ORIGINAL RESEARCH

Personalizing Death in the Intensive Care Unit: The 3 Wishes Project

A Mixed-Methods Study

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Background: Dying in the complex, efficiency-driven environment of the intensive care unit can be dehumanizing for the patient and have profound, long-lasting consequences for all persons attendant to that death.

Objective: To bring peace to the final days of a patient's life and to ease the grieving process.

Design: Mixed-methods study.

Setting: 21-bed medical–surgical intensive care unit.

Participants: Dying patients and their families and clinicians.

Intervention: To honor each patient, a set of wishes was generated by patients, family members, or clinicians. The wishes were implemented before or after death by patients, families, clinicians (6 of whom were project team members), or the project team.

Measurements: Quantitative data included demographic characteristics, processes of care, and scores on the Quality of End-of-Life Care–10 instrument. Semistructured interviews of family members and clinicians were transcribed verbatim, and qualitative description was used to analyze them.

Results: Participants included 40 decedents, at least 1 family member per patient, and 3 clinicians per patient. The 159 wishes were implemented and classified into 5 categories: humanizing the environment, tributes, family reconnections, observances, and "paying it forward." Scores on the Quality of End-of-Life Care–10 instrument were high. The central theme from 160 interviews of 170 persons was how the 3 Wishes Project personalized the dying process. For patients, eliciting and customizing the wishes honored them by celebrating their lives and dignifying their deaths. For families, it created positive memories and individualized end-of-life care for their loved ones. For clinicians, it promoted interprofessional care and humanism in practice.

Limitation: Impaired consciousness limited understanding of patients' viewpoints.

Conclusion: The 3 Wishes Project facilitated personalization of the dying process through explicit integration of palliative and spiritual care into critical care practice.

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Dying is a universal life passage but creates a major existential crisis for most dying persons and their families. The matter of dying, and the manner of dying, can exact an enormous toll on the dying person and persons attendant to that death. In the stark technologic setting of the intensive care unit (ICU), dying can be dehumanizing. For family members of dying or deceased critically ill patients, depression, anxiety, and posttraumatic stress disorder are common (1, 2). Clinician suffering can induce vicarious traumatization (3) and compassion fatigue (4).

End-of-life care is a crucial domain of medicine, often forgotten in technologic, efficiency-driven environments. When critical illness no longer responds to treatment or when life support will likely result in outcomes incongruent with patients' values, clinicians should ensure that patients die with dignity (5, 6).

We developed the 3 Wishes Project to try to bring peace to the final days of critically ill patients and to ease the grieving process. By eliciting and implementing a set of wishes identified by patients, families, clinicians, or the project team, our objectives included the following: for patients, to dignify their deaths and celebrate their lives; for family members, to humanize the dying experience and create positive memories; and for clinicians, to foster patient- and family-centered care and inspire a deeper sense of vocation.

METHODS

Design

This mixed-methods study was conducted in a 21-bed medical–surgical tertiary care ICU, 1 week per month from January 2013 to November 2014. Consecutive patients and families were invited to participate after they decided to withdraw advanced life support in anticipation of death or after discussion with the physician, who determined that the probability of dying in the ICU was greater than 95%. Patients were excluded if they were admitted to the ICU for less than 6 hours. After research ethics board approval, informed consent was obtained from each patient when possible or from his or her family.

See also:

Editorial comment 318

Web-Only
Supplements

EDITORS' NOTES

Context

The busy, technologic setting of the intensive care unit may interfere with the ability of dying patients, their families, and their clinicians to personalize and humanize care at the end of life.

Contribution

After simple wishes were elicited and implemented, patients' families and clinicians reported a sense of peace and positive memories by dignifying the dying process for critically ill patients.

Implication

An organized and collaborative approach to engaging patients, their families, and their clinicians to grant wishes helped to personalize the process of dying in the intensive care unit.

We used qualitative and quantitative methods after extensive pilot work. Sympathy cards from the staff and project team were mailed to each family within 3 weeks of the patient's death.

Patients

We collected information about age, admitting diagnosis, illness severity, and process-of-care variables (administration, withdrawal or withholding of advanced life support [such as mechanical ventilation, inotropes or vasopressors, renal replacement therapy, and cardiopulmonary resuscitation]) and recorded time of death.

