Nurse–Patient Communication in Cancer Care: A REVIEW OF THE LITERATURE

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ABSTRACT

Patients with cancer seem to experience distress particularly in the first period after diagnosis, and are likely to develop an affective disorder in the first 2 to 3 months. Communicative behaviors of nurses seem to play an important role in meeting the cognitive and affective needs of patients with cancer. This review of the literature examines the communicative behaviors of nurses during care activities with patients who have cancer. The studies show that emphasis is placed on the affective side, in which facilitating behaviors such as empathy, touch, comforting, and supporting are considered essential in caring for patients with cancer. Unfortunately, further studies in this review demonstrate that communication in oncologic care is complicated by such emotionally laden issues as the consequences associated with the life-threatening character of the disease and the far-reaching consequences of the medical treatment. This results in barriers to effective communication between patients with cancer and nurses. It is important, therefore, that nurses working with patients who have cancer are provided both structurally and repeatedly with continuing education programs in communication. Finally, most of the studies covered in this review have an explorative character. Future research in this area should pay attention to the use of controlled studies, large sample sizes, and observational instruments.

Over the past 30 years, communicative exchanges between health care providers and patients have become an area of increasing interest for research because researchers as well as medical and nursing professionals are becoming progressively more aware of the importance of communication and its impact on patient outcomes ([1]). In addition, elaborate research in this field has led to a growing awareness that the provider–patient interaction is a complex phenomenon. Although the provider and patient are pursuing a common objective, their positions are not equal, their interaction and cooperation are nonvoluntary, and their perspectives are often different ([2,3]).

The aim of this article is to provide an overview of communication between and patients with cancer and nurses. Communication is especially important where life-threatening illnesses such as cancer are concerned. Patients with cancer seem to experience psychological and relational problems particularly after diagnosis ([4,5]). Many concerns involve uncertainty about the deterioration of their health, future prospects, confrontation with death, and fear of the dying process ([6]). When patients' emotional resources are inadequate to cope with the stress, psychological distress may result.

Maguire ([7]) emphasized that patients who are not coping effectively with cancer after diagnosis are likely to develop an affective disorder. In addition, the far-reaching consequences of the treatment can cause increased emotional distress, which in turn can lead to acute anxiety and depressive states ([8]). Anxiety and depression are, therefore, the most common psychosocial problems among patients with cancer ([9]).

Furthermore, one fourth of these patients seem to need special help for these problems ([9,10]). Authors state that to prevent severe psychosocial problems and to increase quality of life for patients with cancer, medical and nursing professionals in particular have an important task with regard to informing patients, assessing their problems, giving them emotional support and, if necessary, referring them ([10–12]).

Wilkinson ([13]) stressed the importance of effective communication to successful nursing and medicine, stating that effective communication is achieved when open two-way communication takes place and patients are informed about the nature of their illness and treatment, and encouraged to express their anxieties and emotions.

STUDY AIM

As the introduction reveals, the communicative behaviors of nurses play a crucial role in meeting the cognitive and, particularly, the affective needs of patients with cancer. These behaviors can help patients who experience considerable distress in the first period after diagnosis to integrate the disease into their daily lives.

Until now, researchers have placed primary emphasis on the communicative behaviors of physicians. Because most of the available literature is about physician–patient communication, and because research into nurse–patient communication vis-à-vis physician–patient communication is more exploratory and qualitative, it is worth shedding more light on patterns of nurse–patient interaction in oncologic care.

The aim of this study was to gain insight into state of the art research on the communicative behaviors of nurses during care activities with patients who have cancer. For this purpose, the following question is addressed in this article: What communicative behaviors of nurses can be distinguished during the care of patients with cancer?

METHODS

To obtain the relevant literature, a search was made of three databases: Medline, Nursing and Allied Health Literature, and the Library Catalogue of the Netherlands Institute of Primary Health Care. The literature from 1980 through 1997 was selected. In keeping with the aim of this article, the literature was restricted to research on nurse–patient communication in cancer care. The following key words also were used in combination: cancer/oncology in combination with nurse–patient interaction/communication/relation, nurse communication skills, nurse caring behaviors. A total of 127 articles were found in this way.

The following inclusion criteria were used for the review:

- The study was directed at the interaction between nurses and oncology patients.
- It used observation techniques, interviews, or questionnaires.
- It was published in English or Dutch.

All the studies meeting these criteria were included, regardless of the quality and sample size. Twenty studies met the inclusion criteria.

