Lessons on caring: wisdom from patients who changed us

Rachel Rusch,[1] Gitanjli Arora,[2] Akilah Burford,[3] Ira Byock,[4] Heather Bemis,[5] Heather Coats,[6] Paul Galchutt,[7] Tamryn Fowler,[8] Richard E Leiter,[9,10] Tricia Mamer,[11] Jared Rubenstein,[12,13] William E Rosa ,[14] Allison Silverstein [1]

For numbered affiliations see end of article.

Correspondence to
Dr Allison Silverstein; allison.silverstein@childrenscolorado.org

Received 10 July 2026
Accepted 17 July 2026

ABSTRACT

In the sacred spaces of serious illness, dying and bereavement, patients and families are our greatest teachers. In this feature, we reflect on lessons drawn from years of work in palliative medicine, integrating bedside experiences, practical guidance and narrative reflections to illuminate how, by serving others, we too are changed. The lessons are additionally grounded in literature stemming from clinical experience and interprofessional scholarship. This report foregrounds lived experience as a source of clinical knowledge, encouraging human-centred practice. Offered with gratitude to the patients and families who entrust us with their stories, this report is intended as both a reflective guide and a teaching tool for clinicians seeking to practise with greater humility, presence and intention.

WHAT WAS ALREADY KNOWN?

⇒ Patients and families are powerful teachers in serious illness.
⇒ Lived experience complements traditional clinical knowledge.

WHAT ARE THE NEW FINDINGS?

⇒ Lessons from bedside experience and scholarship are synthesised into practical guidance.
⇒ Narrative reflection is presented as a tool for developing human-centred practice.

WHAT IS THEIR SIGNIFICANCE?

⇒ Encourages more intentional, humble, and relationship-centred care.
⇒ Supports integrating experiential knowledge into clinician education and future scholarship.

INTRODUCTION

In the most sacred and intimate spaces of illness, loss and healing, patients and families have been our greatest teachers. Through their words, their choices and their multi-faceted expressions of courage, they reveal truths no textbook can offer. Here we present distilled lessons that have profoundly shaped how we understand suffering, resilience, love and the role of presence in clinical care.

Each lesson begins with practical guidance, followed by a brief reflection from the co-authors that situates its relevance for clinical care and calls us to action. From the fierce resolve of a mother honouring her daughter's legacy to the laughter shared between a young patient and a night nurse, these stories inspire us to listen more deeply, care more intentionally and recognise that through walking alongside others, we ourselves are changed.

These lessons also represent reminders: that grief has no predefined pathway; that hope can coexist with hard truths; that laughter can fill the room alongside sorrow and that saying "yes" to the most unexpected moments can alter everything, for patients, families and clinicians alike. These teachings ask us not to rank suffering or assume we can fix all hurts, but instead to witness, serve and remember that our presence, however ordinary it may feel, can leave an extraordinary impact.

We offer these insights with humility and abiding gratitude to the patients and families who have entrusted us with their stories. May these lessons guide us toward a practice of care rooted in purpose, reverence and intention. We encourage readers to return to them often, as personal reminders and as teaching tools for trainees and colleagues just beginning their journey in medicine.

* The names and identifying details in this work have been changed to protect

Check for updates

© Author(s) (or their employer(s)) 2026. No commercial re-use. See rights and permissions. Published by BMJ Group.

To cite: Rusch R, Arora G, Burford A, *et al*. *BMJ Supportive & Palliative Care* Epub ahead of print: [please include Day Month Year]. doi:10.1136/spcare-2026-006534

BMJ Support Palliat Care: first published as 10.1136/spcare-2026-006534 on 30 July 2026. Downloaded from http://spcare.bmj.com/ on October 28, 2026 at Duke University Medical Center Library . Protected by copyright, including for uses related to text and data mining, AI training, and similar technologies.

privacy. Any names used are pseudonyms, and certain characteristics or circumstances have been modified to preserve confidentiality while maintaining the integrity of the narratives.

There is no hierarchy of suffering

Regardless of the objective circumstances or characteristics of a case, each patient and family response remains relative and valid.