Wish Elicitation and Implementation

After enrollment, a project team member or bedside clinician sensitively elicited at least 3 wishes from the patients, family members, or other clinicians caring for the patients. We documented what the wishes were and whose wishes they were. When we introduced the project, our focus was how best to honor the patient. All wishes were for the patient or family. We documented when and by whom they were implemented—patients, families, clinicians, or the project team.

Families and Clinicians

We conducted semistructured interviews with at least 1 family member per patient, including the main spokesperson (Supplement 1, available at www.annals.org). The only exclusion criterion was declining to participate, in which case we resampled family members or visiting friends. We contacted each family by telephone 1 to 6 months after the patient's death.

We conducted individual semistructured interviews with 3 clinicians per patient (Supplement 2, available at www.annals.org). We purposely sampled clinicians caring for the patient in the last 72 hours of life (7). The only exclusion criterion was declining to participate, which prompted resampling the patient's other clinicians. We invited clinicians by e-mail within 1 to 2 weeks of the death. Six clinicians (3 physicians and 3 chaplains) were also members of the project team.

Our goal was to understand the effect of the project on the dying experience for the patient, family, and clinicians (as relevant) and their overall perceptions about the project. Interviews were digitally recorded, transcribed verbatim, and anonymized.

For families, we recorded age, sex, relationship, and spiritual beliefs. We requested in-person completion of a validated self-administered survey, the Quality of End-of-Life Care–10 instrument (8). For clinicians, we recorded age, sex, role, ICU experience, and spiritual beliefs. Some families brought letters and poems about their experiences, and some clinicians wrote reflections.

Statistical Analysis

We analyzed quantitative data by using descriptive statistics. The wishes were interpreted and classified in several dimensions (category, realization, origin, timing, and cost).

We analyzed interview transcripts, family letters, and field notes using the qualitative descriptive approach to yield a descriptive summary of study findings, which were organized and presented in the language of the participants with minimal theoretical interpretation (9). We analyzed data by using qualitative content analysis, whereby codes were derived directly from the data rather than through use of predetermined categories (10). Two investigators independently read 10 transcripts in a process of open coding and, by consensus, developed the initial list of codes (11). A qualitative researcher coded all of the remaining transcripts. As data collection proceeded, new information and insights were incorporated into data collection and analysis, making the processes reflexive and interactive. As the initial coding list evolved, changes were documented in an audit trail (12) and new codes were applied to previously coded transcripts. As interviews were done, 2 investigators met bimonthly to organize the codes into meaningful categories (known as axial coding) and discuss potential relationships among them (11). Two investigators organized the categories of codes into 3 higher-level clusters (7) and, through an inductive and deductive approach, identified a central theme. Exemplars from the data were identified for each code and category. NVivo, version 10.0 (QSR International), was used for data management and analysis.

Data saturation was achieved after 40 patients were enrolled and was assessed by 2 investigators through review of transcripts (main coder) and coding reports (secondary coder) and audit trail examinations. Investigator triangulation was achieved through the interdisciplinary research team, representing physicians (critical or palliative care), chaplains, nurses, and respiratory therapists. We obtained several perspectives by sampling families and different professions with varied ICU experiences. We achieved methodological triangulation by using mixed methods (13, 14). Member-checking occurred individually, in person (20 nurses),

