Good communication in cancer nursing

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The author examines patient satisfaction studies which indicate a deficit in nurses' communication skills, and discusses her own research into how effectively nurses communicate with people who have cancer. She argues that if these skills are to be improved, there is a need for more experiential methods of teaching, designed to raise nurses' levels of self-awareness.

'Effective communication is perhaps the most important attribute of successful medicine and nursing' (1), but what is meant by 'effective communication'? According to Cassee, 'effective communication is achieved when open two way communication takes place and patients are informed about the nature of their illness and treatment and are encouraged to express their anxieties and emotions' (2).

This definition assumes that all patients want to be informed about the nature of their illness. It also assumes that communication in the form of information-giving benefits all patients.

Various physical and psychological methods have tested the effects and benefits of open communication. Whether the measures are physical indicators, self reported questionnaires or interviews, they all point to benefits for patients. There is no evidence to suggest open communication or information-giving has the detrimental effect of increasing anxiety. In fact, the reverse is true, as seeking information about cancer and its treatment has been identified by patients as a coping mechanism (3), as it appears to help them gain control in their situations (4).

There is evidence that a proportion of patients may have initial problems adjusting to a diagnosis of cancer, with the first three months following diagnosis being the most distressing period for 70 per cent of patients (5). The key issue when giving information to patients is not whether to tell or not tell, but to identify just how much information each patient requires.

Nurses frequently have to cope with patients' emotional distress and have to identify how much they want to know. Unfortunately, patient satisfaction studies continue to suggest few patients are happy with the level or quality of information or emotional support they receive. Results of studies among patients with cancer show that satisfaction ranges from less than 30 per cent to more than 80 per cent.

**Dissatisfaction expressed**

Regardless of the diversity of methods used in measuring satisfaction, it appears that on average between one quarter and one third of patients with cancer have expressed dissatisfaction with the information they receive regarding their treatment and nursing care (6-10).

The crucial question is how many nurses have effective communication skills with which to assess patients' needs and problems, and which offer the information and the emotional support the patients clearly require?

The first influential study to highlight the difficulties nurses have in communicating with patients who have cancer was conducted in America by Quint (11). Using participant observations, Quint noted first that a diagnosis of cancer affected the nurse's organisation of care. The

<table>
<thead>
<tr>
<th>Table 1. Percentage blocking, facilitating and coverage scores for each interview</th>
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<tbody>
<tr>
<td>Interview A New patient</td>
</tr>
<tr>
<td>Median</td>
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<tr>
<td><strong>Facilitating verbal behaviour</strong></td>
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<tr>
<td><strong>Blocking verbal behaviour</strong></td>
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<tr>
<td><strong>Total coverage scores</strong></td>
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* For each patient there was a theoretical minimum score of 0 and a maximum score of 21.

This article is an edited version of a paper delivered at the 7th International Conference on Cancer Nursing, held in Vienna in August of this year.
Table 2. Nurses’ spontaneous awareness of blocking verbal behaviours

<table>
<thead>
<tr>
<th>Nurses’ awareness</th>
<th>Interview A Responses</th>
<th>Interview B Responses</th>
<th>Interview C Responses</th>
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<tbody>
<tr>
<td>Spontaneous awareness</td>
<td>20</td>
<td>37</td>
<td>13</td>
</tr>
<tr>
<td>No awareness</td>
<td>34</td>
<td>63</td>
<td>40</td>
</tr>
<tr>
<td>Not asked</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Totals</td>
<td>54</td>
<td>100</td>
<td>54</td>
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care of the patients was rotated among the nurses. This prevented relationships being established and protected the staff from becoming well-acquainted with the human problems the patients were experiencing.

Second, conversational tactics were used to interrupt any interaction that threatened to focus on a patient’s diagnosis or prognosis. These tactics included talking inappropriately about getting well and excessive small talk. When patients asked direct questions they were frequently treated in one of four ways by the nurses:

- They were not answered but referred to other health professionals
- The subject was changed
- The questions were ignored with the nurses remaining silent
- Stereotyped statements like ‘we all have to go some time’ were made.