RESULTS

Several communicative behaviors used by nurses in an oncology setting can be identified in the literature. Table 1 gives an overview of research on nurse communicative behaviors during care activities with patients who have cancer.

[TABLE 1]

Empathy

The first three studies summarized in Table 1 show that empathy, a concept that originates in the work of psychotherapists, seems to play a significant role in the communication between nurses and patients with cancer ([14–16]). Raudonis ([15]) identified two major categories of empathy in a hospice setting: affirmation as a person and friendship. *Affirmation as a person* refers to the patient being acknowledged by the nurse as an individual, a person of value, regardless of the diagnosis and the stage of disease. *Friendship* in a hospice setting refers to an intense, deep, and meaningful relationship between nurses and patients with cancer, in which feelings and information are shared reciprocally. In addition, Raudonis found that an empathic relationship between nurses and hospice patients had a positive impact on patients' physical and emotional well-being.

Reid-Ponte ([14]) stated that empathy signifies several behaviors and defined empathy as "a certain sensitivity to others' feelings and ability to explore those feelings, to express sympathetic understanding, and to act in a caring or nurturing way" (p. 284). In her study, Reid-Ponte found that nurses generally scored low in the use of empathy skills in the daily care of patients with cancer. Furthermore, Reid-Ponte found a significant relationship between nurses' empathy skills and patients' experience of distress. Her explanation was that nurses who scored high on perceiving and listening may elicit more distress responses from patients with cancer. In other words, empathy may facilitate patients' expression of their physical and emotional distress. Additionally, Reid-Ponte found that perceiving and listening scores decreased as nurses' education level increased, and that nurses' empathy scores for verbal response decreased significantly as their age and years of experience increased.

La Monica et al. ([16]) stressed the significance of establishing a helping relationship with patients in order to fulfill nursing goals, and stated that empathy is an important component in achieving such relationships. In La Monica's study, it appeared that nurses' empathy levels did not change after training. Furthermore, La Monica found that empathy relieves the pain, depression, and anxiety of patients with cancer.

Types of Attending and Types of Touch

The Bottorff ([17–19]) studies shown in Table 1 define four caring activities known as "types of attending" as well as different types of touch that seem to accompany these initial variations in the attending of patients with cancer in a clinical setting. The first type of attending is defined as *doing more,* which refers to the nurse doing something beyond what usually is required to complete the care. The nurse's attention is focused on the patient, providing the patient the opportunity to confide in the nurse.

In doing more, comforting, connecting, and working touches seem to figure most frequently. A "comforting" touch is given to reassure, calm, or encourage the patient. It is considered an expression of the nurse's caring and concern. A "connecting touch" is given in the case of a more superficial talk about care, a social talk, or a talk in which the nurse gives instructions. "Working touches" include all the types of physical contact necessary to complete activities.

The second type of attending is defined as *doing for,* which denotes nurse responses to patient requests and needs that are not treatment related. It can be characterized by a personalized approach to giving assistance. In doing for, working and connecting touches predominate.

The third type of attending is characterized as *doing with,* which is a willingness to work cooperatively with the patient. The nurse focuses on both the task and the patient. In doing with, working touch seems to occur frequently, and some connecting and orienting touches also occur. The main purpose of the "orienting" touch is to clarify. Nurses most often use their fingertips in pointing to particular areas of the patient's body.

The last type of attending is characterized as *doing tasks*. In this type of attending, the nurse focuses on equipment, treatment, and getting the job done. There is an exclusive focus on tasks. In doing tasks, the working touch seems to predominate.

With respect to touch, another distinction is made between task-oriented or procedural touch and comforting or affective touch, as described in the study by Morales ([20]) included in Table 1. “Task-oriented” or “procedural” touch is associated with a technical procedure that has a curative purpose, whereas comforting or affective touch is intended to ease psychological and physical distress and to convey confidence ([20]). Bottorff’s working and orienting touch are similar to task-related touch. The comfort, social, and connecting touches identified by Bottorff are similar to affective touch.

Bottorff et al. ([17–19]) emphasized awareness of types and meaning of touch, which might afford nurses the opportunity to increase the therapeutic value of touch as nursing intervention. Morales ([20]) also stressed that nursing touch is an important behavior for transmitting confidence, and found that two aspects of confidence in patients with cancer can be enhanced by nurses through touch: being helped to enhance coping abilities and being accepted as a person within the process of disease. Morales ([20]) found that although nurses reported the importance of affective touch for enhancing patients’ confidence, this nonverbal behavior was minimal during interactions between nurses and patients with cancer in daily care. Morales concluded that more emphasis should be given to touch in nursing education.