Table 1. Patient Characteristics

Variable	Patients (*n* = 40)
Baseline characteristics	
Mean age (SD), *y*	68.1 (15.5)
Women, *n (%)*	20 (50.0)
White race, *n (%)*	35 (87.5)
Mean APACHE II score (SD)	30.1 (9.6)
Location before ICU, *n (%)*	
Hospital ward	20 (50.0)
ED	10 (25.0)
Dialysis unit	1 (2.5)
Operating room	1 (2.5)
Other hospital ward	8 (20.0)
ICU admitting diagnosis, *n (%)*	
Cardiovascular/vascular	14 (35.0)
Respiratory	12 (30.0)
GI	5 (2.5)
Neurologic	4 (10.0)
Sepsis	4 (10.0)
Renal	1 (2.5)
Admission type, *n (%)*	
Medical	39 (97.5)
Surgical	1 (2.5)
No CPR order on ICU admission, *n (%)*	9 (22.5)
Dialysis-dependent before ICU, *n (%)*	8 (20.0)
Spiritual belief, *n (%)*	
Roman Catholic	10 (25.0)
Agnostic	7 (17.5)
Baptist	4 (10.0)
Anglican	4 (10.0)
Muslim	2 (5.0)
Lutheran	1 (2.5)
Greek Orthodox	1 (2.5)
United	1 (2.5)
None	6 (15.0)
Unknown	4 (10.0)
Reason for enrollment, *n (%)*	
Very poor prognosis	24 (60.0)
Decision to withdraw advanced life support	16 (40.0)
Characteristics during the ICU stay	
Advanced life support administered at any time in ICU, *n (%)*	
Mechanical ventilation	40 (100.0)
Inotropes	28 (70.0)
Dialysis	16 (40.0)
Median duration of advanced life support (IQR), *d*	
Mechanical ventilation	6.0 (4.0–14.0)
Inotropes	4.0 (2.0–6.0)
Dialysis*	4.5 (1.0–14.5)
Advanced life support withdrawn just before death, *n (%)*	
Mechanical ventilation	27 (67.5)
Inotropes	8 (20.0)
Dialysis	3 (7.5)
Advanced life support withheld after enrollment, *n (%)*	
Mechanical ventilation	3 (7.5)
Inotropes	2 (5.0)
Dialysis	9 (22.5)
CPR at time of death, *n (%)*	2 (5.0)
Spiritual care consult in ICU, *n (%)*	29 (72.5)
Palliative care consult in ICU, *n (%)*	16 (40.0)
Median hospital course (IQR), *d*	
From hospital admission to ICU admission	1.5 (0–10.0)
From ICU admission to death	5.5 (3.5–13.0)
From hospital admission to death	8.5 (4.0–30.0)
From ICU admission to enrollment in 3 Wishes Program	4.0 (2.0–8.5)
From enrollment in 3 Wishes Program to death	1.0 (0–2.0)
Location of death, *n (%)*	
ICU	38 (95.0)
ED	1 (2.5)
Ward	1 (2.5)

APACHE = Acute Physiology and Chronic Health Evaluation; CPR = cardiopulmonary resuscitation; ED = emergency department; GI = gastrointestinal; ICU = intensive care unit; IQR = interquartile range.
* In patients newly receiving it in the ICU.

by telephone (5 families) and e-mail (5 physicians-in-training), and collectively (a 5-physician staff meeting, 10-person multidisciplinary quality council meeting, interprofessional rounds, and spiritual care rounds). We used oral, written, and visual tools tailored to the audience to encourage dialogue.

Role of the Funding Source

This study was funded by the Hamilton Academy of Health Science Research Organization and Canadian Intensive Care Foundation. The funding source played no role in the design, conduct, or reporting of this study.

RESULTS

Patients

One of the 41 screened patients died 4 hours after ICU admission. All 40 eligible patients were included; mean age was 68.1 years (SD, 15.5) (**Table 1**). Most patients had medical diagnoses (39 [97.5%]); 20 (50.0%) as transferred from the ward and 10 (25.0%) as transferred from the emergency department.

Wishes

Wishes were classified into 5 categories: humanizing the environment (such as bringing favorite flowers or cherished momentos into the room), personal tributes (such as having a tea party or planting a tree in the patient's name), family reconnections (such as locating a lost relative or sponsoring a memorial meal), rituals and observances (such as blessings, renewal of wedding vows, or firework displays), and "paying it forward" (such as organ donation, contribution to a significant charity, or unsolicited family donation to this project) (**Table 2**).

Overall, 159 of 163 (97.5%) of wishes were implemented—at least 3 wishes for each patient–family dyad (median, 4 wishes [interquartile range, 3 to 4]). Wishes originated from clinicians (82 [51.6%]), families (62 [39.0%]), patients (11 [6.9%]), and others (4 [2.5%]). Based on their knowledge of the patients or families, clinicians may have suggested wishes, which often prompted families or patients to think of wishes themselves. Some families did not suggest wishes because they felt supported, and a few were in shock or were intensely grieving. Wishes were implemented both before (82 wishes [51.6%]) and after (77 wishes [48.4%]) death. The wishes were inexpensive and ranged from $0 ("invaluable") to approximately $200 per patient.