> Sitting with families in their grief repeatedly shows us: there is no singular form or definition of suffering. Experiences of pain, stress, relief, and comfort are highly contextualized and kaleidoscopic. While healthcare systems may acculturate us to focus on those with the most apparent markers of physical need, our skills and compassion are often most critical where prognostic clarity and access to support are limited.[1] Ambiguous losses—losses other than death that elicit profound grief[2]—are abundant across medical journeys and can be strongly informed by the way clinicians interact with patients and families on an interpersonal level.[3] We must continually strive to ground our care in non-judgement and compassion, meeting each individual and family system with respect to their unique lived experience. In practice, this can take the form of continued professional education regarding implicit bias, availing ourselves to the support and insight of our ethicist colleagues, and creating system-led opportunities for enhancing trauma-informed care, processing moral distress, and engaging in self-reflection. In doing so, we not only move closer to true person-centered care, but also begin to deepen our collective ability to bear witness to various forms of suffering over time.
>
> *A clinician in the neonatal intensive care unit said to a mother of an infant born at 34-weeks, "He's just a 'feeder and grower'—there's no need to be so anxious." The mother politely nodded, the clinician left, and she turned to me, her hospital assigned Psychologist, with hurt bewilderment: "My newborn is in the ICU, right?" That moment reminded me that each person is inhabiting a unique lived experience that should be supported with curiosity and without presumption. A comment intended to provide reassurance can be experienced as invalidating or dismissive if the family perspective is not adequately acknowledged. I've additionally witnessed families, even in the depths of despair, find solace, comfort, and joy in the most unexpected of places. Singing songs in the moments before death, commenting on the nature of the light through a window shortly after news of relapse, or reaching for a hand as the greatest balm to pain. These experiences have reinforced that the concept of suffering is not universally defined, that each response is valid, and that bearing witness with compassion and presence is often the most meaningful support we can provide.*

Grief doesn't follow protocol

In the face of devastating loss, people may seek partnership with their healthcare team to preserve legacy, connection and meaning.

> Grief resists checklists, timelines, and expectations, although our healthcare systems may demand otherwise. In the face of profound loss, striving to fix what cannot be fixed matters less than showing up, bearing witness, and holding space for grief to unfold. In these moments of powerlessness, even the smallest acts—routines, rituals, or gestures of care—can become powerful expressions of love and agency. In hospital settings, this may include honoring different responses to death, including whether families wish to participate in postmortem rituals at bedside. Some families find comfort in end-of-life ceremonies or in gentle suggestions from experienced clinicians for support, empowerment, and permission as they navigate grief. Such opportunities for partnership are rarely about clinical necessity; they are about shaping how loss is experienced and remembered in bereavement. For clinicians, such moments call us to lead with curiosity and connection rather than control. Grief is deeply personal, but the need for meaning and human presence is universal and honoring that need may be one of the most healing things we can offer.[4] Even when we cannot change the outcome, we can shape how families experience the moment and how it is remembered.
>
> *I was the oncology nurse at change of shift when a young adult patient on our service died after a prolonged treatment course. Moments after her death, her mother quietly requested, "She died, but I want my daughter assigned to a nurse tonight." The request wasn't about clinical need—it was about love, care, and holding onto meaning amid unimaginable loss. As a new nurse, that moment shattered my assumptions about how grief should look. It taught me that honoring someone's humanity doesn't end with death, and that sometimes the smallest rituals become our fiercest acts of love.*

Love begs to be spoken into our communities – now and with intention

Love may be received by others with varying levels of sorrow, joy, appreciation, gratitude and acceptance.

> Love demands to be spoken aloud, not postponed or assumed. It calls for immediacy and warmth, woven deliberately into our communities while we still have time. In a world often caught in distraction or discomfort with vulnerability, speaking love with purpose can transform relationships, offer healing, and create lasting meaning, not just at the end of life, but every day. This remains true in clinical palliative medicine and healthcare at large. Gestures of care, acts honoring humanity, and intentional offerings of connectedness deepen our work and have the power to change outcomes.[5] Whether that is remembering a patient's favorite hobby, taking a hand outstretched in search of comfort, or naming the honor it is to

BMJ Support Palliat Care: first published as 10.1136/spcare-2026-006534 on 30 July 2026. Downloaded from http://spcare.bmj.com/ on October 28, 2026 at Duke University Medical Center Library . Protected by copyright, including for uses related to text and data mining, AI training, and similar technologies.

care for those we serve, such actions can be among our most powerful clinical interventions. Despite an increasingly de-humanized healthcare system, such gestures may have the power to create deep impacts when prioritized alongside the technical aspects of our care.