Comforting Strategies

Bottorff et al. ([19]), as shown in Table 1, conceptualized comforting strategies used by nurses to meet the physical and emotional needs associated with the illness or treatment of patients with cancer.

As with empathy, comforting is considered an important skill in nursing care for patients with cancer. Bottorff et al. ([19]) shed more light on this concept and showed that comforting appears to be an unclearly defined skill in nursing literature. Descriptions of comfort seem to lack specification, or to focus mainly on measures to relieve pain.

Bottorff et al. ([19]) indicated that comforting strategies involve more than mere relief of pain. They also include humor, physical comfort, emotionally supportive statements, and comforting and connecting touch. Comfort provides opportunities for patients to make choices, supplies them with information, and engages them in social exchanges. It also provides a feeling of closeness. These comforting strategies also show aspects of instrumental and affective behaviors and comprise a significant part of the types of attending and touch described, as also defined by Bottorff ([17]).

Specific Comforting Strategies in Palliative Care

In the studies by Fleming et al. ([21]), Degner et al. ([22]), and Rittman et al. ([23]) described in Table 1, specific comfort measures are described, in which the focus of care for patients with cancer shifts from cure to palliation. In the first place, a significant instrumental task in a palliative care setting is providing physical comfort,

which includes reducing the severity of the illness by minimizing symptoms and offering adequate pain control.

Furthermore, specific affective tasks in a palliative care setting seem to be of significance. These include providing psychosocial and spiritual comfort and responding to the family. Providing psychosocial comfort refers to activities directed at emotional care such as listening, touching, and keeping hope alive by helping patients to use the time left for achieving goals that are meaningful to them. Providing spiritual comfort refers to nurses acknowledging the religious and philosophical beliefs of the patient and responding to spiritual aspects by praying with the patient, or by taking the patient to religious services. Responding to the family refers to meeting the needs of the family and providing for privacy, especially during actual death.

The measures described show that providing instrumental and affective comfort becomes nurses' major concern in meeting the specific needs of severely ill patients with cancer.

A major prerequisite for adequate performance of these tasks seems to entail acknowledging the patient's disease status and his or her illness experience, reading the signs of physical and mental changes, and enhancing the patient's sense of person and individuality. Degner ([22]) found that when these specific tasks are performed adequately, nurses are enabled to define a role for themselves in helping the severely ill patient with cancer, and to experience personal growth as a result of their involvement in care. Rittman ([23]) stressed that nurses, in managing the emotional demands of their work, must recognize the importance of their involvement at different levels with the severely ill patient in varied situations. This means being very involved and feeling close to the severely ill patient in certain circumstances and having a relationship with the patient that is less intense in other circumstances.

Finally, in the three studies, good communication and cooperation between colleagues is emphasized, which involves a multidisciplinary approach and adequate provision or reception of support or criticism.

Supportive Behaviors

The studies by Krishanamy ([24]) and Larson ([25]) in Table 1 describe important nurse behaviors from the perspective of the patient with cancer. Krishanamy ([24]) studied supportive and unsupportive nurse behaviors as perceived by patients with cancer. It appeared that patients with cancer perceived behaviors that reflect respect and intimacy, providing companionship, reassurance, encouragement, and accompaniment in stressful situations as most supportive, followed by behaviors providing information and clarification about the disease, treatment, and subjective feelings.

In contradistinction to Larson's study ([26]), it appeared that the emotionally supportive behaviors, listening and talking, became important to patients with cancer only after their "getting better" needs were met. The patients ranked nurses' competence

related to clinical know-how, which is an instrumentally supportive behavior, as most important.

Blocking and Facilitating Behaviors

In eight studies shown in Table 1, authors stress the importance of how nurses use communicative behaviors in meeting the needs of the patient with cancer. These behaviors can hinder or stimulate the patient in expressing his or her concerns and information needs.

In the research on the communication between the nurse and the patient with cancer, these nursing behaviors are the so-called "blocking" and "facilitating" behaviors ([26–29]). It is assumed that by using blocking behavior, nurses prevent the patients from talking about their problems. They ignore patients' cues or switch topics.