Whether these behaviours were related to the American culture or the differences in health care systems was not clear until Bond’s study with British nurses (12). Bond, like Quint, observed and analysed ward nurses’ communications with patients and the results were similar to those of Quint, suggesting verbal blocking tactics were universal among nurses.

Tape recorded observations, rather than participant observations, were carried out by Faulkner who assessed nurses before and after a communication skills programme (13). The training focused on assessment skills relevant to patients who had undergone mastectomy.

Faulkner found that on the pre-training tapes, the nurses’ performances were only adequate on three verbal skills, and the lowest scores were on assessing the psychological state of the patient. Although after training the overall ratings improved, the scores on psychological areas were still below minimal levels of competence.

These initial studies were conducted before the introduction of the nursing process approach to care, which relies heavily on effective communication skills to assess patients’ problems. As a result, greater emphasis has been placed on trying to improve nurses’ communication skills.

To evaluate whether this emphasis has been effective, I examined nurses’ communication skills at two levels (14):

- The extent to which nurses blocked or facilitated patients’ expression of their problems or concerns during a nursing assessment with three patients at different stages of disease.
- How well nurses covered the key areas of the nursing assessment.

The results (Table 1) demonstrate that 20 years on, little has changed. Overall, there was a predominance of blocking verbal behaviours in all three assessments, indicating that nurses continue to use avoidance tactics to prevent patients disclosing their concerns. The level of assessment skills in the key area of the nursing assessment was very superficial, particularly in terms of psychological care.

Communicating effectively

The good news from this study was that not all nurses communicate ineffectively. There was a small group of nurses who were able to help patients at all stages of their illness to talk about their problems and how they were feeling. The question this raises is why are some nurses able to communicate effectively with patients and others are not? Further analysis revealed that certain factors were vital for effective communication to take place.

First, the communication in this study differed significantly between wards. On the wards where effective communication took place, the influence of the charge nurses was enormous. They were democratic leaders compared with the autocratic leaders on the poor wards. This suggests that to communicate effectively, nurses not only need good skills, they also have to have an environment conducive to open communication. The nurses who had completed a recognised post-basic training in cancer nursing were significantly better communicators than those who had not.

It is the vital area of heightened self-awareness, an important aspect of these post-basic courses, that may be the key to improving nurses’ communication with these patients. But do most nurses have good levels of self-awareness? To find this out, it is necessary to consider three questions:

- Are nurses aware of how they communicate?
- Do nurses really want to communicate openly with patients?
- How can nurses improve their levels of self-awareness in order to communicate effectively?
To investigate how aware nurses were of their verbal and non-verbal behaviours, 54 nurses were interviewed using a semi-structured interview schedule. Each interview was tape recorded and two types of behaviour were explored:

- Nurses’ physical avoidance of dying patients
- Nurses’ verbal behaviours during three tape recorded nursing assessments.

Physical avoidance The nurses were asked: have you ever avoided a dying patient? Seventy four per cent admitted that at some time they had deliberately done so. The most frequent reason given was that they did not know what to say. This indicates that most nurses are aware of their physical behaviours.

Verbal behaviours First, the nurses were asked how they felt each of their three nursing assessments had gone in terms of identifying the patient’s problems. The responses formed three categories:

- Satisfactory - 'It went well, no difficulties'
- Awful - specific difficulties experienced
- Unsure - uncertain whether the patient's problems were identified.

Satisfactorily assessed Most nurses felt they had satisfactorily assessed the patient’s problems in all three nursing assessments, but as previously demonstrated from the independent ratings (Table 1), only very few nurses had in fact satisfactorily assessed the patient’s problems. This suggests nurses’ awareness of their nursing assessments was poor.

Second, to establish whether the nurses were aware of the actual verbal behaviours they used to block patients from disclosing their problems, three pieces of audiotape recording from their nursing assessments were replayed. Each piece of tape contained a blocking verbal behaviour. As it was replayed, the nurse’s response was noted.