Table 2. Examples of Wishes Implemented, by Category

Humanizing the environment
Soliciting personal mementos for the patient's room
Playing the patient's favorite television channel 24 h/d
Using the patient's preferred nickname
Recreating date night in the ICU
A rock and roll sing-along with the patient's friends
Playing Scottish bagpipe music at the time of death
Obtaining flowers for the patient's bedside
Personal tributes
Holding a breakfast tribute by the staff for the patient's partner
Planting a tree in the patient's honor
Proposing a toast to the patient at the patient's bedside
Creating a framed word cloud
Holding a tea party at the patient's bedside
Naming a park bench for the patient
Providing a final supper for the family in the ICU conference room
Family reconnections
Encouraging visitation by a beloved pet
Locating an estranged relative
Facilitating a Skype reunion
Resolving residual family discord about the patient's burial place
Tasting the patient's favorite pasta sauce before the patient dies
Allowing a mother to lie in bed with her son as he dies
Dying with all family members present in the room
Rituals and observances
Birthday celebration for the family in the ICU conference room
Renewal of wedding vows at the patient's bedside
Firework display
Wedding ceremony at the patient's bedside
Defer withdrawing life support until after a religious holiday
Release of a helium balloon with a message to the patient
Memorial service at the patient's bedside
Paying it forward
Family member securing a hospital volunteer position
Organ donation
Unsolicited family gift to future families
Project's donation to a charity significant to the patient
Family's donation of a stuffed "happy pill" for other grieving families
Lunch gift certificate for a family gathering after the funeral
Project's donation to an infant's personal education fund

ICU = intensive care unit.

We collated the implemented wishes in a "wish bank" for future use (15).

Families

Table 3 summarizes family member characteristics (50 persons affiliated with 40 patients). Most were patients' children (18 [36.0%]) or spouses (11 [22.0%]). All families agreed to be interviewed (100% participation rate). Interviews took place primarily in person (29 [58.0%]), and some were by telephone (11 [22.0%]).

End-of-life care was rated high by Quality of End-of-Life Care–10 scores completed by 26 of 29 families (response rate, 89.7%) interviewed in person (**Appendix Table**, available at www.annals.org).

Clinicians

Table 3 shows the characteristics of 120 clinicians; 55 were physicians (45.8%) (10 staff, 12 fellows, 29 residents, and 4 ICU assistants) and 40 were nurses (33.3%). Median length of ICU experience was 3 years (interquartile range, 0.4 to 12.0). Of 123 clinicians who were initially approached, 3 declined and were resampled (participation rate, 120 of 123 [97.6%]). Interviews occurred primarily in person (118 of 120 [98.3%]); 1 was requested by telephone and 1 by e-mail.

Interviews

The central theme that emerged from 160 interviews of 170 persons was personalizing dying in the ICU through 3 related domains: dignifying the patient, giving the family a voice, and fostering clinician compassion.

Dignifying the Patient

The project fulfilled an unmet need of dying critically ill patients and their families—"being known" in terms of one's life journey.

> *This program honors the everyday hero: someone who may go unnoticed but whose life counted and was a good person. [mother]*

> *It gave me peace that final day—the way she went. . . . I think that's actually helped me in the long run. . . . I believe it's because the death process—the dignity that was given to her and the compassion that was shown to her family—made it much easier to deal with. [son]*

> *I think that it dignified the whole process. At that point, [he] wasn't conscious. The conversation . . . gave him a voice when he was not there. . . . The offering of the wishes gave him a presence in the room. [chaplain]*

Eliciting the wishes helped everyone understand who the patient was as a person and what mattered most to him or her. We held a date night, championed music therapy, and relaxed hospital policy for pet visitation. The program made several donations to causes significant for patients after their deaths.

> *I think the biggest realization is that determining what the wishes are, we sometimes learn things about patients. . . . You know, he was an avid gardener . . . and the family is proposing a donation to the horticultural awards. We may not have known that about him before. . . . The 3 wishes highlights other important things about patients that we don't routinely ask . . . like hobbies, interests, [and] friends. . . . [physician]*

Some clinicians assisted with "the business of unfinished business," such as locating an estranged son for reconciliation or urgent preparation of a will. Staff held a breakfast tribute where they fondly recollected interactions with 1 long-term patient. In 1 family's tradition, salutations were shared in a sendoff as a final toast in the patient's room.

> *The whole process with the . . . program and everything that we went through with this family . . . it just helped. . . . It did make the experience seem dignified and peaceful. It didn't necessarily feel like we were letting someone go; it felt more like we were wishing someone well. [resident]*

One alert patient with inoperable cancer who had a tracheostomy requested to speak again to bid her friends farewell. The tracheostomy precluded granting this wish, but it was reframed.

