Compassion in practice: Difficult conversations in oncology nursing

by Anne Katz

Cancer is more than biology: It is a social disease.
—Dr. Don Dizon

Communication is central to our personal and professional relationships and even more so with our patients. It is through communication that we inform, educate and support our patients and their families. It is also through communication, verbal and non-verbal, that we convey compassion and ease the patient’s path from diagnosis, treatment, recovery and survivorship and, for some, to the end of life.

The objective of the 2018 Helene Hudson lecture at the Annual CANO conference was to highlight how communication, especially in difficult conversations, is the key to compassionate care in oncology nursing. Specifically, the three main objectives were:

- To identify key concepts in effective communication in stressful conversations
- To suggest strategies to help the oncology nurse gain confidence in having these conversations
- To describe models that assist the nurse to have difficult conversations.

CONCEPTS IN COMMUNICATION

Wittenberg-Lyles, Goldsmith and Ferrell (2013) identify key concepts in communication that are important for oncology nurses. These include accommodation, whereby the nurse aligns his/her communication with the needs of the patient and family, increasing trust and breaking down barriers between healthcare providers and the patient and family. Good communication also requires adaptability to where the patient and family are situated in terms of their goals, plans and roles. The nurse also has to realize that the medical world is foreign to patients and so care needs to be taken to ensure that the patient and family understand this new world they have entered. Family/caregiver communication has to be recognized as unique to that particular family and it is important to play to the patient and family strengths.

In addition to family patterns of communication, the health literacy of each member has to be taken into account, as this will influence their level of understanding of the illness and treatment. It is also important to note that health literacy differs from general literacy and even well-educated individuals are compromised when trying to understand the complexities of a serious illness. When dealing with families, it is also important to take into account the fact that each member of the family will have different goals whether these are expressed or not, and this can get in the way of open communication. Relational tensions will often exist within families and between the oncology team members and the family and may be enacted as withdrawal and/or avoidance. Discussing why this is happening with the patient and family can allow for misunderstandings to be corrected and/or changes in the disease process to be fully explained.

Communication is either affective/relational or instrumental/technical. The former is important for nurses in oncology, as many of the sensitive topics that we need to address with our patients result in emotional responses for both the patient and their family, as well as, at times, the oncology nurse. Talking about end-of-life issues, alterations in the disease process including recurrence, loss of fertility as a result of treatment and many other topics is not easy and requires sensitivity and an openness to an emotional response from the patient and/or their family caregiver(s). Many educational programs do not offer training in this sort of communication and, instead, focus on instrumental and technical information such as history taking, explaining treatments or educating the patient about aspects of the disease, etc.

Oncology nurses need to be able to do both: relate in an empathetic manner when discussing sensitive or emotional topics and relay important information to the patient so that they understand the complex nature of the diagnosis and are prepared for treatment. Empathy in a clinical encounter is described as a professional interaction rather than an emotional response to a particular situation (Mercer & Reynolds, 2002). Rather than subjectively feeling another’s suffering, it is a way of understanding the patient’s experience in an intellectual way rather than in an emotional way (Mercer & Reynolds, 2002).

BARRIERS TO COMMUNICATION

It is recognized that, for many nurses, having difficult or sensitive conversations with patients is stressful. Many don’t feel prepared and/or are not sure whose responsibility it is. This may result in conflict, particularly with physicians who are primarily responsible for certain actions, for example, disclosing a cancer diagnosis. However, if the patient seems not to understand what they have been told by the physician, how is the nurse supposed to respond? Nurses are often the intermediaries between patient and physician...
and if the communication from physicians is not clear, nurses are often left not knowing what the patient has been told (Wittenberg-Lyles et al., 2013). This leads to frustration on the part of the nurse and the potential for missed opportunities where a meaningful discussion with the patient/family may not happen because the nurse does not know what the patient has been told by the physician.

Personal factors may also play a role. Nurses may find it difficult to find the time to have longer conversations with patients due to increased patient loads or because they feel they lack the skills to have sensitive conversations (Banerjee et al., 2016). Nurses also report that end of life conversations are difficult because they want to maintain hope for the patient while at the same time needing to be realistic (Leung et al., 2017). However, having challenging conversations while not feeling confident may lead to compassion fatigue (Wentzel, 2017) and potentially burnout (De La Fuente-Solana et al., 2017). Nurses who experience compassion fatigue are more likely to be distressed in the presence of others’ suffering and have less empathy (Duarte & Pinto-Gouveia, 2017).