I met Jason in the outpatient advanced cancer clinic. In his mid-40s and after years of treatment, he understood that his cancer was progressing and his prognosis worsening. While still able, Jason embarked on a legacy project, video recording one-on-one encounters with friends, family, and coworkers. Each conversation began with familiar reflections on shared history, but then Jason, looking directly into the camera, spoke simply and clearly: "I love you." This unexpected declaration surprised many of his loved ones. At his funeral—a celebration of life—I watched an edited video of these moments, stitched together by friends. Though I don't recall the scriptures read, I vividly remember the raw emotion in the room as Jason's loved ones received his words with a mix of joyful laughter, tears, tight embraces, and quiet acknowledgment. This reminded me of the power of love expressed, and it is something that I honor by bringing it into my clinical work in palliative medicine.

There is a gift in the knowing

For some, a person's knowledge of how they will die may be a privilege, asset and tool, inviting us all to revisit our daily priorities in living and dying.

Not everyone has the foresight of how their life may end, and those who do may often approach life with a sharpened clarity about what matters most. Rather than diminishing life, such knowledge can inspire post-traumatic growth, a strengths-based orientation that contrasts with the fear and paralysis of post-traumatic stress.[6] For those of us privileged to bear witness, these moments become lasting reminders of the resilience, meaning, and perspective that people with serious illness can embody and offer. This lesson can be additionally powerful to hold within our own lives outside of clinical care. How might we live if we knew how and when our death might come? How might such framing support our own coping in the uncertainty of life? Ultimately, the courage to live fully, whether in the face of illness or alongside life's gifts and stressors, is a universal lesson that transcends circumstance and reminds us all to honor each day.

One day, after countless conversations during long shifts together, a patient with leukemia pursuing bone marrow transplant said to me: "I find it a privilege knowing how I am going to die, the cancer will get me, and you do not have that privilege." He later wrote those words in a card I keep more than twenty years later. His candor struck me, not just because of his prognosis, but because of how fully he continued to live despite it. He showed me that knowing could be freeing and that clarity could fuel strength and meaning even in suffering. I carry his words with me still, as a daily reminder to consider my own priorities in life and to honor the gift in the knowing when patients choose to share it.

Our actions and presence create a story far beyond the moment

Our presence, or lack thereof, may create a narrative that will be remembered for days, weeks, months and years to come for our patients and their communities.

The choices we make—how we show up, what words we use, and the stance we take—become part of the larger arc of a family's experience of illness and loss. While we, as palliative medicine clinicians, may only get to know our patients and their families for a short period of time, these moments may comprise some of the most significant chapters in our patients' stories. Research shows that surrogates faced with end-of-life decisions in the intensive care unit suffer high rates of post-traumatic stress and are at risk for complicated bereavement.[7] In this light, our role becomes not only clinical but also narrative: to help shape a story families can carry forward without the weight of guilt, second-guessing, or feeling abandoned.

I remember a young man in his twenties who was diagnosed with widely metastatic rhabdomyosarcoma after a year of misdiagnoses. By the time I met him, he was encephalopathic, in multisystem organ failure, and his family was reeling in shock. They told us they needed to know that everything possible had been done. I knew that withdrawing life-sustaining treatments would fracture the story they would carry. So, with my team, we recommended continuing the current level of care while ensuring his pain was managed. The ICU team did not offer CPR or mechanical ventilation, but he remained on vasopressors, comfortable, and surrounded by his family when he died. For them, that story mattered. And for me, it was a reminder that our presence in these moments shapes not only how patients die but also how families live with those memories.

Hope is not denying reality

Relationships to hope are unique and personal as people hold steadfast to the faith that their clinical dilemma may change.

Too often, we view hopeful families as "not getting it." Might we consider, families hope not because they are in denial, but because they know—that the cancer is advanced, that imaging indicates brain atrophy, that their child is not a candidate for disease-modifying treatment. Yet we frequently misinterpret expressions of hope and faith amidst a terminal diagnosis as a lack of prognostic awareness.[8] Hope should instead be honored as a vital source of strength, quality of life, and protection against overwhelming despair. In palliative medicine, our role is not to extinguish hope but to share in it, while also gently exploring what matters most if those hopes are not realized. Hope can serve as a light shining through the clouds of guarded and poor prognosis, limiting despair from completely

BMJ Support Palliat Care: first published as 10.1136/spcare-2026-006534 on 30 July 2026. Downloaded from http://spcare.bmj.com/ on October 28, 2026 at Duke University Medical Center Library . Protected by copyright, including for uses related to text and data mining, AI training, and similar technologies.

overshadowing our patients' and their families' lives. By remaining compassionately present with patients and families, we may find that they are not disregarding the clouds but instead appreciating the sun while it can still be seen and felt. And by standing with them, safety can be created for them to turn to you when the clouds close in.