> *And without that [the project] . . . she would never have [received] a laptop. She never would have had the opportunity to Skype with those people or e-mail them, and I think that was an important component of . . . her care here. [resident]*

This project created unseen but meaningful connections when death loomed.

> *This was the work of spiritual care embodied. The wishes were a concrete means to engage something that was greater than everything else that was in the room. . . . The wishes were a medium through which the family could reengage him . . . the life they shared together. It was deeply honoring. [chaplain]*

Giving the Family a Voice

Learning about patients from families affirmed the families as partners in the caring process instead of "visitors."

> *So my mom's lying there, cognitively dead. Her heart's still beating, she's on life support . . . you have no idea who she really was. And this–it was just wonderful. It struck a chord because it allowed me to . . . talk about her, and, you know, give the staff . . . a vision of who she was. [daughter]*

> *It gave the whole family a voice . . . and it helped, I think; everybody put into perspective what [he] wanted, and not what everybody else wanted for him. [resident]*

> *That's our third wish [that the project continue]. We want to make sure that we're a voice and we're heard, and that this does carry on. [daughter]*

Table 3. Family Member and Clinician Characteristics*

Characteristic	**Family Members (*n* = 50)**	**Clinicians (*n* = 120)**
Mean age (SD), *y*	55.8 (12.6)	36.7 (11.4)
Women, *n (%)*	29 (58.0)	78 (65.0)
Interview format for 40 interviews, *n (%)*†		
Face-to-face	29 (72.5)	118 (98.3)
Telephone	11 (27.5)	1 (0.8)
E-mail	0 (0)	1 (0.8)
Median time from patient death to interview (IQR), *d*	112.0 (41.0–227.5)	14.5 (6.0–26.0)
Spiritual belief, *n (%)*		
Catholic	16 (32.0)	29 (24.2)
Agnostic	8 (16.0)	15 (12.5)
Christian	4 (8.0)	25 (20.8)
Anglican	2 (4.0)	6 (5.0)
Muslim	2 (4.0)	12 (10.0)
Spiritual‡	2 (4.0)	9 (7.5)
Baptist	3 (6.0)	1 (0.8)
Greek Orthodox	1 (2.0)	1 (0.8)
United	1 (2.0)	1 (0.8)
Protestant	1 (2.0)	0 (0)
Bahá'i	0 (0)	1 (0.8)
Ecumenical	0 (0)	1 (0.8)
Hindu	0 (0)	1 (0.8)
Jewish	0 (0)	2 (1.7)
Buddhist	0 (0)	1 (0.8)
Atheist	0 (0)	3 (2.5)
None	3 (6.0)	12 (10.0)
Missing	7 (14.0)	0 (0)

IQR = interquartile range.

* Percentages may not sum to 100 due to rounding.

† Some interviews involved >1 family member (e.g., the patient's husband and daughter or 2 parents). Family members that were interviewed included 18 children (36.0%), 11 spouses/partners (22.0%), 7 siblings (14.0%), 5 parents (10.0%), 4 close friends (8.0%), and 5 others (10.0%) (e.g., daughter-in-law, son-in-law, or nephew). Clinicians that were interviewed included 55 physicians (45.8%), 40 nurses (33.3%), 6 respiratory therapists (5.0%), 4 chaplains (3.3%), 3 medical students (2.5%), 3 project team members (2.5%), and 9 others (7.5%) (e.g., social worker, physiotherapist, or dietitian).

‡ Not specified.

The alternate focus of eliciting and fulfilling the wishes seemed to help mitigate common feelings of helplessness and heartache.

> *I think it is because it gives a little bit of . . . power over . . . what's actually happening. . . . By giving them that opportunity . . . 3 wishes like this . . . I think it brings them a little more of control over . . . the process. . . . They can feel that they're actually doing something for their loved one. [resident]*

> *Life is beautiful, but there's always this loss and sadness, too. . . . It [the project] was like a little rainbow in all that sadness . . . something that just helped with the whole process. [daughter]*

Physical contact between ICU patients and families can be limited and uneasy. One mother's wish was to lie with her son in his bed, as she did at his birth, before the declaration of brain death and organ donation.

> *We cared about the Mom. . . . She wanted to be in the bed hugging her son when he passed*

Figure. Example of a word cloud.