On the contrary, nurses who facilitate patients in talking about their problems seem to be able to achieve more "in-depth" assessment of patients' problems. This facilitating behavior on the part of nurses is associated with greater patient satisfaction with care, and with patients reporting a more confidential interaction ([30]). As regards the blocking and facilitating behaviors, Wilkinson ([26]) identified four styles: the facilitators, the ignorers, the informers, and the mixers.

The *facilitators* use skills such as picking up cues and clarifying and summarizing patients' problems. With these skills, patients are helped to talk about their concerns. Because facilitators are able to interact effectively with patients who have cancer in emotionally laden situations, they seem to achieve more in-depth assessments. The ignorers neglect patients' cues and switch topics when talking with the patient. This enables them to keep out of emotionally laden situations. The *informers* give inappropriate information and opinions throughout the interaction with the patient. These relate mainly to physical areas, especially procedures that have to be carried out. The *mixers* are nurses who use a mixture of blocking and facilitating behaviors. These nurses recognize their use of blocking verbal behaviors during their interaction with patients to a greater extent than the informers and the ignorers.

Wilkinson ([26]) found that nurses used blocking behaviors more than 50% of the time during conversations with patients who have cancer. These findings agree with the studies of Heaven and Maguire ([29]), Booth et al. ([28]), and Maguire et al. ([31]), who found that nurses, despite communication training, were not very successful in identifying what patients' concerns were.

In the study of Heaven and Maguire ([29]), only 52% of the patients' biggest concerns were identified before training, with 59% identified afterward. Booth et al. found that the more the patient with cancer disclosed feelings, the more blocking behaviors occurred. Maguire et al. found that the use of leading questions and clarification of physical aspects strongly inhibited patients' disclosure of significant information. On the contrary, the use of open directive questions and empathy facilitated patients' disclosure of concerns and feelings about their illness and treatment.

The study by Webster ([32]) shows that severe blocking behaviors also occur during the care of patients dying with cancer. Blocking behaviors in this context are

predominantly characterized by the use of avoidance behaviors or distancing tactics in circumstances perceived by nurses as stressful. These behaviors agree with Degner's ([22]) description of affective and instrumental behaviors (Table 1), which were found to be executed in a positive (facilitative) or negative (blocking) way (not documented in(Table 1). The specific blocking behaviors identified in these studies for patients dying with cancer can be summarized as follows:

* *denial of the seriousness of patient's condition*, which results in neglect and poor symptom management because of poor knowledge

* *not responding to patient's emotional, spiritual, and informational needs*, which results in abrupt changing of the subject of conversation, behaving as though the patient had not spoken at all, concentrating intensely on the physical task at hand, pursuing the least threatening aspect of conversation, introducing a joking atmosphere

* *not responding to the needs of the family*, which results in behaviors that show lack of respect for family, for example, not providing privacy to the patient and family, ignoring the family's need for information; and behaviors that block family involvement, passing judgment on family behaviors toward the dying patient.

Webster ([32]) found that most of the nurses participating in the study were conscious of using these distancing tactics. They were afraid of losing control over the situation when not using them.

Dennison ([33]) studied the verbal communication that took place when nurses were administering cytotoxic chemotherapy in a specialized gynecologic oncologic unit. Most interactions were initiated by the nurses and concentrated on information giving. Detailed, clear, precise explanations were provided, reflecting the highly technical nature of the procedure. However, nurses rarely assessed patients' understanding of the situation or their feelings. Dennisson emphasized that there is a need to structure and improve the emotional, supportive, and information-giving techniques employed by nurses.

In Bond's ([34]) study, observations and reports of interactions showed that dyadic interaction rarely took place between patients with cancer and nurses in a ward. On the whole, nurses showed an overwhelming concern with the physical care and treatment problems. Although nurses were aware of adjusting patients' problems after diagnosis, there rarely was discussion of personal problems or social matters that could be affected by the illness.

Finally, the study by Suominen et al. ([35]) concentrated on nurses' performance of behaviors as perceived by patients with cancer and the nurses themselves. Suominen et al. found that especially during hospitalization, patients with cancer felt they received insufficient information and inadequate psychological and social support. Patients felt that nurses did not talk to them, share experiences with them, listen to them, or treat them on an individual basis. However, most of the nurses disagreed with these patients' perceptions. Furthermore, both patients and nurses thought

nurses were preoccupied with their work. In reviewing most of the patients, nurses did not have enough time for them. A majority the patients reported that nurses did not provide support for their relatives, whereas a minority of the nurses reported that they were not providing support for the patients' relatives.