Table 2 indicates that in 30 per cent of first replays, the nurses spontaneously stated: ‘Oh, I knew I was doing that at the time’, or ‘I know what’s coming next - I can remember saying it’, and correctly identified the blocking behaviour they used. In 70 per cent of replays, the nurses made no comment. In each of these cases, the piece of tape was replayed and the researcher commented that something had just happened in that piece of interview and asked if the nurse could identify it. In 70 per cent of replays, the nurses were able to identify what had happened. In the remaining replays, nurses were still not able to see what had happened.

These results demonstrate that although nurses are fully aware of their physical avoidance behaviours and are honest enough to admit to it, their self awareness of verbal behaviours is poor.

The nurses who had the best self awareness were from two groups: a group of good communicators who had used effective communication throughout their nursing assessments, and a group of poor communicators who had used a particular blocking behaviour. These were changing the subject and giving inappropriate information. The worst level of self awareness, however, was in a group of nurses who used the more subtle blocking behaviours, such as:
- Normalising, for example, stereotyped comments:
  Patient: ‘I’m worried about this operation.’
  Nurse: ‘Everyone feels anxious when they have to have an operation. It’s normal.’
- Premature or false reassurances, for example:
  Patient: ‘I am concerned about the biopsy this time. It feels different.’
  Nurse: ‘Don’t worry about the result. It was all right last time. I’m sure it will be this time.’
- Leading questions, for example:
  Nurse: ‘You are feeling well today, aren’t you?’

Most of the nurses in this group were genuinely using these behaviours without realising that they were blocking patients from discussing problems. The nurses had to be focused on these behaviours with a suggestion that something had happened before they realised they had prevented patients from continuing to talk about their concerns. This indicates that many nurses do not know that certain verbal strategies hinder effective communication.

So, to answer the question, ‘Are nurses aware

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<thead>
<tr>
<th>Table 3. Is it nurses’ role to discuss patients’ feelings about diagnosis and prognosis?</th>
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<tr>
<td>Nurses’ responses</td>
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<tr>
<td>-------------------</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
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<tr>
<td>Total</td>
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<tr>
<th>Table 4. Talking truthfully with patients on how they feel re diagnosis and prognosis?</th>
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<td>Nurses’ responses</td>
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<tr>
<td>-------------------</td>
</tr>
<tr>
<td>Yes, no problems</td>
</tr>
<tr>
<td>Like to, but lack skills</td>
</tr>
<tr>
<td>Only so far (identify and refer)</td>
</tr>
<tr>
<td>No, I don’t want to</td>
</tr>
<tr>
<td>Total</td>
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of how they communicate?' the answer has to be that, on the whole, most nurses are not. What about the nurses who were poor communicators but who were also very aware that they had consistently prevented patients from talking about their problems? As a reminder of the effect this can have, here is a short extract from a nursing assessment. This patient had cancer of the lung and was in the middle of a second course of chemotherapy for a recurrence.

**Nurse:** 'How have you gone on over your treatment up until now?'

**Patient:** 'I'm OK but I'm nervous, you know, about the sickness.'

**Nurse:** 'Well, a lot of patients are. We find a lot of them as they come through the door don't really realise that they will get these symptoms. It's quite normal really.'

**Patient:** 'Well, I know that, but you know I go off my food, my taste buds go away, it's horrible. Isn't there something you can do?'

**Nurse:** 'The treatment doesn't help your taste. A lot of patients say that.'

**Patient:** 'It's this feeling of tiredness, you know. There must be something for that.'

**Nurse:** 'Yes, I know. Everyone complains of that. How are you doing for transport after your treatment?'

**Patient:** 'Transport...I've got a lady friend who can have, here is a short extract from a nursing assessment. This patient had cancer of the lung and was in the middle of a second course of chemotherapy for a recurrence.

**Nurse:** 'So you do manage.'

**Patient:** 'Well, I suppose so at the moment. Mary is staying just in case anything happened....' She said: 'We are looking forward to seeing you and your bed and everything is all made'.'