This word cloud was generated for a young man with chronic end-stage respiratory illness. As part of the 3 Wishes Project, we explained to his parents, sister, and some friends in his room that we hoped to create a framed collage of words as a keepsake for them. We showed them an example. We asked them to tell us more stories about his life to help us get to know him, asking what was important to him—his personality and passions and persons in his life. Unpressured and without expectation, we asked which concepts or memories they thought would be meaningful to represent. His family and friends reminisced, making direct suggestions about words to include. Listening to their narratives, we suggested other words. Later that afternoon, we chose words from the stories to make a framed word cloud that we placed in the patient's room. The word cloud prompted recollections among family and friends who attended until his death a few days later. For clinicians, it served as a touchstone to appreciate the footprint of his life and learn about what mattered most to him. The family later told us that they displayed the word cloud at his funeral. Reprinted with permission from the patient's parents.

> *away, and we provided that opportunity for her. [nurse]*

Families requested early birthday celebrations, renewal of wedding vows, wedding ceremonies, prayers, and other observances.

> *I just remember everybody being so amazed by the creativity and the ability for things to be facilitated [for our wedding]. I think it was really therapeutic for a lot of people . . . a lot of people got represented through those wishes . . . it wasn't just me giving 3 [wishes]–it got spread around so everybody kind of had a piece in what happened that day, and I think that's huge, actually. [husband]*

Culturally sensitive end-of-life care helped to recognize each family's community.

> *Sometimes it's learning from the family. Sometimes we're not the expert. "You know your mother. You understand your culture. . . . Help us . . . so that it's meaningful for all of us." This project puts an entirely different lens on the camera and allows people to . . . practice differently. [social worker]*

The project team elicited meaning and milestones in a patient's life story from several families, then created a colorful collage of concepts, expressions, and events in a framed word cloud (**Figure**). Reminiscing aloud changed the conversations in the room.

> *I think the biggest thing was the word cloud. . . . They started to remember things about the patient and talk about significant relationships and significant things in his life . . . who he was and what these words represented . . . it was calming for them. They were able to laugh a little bit and tell some stories. . . . I think it just helped ease them into the transition. I think it may have even, for her, signified that . . . we're going to be moving to the next stage. I saw a very, very big change in their . . . whole demeanor after they went through that. [nurse]*

> *Going in and out of the room, not seeing him make any improvements, it was very difficult. . . . Just being able to have someone come and say to us, "We'd like to do this for him. Come to the quiet room and we can sit down and talk and explain what the word cloud is about. . . ." It was all a very positive atmosphere*

> *as opposed to what was happening in the room. . . . It kind of eased it up a little bit. It made us think of good things that happened. [father]*

Families treasured the word clouds after the patients' deaths.

> *Receiving a family word cloud meant more to us than anything. It was wonderful—a keepsake in our mother's honor. [son]*

> *We put his word cloud at the funeral home so everyone could see this is what they did. We've told absolutely everybody that we know how [the project] honored him. . . . It's a lasting tribute. [mother]*

Fostering Clinician Compassion

Eliciting the wishes encouraged self-awareness and reflection. Implementing the wishes created a sense of collective purpose for bedside staff.

> *The most significant, meaningful aspect, or memorable aspect, to me was collaborating with my team and presenting this concept to the family, which completely overwhelmed them . . . then going through with the plan and participating in this celebratory last supper with them. It was a phenomenal experience. [nurse]*

> *I think it's a recognition that everybody here serves, and serves in a different way, and one of the ways we want to recognize who the person is in front of us is to ask them what they need. That's all 3 Wishes is about, right? It's "What do you need right now? What does your family need right now? What do I, as a clinician, need for you right now, looking after you?" [physician]*

The project acknowledged a shared humanity with patients and families.

> *The simplicity of the whole project, yet the depth of it. . . . This project does force everyone to really look deep inside at . . . how they . . . might feel about end-of-life . . . this is putting the absolute human side [into] the whole experience. I think this project is so powerful. [nurse]*

Conversations beyond the conventional medical agenda (16)—asking what would be helpful at the end of life—were considered just as significant as what the wishes were, or whether they were realized.

> *I think it's all about who's delivering it, and it probably matters very little of what you actually do for the person and probably matters a lot about listening and actually trying to help them. . . . It helps in a lot of the areas of medicine that we fall down on—which is the caring. [physician]*

Spirituality can offer solace by planning for or processing a devastating situation (17). Intimate caregiver engagement helped patients and families to convey their transcendent hopes. One wish was for the chaplain to help resolve discord about whether a patient would be cremated or buried, and if cremated, where the ashes would rest.

