver or facilitate these across the entire range of religious and secular orientations.

ETHICAL CONSIDERATIONS

The practice of nursing at the end of life is regulated by the simultaneous application of four bioethical principles—autonomy, beneficence, nonmaleficence, and justice—whose application often raises dilemmas. Autonomy requires disclosure of prognoses to patients who request it; the principle of beneficence, which historically has been invoked to justify the practice of withholding, is seriously compromised by the finding that effective prognostication does not create psychological harm [5]. Non-maleficence not only excludes the iatrogenic causation of harm, but also the suffering caused by poor symptom control, ethically incongruent communication, and withholding information that enables decision-making. Justice requires fair care regardless of culture, while also respecting patient preferences despite cultural differences. Nurses operationalize these principles through advocacy and culturally sensitive communication, while engaging in frank interdisciplinary, multi-professional team communication, balancing the truth and wish-list with clinical and moral integrity [3].

CONCLUSION

Palliative nursing is a dynamic, evidence-based discipline that plays an invaluable role in care for end-stage cancer. Multimodal symptom management, tailored psychosocial communication, spirituality-sensitive care, and ethical decision-making—all within a patient- and family-centered, interdisciplinary context—are the hallmarks of the practice to which our profession aspires. By carrying out these roles competently and compassionately, nurses not only care for the dying process; they also maintain the values of personhood and dignity for patients and guide them, as this commentary's title states, from pain to peace.

CONFLICT OF INTEREST

The author declare no conflict of interest.

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