**Nurse:** 'Oh, that's nice.'

**Patient:** 'She's a good'un you know. I get myself

strung up with this sickness.'

**Nurse:** 'Well, all we are waiting for is your blood results and after that you can go home tomorrow and there'll be no problems. After your next treatment, it will be your last treatment, won't it?'

**Patient:** 'I hope so. It's so horrible, something terrible.'

**Nurse:** 'Never mind. You'll get through it, everyone says it's awful.'

### Avoiding openness

This extract demonstrates clearly that the nurse was at all costs going to avoid talking openly to patients and not answer direct questions. This leads to the second question: do nurses really want to communicate effectively?

In an attempt to answer this, several questions were put to the nurses. First, they were asked their views on whether they considered it their role to talk to patients about their feelings regarding diagnosis and prognosis. There appeared to be little doubt in the nurses' minds that it was Table 3).

When the question was put in a different way - in all honesty, did the nurses believe they could, or did they want to, communicate openly with patients about the very emotive and crucial issues surrounding diagnosis and prognosis - the responses were very different (Table 4).

When the nurses were asked to explain what it was that stopped them talking to patients openly, some answered 'nothing', but the rest of the replies fell into three categories (Table 5). The final group of nurses' responses were extremely important. They admitted it hurt or upset them so much when they had tried to communicate openly with patients, they had now decided that if they were to survive in cancer nursing, they could not continually expose themselves to patients' emotional problems.

Such opinions raise the following issues:

- Have our expectations of how nurses communicate become unrealistic?
- Is it morally right to expect all nurses to get so close to patients if it causes some of them such distress?

Whatever one feels about these issues, it now seems important as a profession to recognise that the answer to the question 'do nurses really want to communicate openly with patients' is 'no'; in reality, not all nurses do want to communicate openly.

Furthermore, it is important that nurses are allowed to look at themselves, explore their own feelings and make decisions about this area of
nursing care without feeling a failure or that they are letting patients down.

The implications of such views may mean that it is necessary to look in more detail at skill mixes among teams of nurses. Each team should include nurses who feel competent and comfortable giving psychological care and others who feel happier giving physical care. This leads to the final question: how can nurses learn to communicate effectively?

Clearly, post-basic education in cancer care is vital and courses with a communication skills programme are the most effective (14). Course contents for such programmes vary. Medical training which includes a highly structured communication skills programme for small groups of students has been shown to be particularly useful (15,16), especially if the course includes the following elements: demonstration tapes; practice under controlled conditions; feedback from teachers and peers; time to explore personal attitudes (16). In nurse education, courses which have encouraged exploration of attitudes surrounding cancer, death and dying also seem valuable (14,17).

Second, effective courses seem to be those which include a communication skills programme completed over a period of weeks (18). This allows nurses to learn skills, and then to practise them gradually with supervision and support from a teacher and peer group.

As raising self awareness has been shown as a powerful means of improving communication skills (19,20), courses should provide nurses with opportunities to look at themselves. This could include audio- or videotaped interactions with patients or colleagues role-playing patients, with support and feedback from teachers.

Finally, communication skills training should include knowledge of non-verbal and verbal behaviour, assessment skills and techniques for handling difficult questions and situations. The situations in which nurses frequently ask for help focus on diagnosis, prognosis and death (18). One way of enabling nurses to practise these skills and techniques in a controlled environment is role play which if handled sensitively can be effective.

**Experiential methods**

In conclusion, most patients want open communication with health professionals. Research indicates, however, that nurses’ skills in this area have not improved over the last 20 years. One reason for this could be that as a profession we have expected too much. For self protection, some nurses cannot and do not want to expose themselves continually to patients’ distressing problems, and they should be respected for their honesty. There are many nurses who feel they can or would like to learn to communicate effectively.

To help these nurses, more experiential methods of teaching are called for. Nurses who have experienced such methods have raised their self awareness and clearly reaped the benefits. It takes courage to learn from ourselves but we owe it to patients to take up this challenge.