I remember sitting with a family whose child's prognosis was undeniably poor. Behind closed doors, the medical team questioned whether the parents truly "understood." But when I asked them to share what they were holding onto, they spoke with clear-eyed awareness of the medical facts and, in the same breath, of their hope that things could change. They feared most that the doctors had given up. In that moment, I realized my role was not to correct their faith but to honor it—to sit with them in the light they still saw, even as the clouds gathered. That conversation shaped how I show up with families: not as the one to measure the validity of their hope, but as the one willing to stand beside them in it.

Listening is among the most crucial of interventions

Learning to listen without interrupting, suggesting or fixing is of the highest priority.

Listening may not look like a medical procedure, but it symbolizes one of the most therapeutic acts we can offer. Too often, clinicians interrupt patients within moments —on average after only 11 seconds.[9] Yet when we pause, the benefits are profound. Active listening, defined as making a conscious effort to hear and understand, demonstrating concern, limiting interruptions, asking open-ended questions, and giving full attention, creates trust and connection.[10] From the patient perspective, listening is not only essential for gathering data and diagnosis but also serves as a therapeutic act in itself and strengthens the doctor-patient relationship.[11] Even subtle shifts make a difference: when clinicians follow empathetic statements with silence rather than more talking, patients and family members may be upwards of 18 times more likely to respond in ways that signaled alliance with the clinician.[12] Listening to understand rather than to fix sits at the heart of palliative medicine—and of all relationships.

I still think back to a mother who told me, "Everyone always tells us parents we need to be strong advocates, but nobody ever tells doctors they need to be strong listeners." Her candor struck me because she was right. I've been told, "You palliative care doctors have the best words," but I suspect the reason people feel that way is not about words at all. It's about listening. I remember how her wisdom stayed with me during family meetings, how I leaned into silence after an empathetic statement, and how often that silence invited families to share more deeply. That single comment reshaped how I show up, not just as a physician but also as a partner, a friend, and a parent. I am reminded daily that being a strong listener is one of the most powerful ways to care.

Leave room for laughter

Laughter may be loud, unexpected and judged as inappropriate; yet it is a stark reminder of the range of co-existing emotions all of us need to heal, even in the face of death.

Humor represents an essential part of living, so it naturally holds a vital place in dying. When used thoughtfully, humor and laughter have a unique power to create space and heal, easing the tension and fears that often accompany death and the end of life. Rather than diminishing the seriousness of loss, humor can serve as a compassionate bridge, connecting people and creating space for comfort and resilience in the face of profound difficulty.[13 14] This healing aspect of humor helps individuals and families navigate the emotional complexities of dying with greater ease and humanity.

The first patient I truly connected with showed me how humor can be a powerful way to face death. He was a teenager who, despite his illness, insisted on laughter, pranking staff and finding joy in the darkest moments. His parents avoided talking about death, calling it "negative thinking," but he wanted honesty. One night, he asked, "Can we talk about dying?" I said, "I'm here to listen." From then on, we shared nightly talks filled with both truth and laughter. When he said, "You know I'm dying, right?" I replied, "Tell me something I don't know." He laughed and said, "Thank you, for not making these conversations hard and for making them so much fun and easy to talk about." When we leave room for laughter, giving humor its rightful place at the bedside, we honor the wholeness of those we serve, and sustain the wholeness within ourselves.

Choose to see, rather than save

The people who allow us to care for them have strength and wisdom beyond our imagination. They need to be seen, even when we cannot save them.