DISCUSSION

Patients with cancer seem to experience very considerable distress particularly in the first period after diagnosis, and are likely to develop an affective disorder in the first 2 to 3 months. The communicative behaviors of nurses seem to play a crucial role in meeting the cognitive and, more especially, the affective needs of patients with cancer.

Wilkinson ([13]) stated that effective communication with patients who have cancer 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 concerns. This statement corresponds with the research on doctor–patient communication, in which a clear distinction is made between instrumental or task-related behaviors and affective behaviors used to meet patients' needs.

Instrumental behaviors refer to technical interventions "in order to solve the problem, for which the physician is consulted" on the basis of his expertise. Affective behaviors refer to nontechnical interventions, which are important mainly in gaining the patient's confidence and in paying attention to other aspects of the patient's quality of life ([36,37]). From a patient's perspective, these behaviors coincide with two needs that must be met during the information exchange with the provider: the need to "know and understand" and the need to "feel known and understood" ([38]).

A conceptual link has been made between the literature of doctor–patient communication and the literature of stress and coping ([39]). The instrumental or technical behavior of the provider corresponds with "problem-oriented coping," or the patient's effort at solving problems brought about by the disease, whereas the affective behavior of the provider corresponds with "emotion-oriented coping," or the patient's handling of emotions evoked by the disease. Both behaviors can have a positive impact on the patient's coping process, especially in the case of the patient with cancer, who feels stress on being confronted with a life-threatening disease.

The nursing activities reviewed in this article demonstrate that nurses also perform instrumental and affective behaviors during care activities with patients who have cancer, but their instrumental and affective communication is not as explicitly described in the research as doctor–patient communication. As a consequence, the picture of nurse-sourced important communicative behaviors during care activities with patients who have cancer remains unsystematic.

Nevertheless, a number of the studies reviewed show that emphasis is placed on the affective side, in which empathy, touch, facilitating and blocking behaviors, and comforting and supporting skills are considered to be essential themes in caring for

patients with cancer. This corresponds with the character of the nursing profession, in which not only instrumental care but also intimacy with patients who have cancer is considered important ([15,22,40,41]).

Unfortunately, other studies in this review demonstrate a gap between the need of patients with cancer for emotional support during the treatment and nurses' ability to give them adequate emotional care ([7,24,26,28,29,31,32,34,35]). In these studies, nurses perform predominantly instrumental behaviors or use distancing tactics, which block the expression of concerns by patients with cancer or present an obstacle to their asking questions. Consequently, patients with cancer receive information that does not match their personal needs and poor psychosocial treatment from the nursing professionals ([2,13,28,32]).

On the whole, nurses seem to be aware of the discrepancy between their perception concerning quality of care on the one hand and the nature of the actual care on the other. They report "informing," "assessing," "giving support," and "problem solving" as important tasks in caring for patients with cancer, while describing their use of strategies to avoid letting patients talk ([26,32,33]) or their performance of mainly somatic or instrumental tasks in practice ([33]).

The principal explanation authors mention for the problematic interaction between these professionals and patients with cancer is the complexity of communication in an oncologic setting. The literature reveals that communication is complicated by emotional issues in patients with a poor prognosis, especially patients with cancer ([2,42,43,44]). Faller and Schilling ([45]) pointed out that patients with cancer give themselves significantly more hope than doctors and nurses do. Interaction time with patients who have cancer tends to be abbreviated, and distancing tactics are used ([43]) because of the unease that physicians and nurses experience in discussing emotional issues. One view is that when these providers deal with patients who have cancer, fear of their own death becomes intensified ([46]). Another view of doctors and nurses focuses on uncertainty: If they talk openly with patients who have cancer, they could be faced with problems with which they will not be able to cope ([32,43]).

One result of these difficulties in nurse–patient communication is vagueness ([47]). For patients who avoid information because they have reached a particular stage in their coping process, vagueness is not a real problem. However, a barrier exists when patients eager for information receive vague responses from medical or nursing professionals. Vagueness can be seen as a struggle between awareness of the patient's right to know and the desire to protect the patient by withholding information or providing nonalarming information in a supportive manner ([47]). This is how physicians and nurses attempt to survive emotionally and avoid confrontation with the overwrought emotions and anxiety of patients with cancer. It illustrates the "pact of silence," by virtue of which providers and patients do not openly discuss issues for different reasons. A consequence of this problematic information exchange is that doctors and nurses do not routinely detect patient concerns.