**COMMUNICATION SKILLS TRAINING**

It has been suggested that communication skills training (CST) may increase both nurses’ confidence in their ability to have difficult conversations, as well as improving outcomes for patients. The purpose of CST is to improve the quality of communication between healthcare providers and patients, and increase empathy, as well as practising how to communicate in difficult situations (Barth & Lannen, 2011). However, a Cochrane review (Moore, 2013) of 15 randomized controlled trials suggests there is no evidence that this kind of training has an impact on mental or physical health of patients, patient satisfaction or healthcare provider burnout.

So how can confidence and comfort in talking about sensitive topics be improved among oncology nurses? If training is not effective, could communication tools be helpful (McMullen, 2017)? A number of tools exist to aid in discussion or assessment of sensitive topics. For example, the PLISSIT Model (Annon, 1974) has been widely used in the area of sex therapy. Similarly, the BETTER Model (Mick, Hughes, & Cohen, 2003), created by oncology nurses, has been suggested as a valuable tool to address sexuality specifically in individuals with cancer. Two other tools, the 5As model (Bober, Carter, & Falk, 2013) and the SPIKES Model (Baer & Weinstein, 2013) may be useful in addressing other sensitive topics encountered in oncology nursing, namely overweight/obesity and treatment-related infertility.

**MODELS FOR COMMUNICATION**

There are a number of tools that are used with specific populations by cancer type or for specific purposes such as assessing for financial toxicity (McMullen, 2017). A more general tool that promotes communication may be more useful and can be used for sensitive conversations with patients with diverse issues. Key to having sensitive conversations is that they are patient-centred and have an element of education that assists the patient in finding a resolution for whatever the issue is.

The 5As model has been used widely to address tobacco cessation. The five steps in the model are ask, assess, advise, assist and arrange. An example of how these can be used in talking about healthy weight with an overweight or obese patient is presented in Figure 1.

The SPIKES Model is a slightly more complex one, but it takes into account heightened emotions that may be present for the patient. This six-step process begins with ensuring there is privacy and an example of a conversation about loss of fertility is shown in Figure 2.

**CONCLUSIONS**

Cancer care is relational at its core and oncology nursing is based on the relationships we have with our patients throughout the disease trajectory. We have to communicate so much to our patients to support all aspects of their care and to mitigate the side effects of the treatments they receive. Having

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**Figure 1: The 5As model**

**Ask:** Start by asking the patient what they know and/or understand

Dr. X has asked me to talk to you about weight and how it affects people with cancer. What do you know about the risks of being overweight and cancer?

**Assess:** It is important to understand the patient’s perspective on the issue

Many overweight people say that they have tried to lose weight many times. What efforts have you made in the past?

**Advise:** Clear and concise advice is a starting point for a more extensive intervention

Making the necessary changes to your usual way of eating is difficult. Food has many different meanings for all of us. Being overweight can have negative outcomes for people with cancer and if you are willing, I can offer you some help in getting to a healthy weight.

**Assist:** Help the patient to access the resources they need as this may be out of your scope of practice or expertise

We have two nutritionists who are part of the staff here. They meet with patients and their family to help with changing your usual patterns to assist you in getting to a healthy weight. I can see if one of them can see you while you are here at your clinic visit.

**Arrange:** It is important to see the patient in follow up to show support and also to learn what the patient found helpful.

I would like to see you again in about a month to see how you are doing and what you found helpful from your visit to the nutritionist.
difficult conversations is part of that. It is important to remember that interaction with patients is not a checklist. We have to be truly present when we assess for side effects or the impact that cancer has on quality of life because it is in the pause that a patient takes before answering a question that we can detect a problem. Their uncertainty may be a reflection of lack of knowledge that needs to be corrected. Their body language may show us their actual pain rather than the words that they speak. Silence on our part can prompt the patient to disclose what is really bothering them, but we have to learn to be comfortable in being silent and allow ourselves to resist the impulse to move on with another question.

Every patient has a story and leaving room for the story teaches us more than any checklist ever will.

REFERENCES