Most of us enter healthcare with a strong desire to serve. Outside of palliative medicine, this motivation may show up as offering curative treatments where cure is not possible or performing invasive procedures simply to "do something" in the face of critical illness. Within palliative medicine, our actions can also be motivated by wanting to fix. Our impulse to intervene, to rescue, or to "save" can inadvertently center our own need to help, obscuring the expertise, resilience, and agency of patients, their families, and their communities. Instead, we can choose to truly see the fullness of the person whose life we are caring for—to honor their humanity and bear witness without centering ourselves. Allyship and support are not acts of saving; they are acts of recognizing, listening, and creating space for patients and families to claim their own authority in their stories.

I remember a Black mother sharing her fears with me: worried that speaking up would label her as angry, yet equally terrified that silence would leave her child's needs unheard. I named the

BMJ Support Palliat Care: first published as 10.1136/spcare-2026-006534 on 30 July 2026. Downloaded from http://spcare.bmj.com/ on October 28, 2026 at Duke University Medical Center Library . Protected by copyright, including for uses related to text and data mining, AI training, and similar technologies.

discrimination she was experiencing, not only to her, but also to every healthcare professional who might care for her child. Witnessing her child's illness was heartbreaking; knowing that our healthcare system was compounding her suffering felt unbearable. My instinct to step in was partly to assuage my own guilt as a beneficiary of systemic inequity, and partly a desire to rescue her. Because while I couldn't save her

Table 1 Lessons and How to Act on Them

If you remember nothing else…	
There is no hierarchy of suffering.	**Regardless of the objective circumstances or characteristics of a case, each patient and family response remains relative and valid**. ► Treat every patient or family response with equal respect. ► Work with teams to approach situations with openness, avoid comparisons and honour each person's experience on its own terms.
Grief doesn't follow protocol.	**In the face of devastating loss, people may seek partnership with their healthcare team to preserve legacy, connection and meaning**. ► Attend to each person's unique mourning process and honour their individual way of coping. ► Work with teams to help patients and families express, process or ritualise grief according to their needs.
Love begs to be spoken into our communities – now and with intention.	**Love may be received by others with varying levels of sorrow, joy, appreciation, gratitude and acceptance**. ► Make deliberate efforts to show kindness. Look for small, meaningful ways to express love and support to patients, families and colleagues. ► Work with teams to share love openly and intentionally, knowing that no matter how it is received or responded to, its presence is meaningful.
There is a gift in the knowing.	**For some, a person's knowledge of how they will die may be a privilege, asset and tool, inviting us all to revisit our daily priorities in living and dying**. ► Recognise and respect a person's awareness of their own dying. ► Work with teams to invite patient reflection on what truly matters in life. This can guide meaningful choices and priorities.
Our actions and presence create a story far beyond the moment.	**Our presence, or lack thereof, may create a narrative that will be remembered for days, weeks, months and years to come for our patients and their communities**. ► Fuel interactions with intention and awareness. ► Work with teams to show up thoughtfully and fully, recognising that we can leave a lasting impact on patients and their communities.
Hope is not denying reality.	**Relationships to hope are unique and personal, as people hold steadfast to the faith that their clinical dilemma may change**. ► Recognise that hope sustains patients and families through uncertainty. ► Work with teams to encourage and validate hope, understanding that it can coexist with difficult truths.
Listening is among the most crucial of interventions.	**Learning to listen without interrupting, suggesting or fixing is of the highest priority**. ► Focus on hearing patients fully to honour their voice and experience. ► Work with teams to practice listening first. Truly being heard can be more healing than any solution we might offer.
Leave room for laughter.	**Laughter may be loud, unexpected and judged as inappropriate; yet it is a stark reminder of the range of co-existing emotions all of us need to heal, even in the face of death**. ► Allow room for humour and lightness. ► Work with teams to recognise and embrace laughter, even when it feels unexpected or out of place—these moments can be profound acts of healing amid serious illness and support resilience and human connection.
Choose to see, rather than save.	**The people who allow us to care for them have strength and wisdom beyond our imagination. They need to be seen, even when we cannot save them**. ► Focus on recognising the strengths and resources of patients and their families rather than trying to fix or rescue them. ► Work with teams to centre the voices of patients and families to honour their expertise, resilience and agency.
Try to say yes.	**Saying yes reflects our commitment to serve. Sometimes people ask for things that may seem small to us but may be deeply meaningful for a patient or family**. ► Be curious and open to unique hopes or requests that lie outside of the medical plan. ► Work with teams to support these special asks whenever possible, as they often represent our most powerful interventions.