The preceding illustrates the point that oncologic settings, in particular, are characterized by specific aspects that make working and communicating with

patients who have cancer challenging. Vachon ([48]) described the stressors regularly experienced by oncologists and oncology nurses. These include caring for patients who are extremely sick, dealing with patient death at all ages, coping with poor staff communication, experiencing intense involvement with patients and their families, resolving conflicts between research and clinical care goals, and managing the work load imposed by the complicated responsibility of oncology care. Breitbart and Holland ([49]) described the development of physical symptoms, psychological symptoms, and burnout of medical staff as a consequence of stress in a cancer setting.

It is important therefore that nurses working with patients who have cancer will be structurally provided with continuing education programs in the future. Such programs should be focused on facilitative skills to elicit patients' concerns, in which nurses learn how to integrate these skills with task-related care for patients with cancer.

Regarding the quality of the studies in this review, it can be concluded that there are methodologic shortcomings. In the first place, small sample sizes were used in several studies. In addition, observational analysis was used in only nine of the studies. Observational analysis is preferred because it is the most direct method of evaluating performed behaviors. Furthermore, the majority of the studies revealed no figures concerning the reliability and validity of the measuring instruments. As a consequence of the small sample sizes and the poorly validated instruments, the quality of several studies is doubtful.

On the basis of this review of the literature, it may be recommended that in future research, more controlled studies in this area should be conducted. These controlled studies should use observational methods that have proved to be reliable and valid. Finally, with regard to generalization of the findings, larger sample sizes should be used.

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TABLE

Source	Setting and sample	What was being studied	Methods	Variables	Reliability and validity	Findings
Raudonis (1993) (15)	14 terminally ill patients receiving hospice care ranging from 3 weeks to 17 months. They experienced multiple home visits by one or more hospice nurses. 4 home care hospices	To study the meaning and impact of empathic relationships on hospice nurses	A natural field study was used, with in depth interviewing for data generation. The interviews were recorded and transcribed. Data reduction and coding took place with the use of three prespecified codes: nature, meaning, and impact. Latent content analysis was used to identify and describe subcategories of these codes: A constant comparative method was used to examine similarities and differences across categories.	Empathy	No findings	Two categories of empathy were identified: affirmation as a person and friendship. A major outcome of the empathic relationships was improvement or maintenance of the patients' physical and emotional well-being or quality of life.
Reid-Ponte (1992) (14)	A convenient sample of 65 professional staff nurses and cancer patients of primary nursing surgical care units in a 957-bed, private, nonprofit teaching hospital.	To study the relationship between Primary nurses' empathy skills and the distress level of their patients with with cancer Primary nurses, demographic variables and their empathy skills	Questionnaires were used to assess empathy (LEP), dimensions to affect mood or affect (POMS), distress (SLC-90-R), and the relation between POMS scores and pain intensity and distress (VAS).	Empathy	LEP: internal consistency: Cronbach's coefficient alpha ranges from 0.96 to 0.98 POMS: no figures VAS: no figures	A significant correlation was found between nurses' emphatic behaviors and disclosure of concerns by patients with cancer.
La Monica et al. (1987) (16)	Two units of a major cancer center in an urban area (USA) 109 registered nurses and 656 clients	To investigate the effects of nurse empathy training on the client outcomes of anxiety, depression, hostility, satisfaction with care; and the impact of group instruction on the empathy levels of nurses	Nurses were presented with an empathy training program (n = 56) or a control program (n = 53) Client outcome measures included the Multiple Affect Adjective Check List and the La Monica/Oberst Patient Satisfaction Scale. Nurse outcome measures included the Empathy Construct Rating Scale.	Empathy	MAACL: reliability and validity are well documented in the literature. LOPSS: Cronbachs alpha was 92. ECRS: Evidence for reliability and validity is not presented in this article.	Clients cared for by nurses in the experimental group showed significantly less anxiety and hostility than clients cared for before the experimental treatment. Mean differences in depression and satisfaction with care were in the hypothesized direction.
Bottorff (1993), Bottorf & Morse (1994) (18)	One private room on an active treatment oncology ward with 8 patients. 32 nurses Audiotaped unstructured interviews with 8 nurses and 6 patients took place to provide data to support observational data.	To examine patterns of touch nurses use when caring for patients with cancer (1993) To identify the types of nurse–patient interactions in which touching behaviors zre used (1994)	A qualitative and observational approach was used inductively to identify the types of attending Nurse–patient interactions were videotaped for 72 hours for each patient. Audiotaped unstructured interviews with 8 nurses and 6 patients took place to provide data to support observational data.	Types of attending/ types of touch	No figures	Five types of touch were identified and described: comforting, c onnecting, working, orienting, and social touch. Four types of attending were identified: doing more, doing with, doing for, and doing tasks. They accompany the the different types of touch.
Morales (1994) (20)	8 cancer patients at a tertiary 12-bed oncology research unit in Puerto Rico	To elicit the meaning of nurses' touch for hospitalized patients with cancer	Data-gathering methods included participant observation and ethnographic interviews. Content analysis was used to identify nurses' touch behaviors.	Types of touch	No figures	Two types of nurses' touch were identified: procedural and affective touch. According to patients perceptions conveying confidence is a central theme of touch by nurses. On the whole, touch by nurses was minimal and procedural in nature.