> *They had a dramatic impact on where my Mom was to be rested, which meant more to us than anything. I've told many people about this program. Nobody's ever heard of such kindness, such compassion. I think we were blessed to have the 3 Wishes. [son]*

Computers, checkboxes, and digital devices entrenched in health care today can repress genuine relating. The project encouraged active, empathetic listening. Learners recounted bearing witness to concrete examples of holistic end-of-life care that they would "take with them."

> *It was a very moving experience. . . . It taught me not to forget the importance of those aspects of our job, and the aspects of listening to, and hearing, what your patients want . . . and also providing comfort in various ways. [resident]*

> *It's transformative. . . . I never would have thought to do these things as a physician. . . . The 3 Wishes Project reengages the human aspect of medicine. [resident]*

DISCUSSION

The 3 Wishes Project brought a set of wishes to fulfillment for dying patients and their families. Most wishes were simple and inexpensive but were often described as invaluable. The project personalized the dying process. For the patient, eliciting the wishes encouraged individualized end-of-life care, guiding us to honor him or her. For the family, it helped to create enduring positive memories, countering the negative visual, auditory, and tactile stimuli propagated by technology. For clinicians, this project promoted interprofessional care, strengthening team bonds and exemplifying humanism in practice.

The professional ethos of medicine has shifted away from personalized care in today's world of "patient as icon, icon as patient" (18). More customized care may swing the pendulum back. An individualized approach to end-of-life care could offer conversational frameworks (19) that might support more authentically connected clinicians. Encouraging behaviors that cue the emotional support (20) valued by patients (21) and fostering personal acts of engagement (16) may help to create therapeutic encounters (22) that aid in terminal transitions of care. Programs aligned with such goals would help to acknowledge that each dying person and each family member are uniquely human (5, 6, 22).

Strengths of our study include development of a feasible, portable, scalable intervention that fosters dying with dignity. We used purposeful sampling of different professionals with varied critical care experience. Participation rates were very high. We interpreted the effect of the project as socially constructed and contextualized through interviews, verified through extensive member-checking. However, ascertaining patients' viewpoints was limited by impaired consciousness in 33 of 40 dying patients. Thus, we focused on understanding the project's effect on patients, their loved ones, and staff from the perspective of families and clinicians (23, 24). Results may differ outside this teaching hospital, with more heterogeneous patients and staff and settings with diverse ethnicities and cultures. Our intent was not to create a communication tool or quality improvement program (25–27); this intervention incorporated attitudes, dialogue, and behaviors consistent with dignity-conserving care (6) to qualitatively investigate whether it might have value.

The 3 Wishes Project aimed to integrate palliative care and spiritual care into critical care practice (28, 29). Eliciting and honoring wishes fostered a community of caring, promoting patient- and family-centeredness as a core component of palliative care (30). It encouraged the verbalization and realization of unmet spiritual needs (17, 31), whether secular or faith-based. Our findings underscore the drive that we all have to search for meaning, memories, and closure in anticipation of death while helping to create preparedness, comfort, and connections during the dying process.

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Appendix Table. QEOLC-10 Family Questionnaire

Domain*	Median Score (IQR)†
1. Talked to your family member (or friend) in an honest and straightforward way . . .	10.0 (9.0–10.0)
2. Responsive to your family member's (or friend's) emotional needs . . .	10.0 (9.5–10.0)
3. Helped you and your family member (or friend) get consistent information from the entire health care team . . .	10.0 (9.0–10.0)
4. Took into account your family member's (or friend's) wishes when treating pain and symptoms . . .	10.0 (9.0–10.0)
5. Admitted when he/she did not know something . . .	10.0 (9.0–10.0)
6. Treated the whole person, not just the disease . . .	10.0 (9.0–10.0)
7. Knowledgeable about the care your family member (or friend) needed during the dying process . . .	10.0 (9.0–10.0)
8. Openly and willingly communicated with *you* . . .	10.0 (10.0–10.0)
9. Acknowledged and respected your family member's (or friend's) personal beliefs . . .	10.0 (9.0–10.0)
10. Made your family member (or friend) feel confident that he/she would not be abandoned before death . . .	10.0 (9.0–10.0)

IQR = interquartile range; QEOLC = Quality of End-of-Life Care.
* From the QEOLC-10 instrument completed by 26 family members.
† Ranges from 0 (“poor”) to 10 (“absolutely perfect”). The middle of the scale with a score of 5 indicates “very good.”