BMJ Support Palliat Care: first published as 10.1136/spcare-2026-006534 on 30 July 2026. Downloaded from http://spcare.bmj.com/ on October 28, 2026 at Duke University Medical Center Library . Protected by copyright, including for uses related to text and data mining, AI training, and similar technologies.

child, perhaps I could save her from the harms of the system.[15] *What she needed was not my saving, but to be seen: as a mother, an advocate, a partner, an expert, and a human enduring unimaginable grief. The strength, wisdom, and resilience she embodied reminded me that our role is not to be saviors, but to decenter ourselves, acknowledge our harms, and leverage our power to create spaces for patients and families to speak their truths. What if allyship means stepping aside, rather than stepping in, to fully center those we hope to serve?*

Try to say yes

Saying yes reflects our commitment to serve. Sometimes people ask for things that may seem small to us but may be deeply meaningful for a patient or family.

A commitment to say "yes" whenever possible sits at the heart of our work. We cannot grant every request, but we can lean into creativity, collaboration, and persistence when patients voice what matters most to them. Saying "yes" signals that we hear them and that illness does not steal their hopes, joys, and identities. Even when a request stretches our imagination or feels impossible, the act of trying builds trust, affirms dignity, and often sparks surprising solutions.[16] In this spirit, "yes" becomes not only a tool of bearing witness, but it also becomes a posture, an orientation toward honoring what gives patients meaning. And this posture matters because we practice within systems that too often strip away agency: policies, prognoses, and protocols can fill the room with "no," with limits, with what cannot be done. To say "yes," when we can, becomes a quiet act of resistance. It reminds patients and families that even in constrained spaces, we can still make room for choice, voice, and self-definition. In choosing "yes," we help restore a measure of agency. In doing so, we defy the assumption that serious illness must eclipse possibility.

I remember Ralph, too weak to leave the hospital after bladder cancer surgery, telling us with urgency that he needed to marry Diane, his partner of nearly ten years. We didn't know exactly how, but once we said yes, chaplaincy, nurses, and even medical students who brought flowers helped us create a wedding in his hospital room. I think too of a 16-year-old with advanced cystic fibrosis who lit up as she showed us a photo of a hairless cat, the kind she could finally have without worsening her breathing. The next day, we walked in and told her, "Let's get you that cat," and the joy on her face said everything. And I will never forget a father, drained from massive colon cancer surgery and tethered to tubes, who told us his only wish was to walk his daughter down the aisle. Saying yes meant months of effort compressed into three weeks—but he did it. In each of these moments, I felt what it means to try, even against the odds, and to share in the joy when yes becomes possible.

CONCLUSION

In the end, these lessons serve not as prescriptions but as invitations. They ask us to slow down, listen deeply, honour the many forms suffering and hope can take and recognise the quiet power of our presence. Table 1 summarises each lesson and provides concrete recommendations for applying them in practice. Through bearing witness to patients and families, we participate in stories that outlive the clinical encounter. If we allow ourselves to be shaped by what we see and hear, the practice of medicine becomes not only more compassionate but also more purposeful. May we return to these teachings often, within our teams, in our own reflection and, most importantly, at the bedside.

Author affiliations
[1]Section of Palliative Medicine, Department of Paediatrics, University of Colorado School of Medicine, Aurora, Colorado, USA
[2]Department of Paediatrics of Children's Hospital Los Angeles, University of Southern California Keck School of Medicine, Los Angeles, California, USA
[3]Quality of Life and Paediatric Palliative Care, Stanford Medicine Children's Health, Palo Alto, California, USA
[4]Dartmouth College Geisel School of Medicine, Hanover, New Hampshire, USA
[5]Division of Comfort and Palliative Care, Department of Anesthesiology Critical Care Medicine, Children's Hospital Los Angeles and University of Southern California Keck School of Medicine, Los Angeles, California, USA
[6]College of Nursing, Department of General Internal Medicine, University of Colorado - Anschutz Medical Campus, Aurora, Colorado, USA
[7]Department of Religion, Health and Human Values, Rush University Medical Centre, Chicago, Illinois, USA
[8]School of Nursing, The University of North Carolina at Chapel Hill, Chapel Hill, North Carolina, USA
[9]Department of Supportive Oncology, Dana-Farber Cancer Institute, Boston, Massachusetts, USA
[10]Harvard Medical School, Boston, Massachusetts, USA
[11]St. Jude Children's Research Hospital, Memphis, Tennessee, USA
[12]Canuck Place Children's Hospice, Vancouver, British Columbia, Canada
[13]BC Children's Hospital, Vancouver, British Columbia, Canada
[14]Department of Psychiatry and Behavioral Sciences, Memorial Sloan Kettering Cancer Centre, New York, New York, USA

Contributors All authors contributed to the concept, writing and final approval of the manuscript. AS will serve as guarantor for this.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent for publication Not applicable.