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Bottorff et al. (1995) (19)	See Bottorf 1994	To identify and describe nurses' use of comforting strategies	A qualitative and observational approach was used to identify comforting strategies used by nurses. Nurse–patient interactions were videotaped for 72 hours for each patient.	Comforting strategies	No figures	Using the qualitative ethology, nurses' comforting strategies included gentle humor, physical comfort measures, emotionally supportive statements and comforting and connecting touch.
Fleming et al. (1987)	145 nursing staff members of an acute care hospital in the United States	To identify and describe comfort needs of patients with advanced cancer, as reported by nursing staff.	An open-ended self-report questionnaire was used to identify comfort needs of patients with advanced cancer Qualitative analysis was used to classify aspects of comfort needs.	Special comfort measures in palliative care	No figures	The following seven key components of comfort were identified: physiological; spiritual; psychosocial; patient's rights, dignity, self-worth, and patient involvement in care; reducing severity of the illness; family/friends; multidisciplinary team approach.
Degner et al. (1991) (22)	10 palliative care nurses from a palliative care unit in Canada 10 educators from different parts of Canada, experienced in teaching nursing students	To identify and describe critical nursing behaviors in care for the dying.	Semistructured (tape recorded) interviews took place. The interview were transcribed and read independently by two investigators to identify essential behaviors. The behaviors were clustered into categories. Final clustering took place after a third independent coding. A review was conducted to identify critical nursing behaviors in care for the dying.	Special comfort measures in palliative care	No findings	Behaviors identified after content analysis of transcribed interviews were providing comfort, responding to anger, enhancing personal growth, responding to colleagues, enhancing quality of life during dying, and responding to the family. These nursing behaviors occurred in a facilitating or blocking way.
Rittman et al. (1997) (23)	6 oncology nurses working on an oncology unit considered by their colleagues to have a high degree of expertise. The nurses had at least 5 years oncology nursing experience.	To explore the experience of nurses engaged in relationships with dying patients in order to describe skills and shared practices of oncology nurses	The hermeneutic method was used: Data consisted of six narratives written by oncology nurses. In-depth interpretation of each narrative took place.	Special comfort measures in palliative care	No findings	Nurses who have expertise in caring for dying patients establish different levels of involvement in different situations. Using the hermeneutic method, four themes were identified: knowing the patient and the stage of illness, preserving hope, easing the struggle, and providing for privacy.
Krishanamy (1996) (24)	8 hospitalized patients with cancer (4 male, 4 female), diagnosed with hematologic malignancy	To identify the nursing behavior patterns perceived as being helpful and unhelpful by 8 hospitalized patients with cancer	8, one-time, semistructured taped interviews were undertaken. The Interviews were transcribed. Gottlieb's classification system was adapted and used to code the transcribed data concerning supportive nursing behavior. A five-category classification of unsupportive behavior patterns was devised after further consideration of Göttlieb's scheme and a review of the relevant literature.	Emotionally supportive behaviors, informationally supportive behaviors, instrumentally supportive behaviors	No findings	The findings of semistructured interviews revealed that for patients with cancer, emotionally supportive behaviors, are the most supportive behaviors, followed by informational supportive behaviors. Unsupportive behaviors were those perceived as lacking or devoid of the emotional component.