Ethics approval Not applicable.

Provenance and peer review Not commissioned; internally peer reviewed.

ORCID iDs
William E Rosa https://orcid.org/0000-0002-0680-8911
Allison Silverstein https://orcid.org/0000-0003-4188-8424

REFERENCES

1 Stone L. Disease prestige and the hierarchy of suffering. *Med J Aust* 2018;208:60–2.
2 Boss P. *Ambiguous loss: learning to live with unresolved grief*. Harvard University Press, 1999.
3 Price J, Kassam-Adams N, Alderfer MA, *et al*. Systematic Review: A Reevaluation and Update of the Integrative (Trajectory) Model of Pediatric Medical Traumatic Stress. *J Pediatr Psychol* 2016;41:86–97.

BMJ Support Palliat Care: first published as 10.1136/spcare-2026-006534 on 30 July 2026. Downloaded from http://spcare.bmj.com/ on October 28, 2026 at Duke University Medical Center Library . Protected by copyright, including for uses related to text and data mining, AI training, and similar technologies.

4 López Pérez Y, Cruzado JA, Lacasta Reverte MA, *et al*. Predictors of Complicated Grief in Caregivers of Palliative Care Patients. *Omega (Westport)* 2025;91:169–96.
5 Arora G, Caliboso M, Baird J, *et al*. Educational Priorities for Providing End-of-Life Care: Parent Perspectives. *Pediatrics* 2021;148:e2021051379.
6 Berger A. Psychosocial spiritual healing. *Ann Palliat Med* 2017;6:203–5.
7 Azoulay E, Pochard F, Kentish-Barnes N, *et al*. Risk of post-traumatic stress symptoms in family members of intensive care unit patients. *Am J Respir Crit Care Med* 2005;171:987–94.
8 Foronda C, Baptiste D-L, Reinholdt MM, *et al*. Cultural Humility: A Concept Analysis. *J Transcult Nurs* 2016;27:210–7.
9 Singh Ospina N, Phillips KA, Rodriguez-Gutierrez R, *et al*. Eliciting the Patient's Agenda- Secondary Analysis of Recorded Clinical Encounters. *J Gen Intern Med* 2019;34:36–40.
10 Younger HR. LEADERSHIP AND THE ART OF ACTIVE LISTENING. *Leader to Leader* 2024;2024:13–9.
11 Jagosh J, Donald Boudreau J, Steinert Y, *et al*. The importance of physician listening from the patients' perspective: enhancing diagnosis, healing, and the doctor-patient relationship. *Patient Educ Couns* 2011;85:369–74.
12 October TW, Dizon ZB, Arnold RM, *et al*. Characteristics of Physician Empathetic Statements During Pediatric Intensive Care Conferences With Family Members: A Qualitative Study. *JAMA Netw Open* 2018;1:e180351.
13 Pinna MÁC, Mahtani-Chugani V, Sánchez Correas MÁ, *et al*. The Use of Humor in Palliative Care: A Systematic Literature Review. *Am J Hosp Palliat Care* 2018;35:1342–54.
14 Linge-Dahl LM, Heintz S, Ruch W, *et al*. Humor Assessment and Interventions in Palliative Care: A Systematic Review. *Front Psychol* 2018;9:890.
15 Nixon SA. The coin model of privilege and critical allyship: implications for health. *BMC Public Health* 2019;19:1637.
16 Salant JA, Singh N, Ansell P, *et al*. "Yes, and…": Improvisational Theater (Improv) as a Novel Educational Tool in Interdisciplinary Palliative Care. *J Pain Symptom Manage* 2024;67:e588.

BMJ Support Palliat Care: first published as 10.1136/spcare-2026-006534 on 30 July 2026. Downloaded from http://spcare.bmj.com/ on October 28, 2026 at Duke University Medical Center Library . Protected by copyright, including for uses related to text and data mining, AI training, and similar technologies.