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Larson (1984) (25)	57 adult patients with cancer, hospitalized for treatment in 3 acute-care hospitals in the United States	To determine which nurse caring behaviors are perceived by patients as being most important or least important	The Caring Assessment Instrument (CARE-Q) was used to obtain patient's perceptions of important nurse caring behaviors.		No findings	Supportive behaviors included trusting relationship; comforts; explains/facilitates; monitors/ follows through; assessable. The results show that patients ranked as most important nurse caring behaviors, the technical behaviors such as competent clinical know-how. Ranked as least important were affective behaviors such as asking for the name the patient wants to be called, and sitting down with the patient. Listening to the patients was ranked by patients as a moderately important nurse caring behavior.
Wilkinson (1991) (26)	54 registered nurses completed 3 audiotaped histories with a cancer patient, a self-administered questionnaire, and a semistructured audiotaped interview. The study was conducted in a specialist hospital and a nonspecialist hospital.	To determine The extent to which nurses facilitate or block patients and awareness of their verbal behaviors Whether there is a relationship between nurses' verbal behaviors and levels of anxiety, social support, work support, and attitude toward death; Nurses' difficulties in caring for cancer patients	Self-administered questionnaires were used to assess demographic data, fear of death, social support, and state trait anxiety. Tape-recorded nursing history took place with patients who had cancer. A coding system adapted from Forest was used to categorize nurses' behaviors. Semistructured tape-recorded interviews on difficulties in caring for patients took place.	Blocking and facilitating behaviors:	Interrater agreement using the categories adapted from Forest: Cohen Kappa coefficient was 0.65 or above. No figures with regard to the other methods	The findings indicate an overall poor level of facilitative communication. Four styles of nurses' (blocking/facilitating) behaviors were identified: facilitators, ignorers, informers, and mixers. Nurses' communication style is influenced by the environment created by the ward sister and the nurses' religious beliefs and attitude toward death, rather than specific education in communication skills.
Booth et al. (1996) (28)	41 hospice nurses of two hospices in the north of England 113 patients were interviewed	To test the impact of training hospice nurses in key assessment skills, and to study the relation between the occurrence of blocking behaviors and perceived professional support	All nurses were presented with a training program. Nurses' assessment measures concerning professional support included a semi-structured interview and a revised version of the House and Wells support scale nurses' assessment measures concerning their attitudes toward communication with patients who have cancer included a 4-point scale questionnaire. Nurses views about their supervisor's competence in doing his or her job was measured with a scale developed by House, and House and Wells. Nurses' assessment skills before and after the training were evaluated with an audiotaped interview with a hospice patient.	Blocking and facilitating behaviors	No findings concerning the reliability and validity of the questionnaires. The interrater system concerning coding the blocking behaviors ranged from 0.64 to 0.93 (Spearman) and from 0.005 to 0.469 (Wilcoxon)	The results of the study showed a weak improvement of nurses' assessment skills after the training. The only significant difference was in the use of open directive questions ($p = 0.002$); The more the patient disclosed feeling, the more blocking behaviors of nurses occurred. Nurses used blocking behaviors less frequently when the they got practical and emotional support from their supervisors.

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Bond (1983) (34)	55 patients with cancer interacting with nurses on an oncology ward of a hospital in England	To study nurses' communication with patients who have cancer	The nurses were directly observed, and nurses' reports concerning the content of their conversation with patients were used. A 4-point rating system (developed by Altdchul) was used to indicate nurses' conceptualizations of their interactions. Another categorizing system was used to measure the level of nurses' understanding of patients physical and mental condition.	Blocking behaviors	No findings	Direct observation and nurses' reports concerning the content of their conversations with patients who had cancer showed an overwhelming concern with physical care and problems associated with ongoing treatment. Rarely was there discussion or exploration of how patients felt about their condition.
Suominen (1995) (35)	140 Finnish women in whom breast cancer was diagnosed within the preceding 3 years 125 nurses: 89 ward nurses and 36 nurses from outpatient clinics in Finland.	To discuss the physical, psychological, and social support of patients with breast cancer, as evaluated by patients as well as by nurses	Two questionnaires with open-ended and multiple-choice questions were developed to measure patients' and nurses' perceptions of support provided by nurses.	Communicative behaviors	No findings	Especially during hospitalization, patients felt that they received insufficient information as well as psychological and social support. However, most of the nurses disagreed with these patients' perceptions. Furthermore, according to the majority of the patients, nurses had insufficient time for them.