Abstract

Oncology nursing aims to promote physical and psychosocial well-being of individuals and families at risk for, or living with, a life-threatening illness. A basic component of nursing practice is the nurse-patient relationship (Canadian Nurses Association, 2002). This relationship has been shown to have a positive impact on individuals’ well-being as they journey through their cancer experience (Herth, 1995).

While the nurse-patient therapeutic relationship is fundamental to nursing care and may be quite subtle in its transaction, it is a complex phenomenon with every encounter being meaningful and impacting both the patient and the nurse. Reflecting on the nature of this relationship can facilitate a richer and deeper awareness of the unique contribution oncology nurses make in the lives they touch and are touched by.

This presentation will explore the therapeutic nurse-patient relationship in oncology nursing. The authors intend to facilitate self-reflection and increased awareness of both the art and science of the therapeutic relationship. In particular, qualities of the nurse-patient relationship, the importance of communication, both verbal and nonverbal, and the use of silence will be explored. We will incorporate theory, evidence, experiential learning along with storytelling, music, poetry and video images to convey our message.

It is such a privilege to be here in Moncton, New Brunswick, with fellow oncology nurse colleagues and friends at the 17th annual CANO conference. Dorothy and I are honoured to provide this year’s distinguished Helene Hudson lectureship. We will explore what is perhaps the core substance of our work as oncology nurses. Kenner (1985), in an article on mind-body-spirit, notes: “Each time a nurse encounters a patient something happens. The meeting is never a neutral event. It is the power of this nurse-patient relationship that makes nursing exciting and not a series of autonomic performances. The nurse must understand that every patient encounter is meaningful, that it always has an impact that affects both the patient and the nurse. The effect may be dramatic or subtle, but something either positive or negative always occurs.”

Last winter Dorothy and I had the opportunity to work together for a three-month period as she completed her final clinical placement for the Acute Care Nurse Practitioner Master’s program at the University of Toronto. During our reflective practice time, we realized that the richness of our dialogue often centred on the stories of our interactions with patients.

We began raising questions. What is it that the nurse brings to create a therapeutic interaction with his or her patient? Do patients achieve wellness because of the relationship they have with their nurse or in spite of it? How does a nurse develop comfort and skill in this area? With increasing emphasis on interdisciplinary care, could another profession equally achieve the same ends?

These questions prompted an investigation into the depth and the nature of the nurse-patient relationship. We examined the literature to identify both empirical and theoretical work in this area. In addition, we incorporated nurses’ stories, poetry and music to help understand and capture both the complexity and simplicity of what unfolds between the nurse and the patient. We hope this presentation will instill excitement and passion for the work you do as oncology nurses. We also hope to inspire and challenge you to fully appreciate this critical piece of nursing, which most of us would readily acknowledge is the essence of our practice.

The objectives of this presentation are:
1. to define, understand and articulate the enactment of the nurse-patient relationship and the expected outcomes of our work;
2. to provide language to what is sometimes identified or perceived as the “soft side” of nursing.

Conceptual Background and Literature Review

Peplau (1964), a nursing theorist, provided some of the earliest thinking about the interpersonal nurse-patient relationship, and its significance in terms of nurses’ work. Peplau in her writings warned...
nurses that unless they contributed to the health and well-being of patients, the traditional nurse-patient relationship would be claimed by others. While this statement is direct and the implications worrisome, I do wonder if we as nurses can clearly articulate this ‘soft side’ of nursing.

To contextualize this presentation, we utilized a philosophical foundation to highlight the unique and vital components nursing brings to the care of others. The first element to consider is that nursing as a discipline is holistic. That is to say, nursing has a strong commitment to the care of the whole person. Nursing leaders such as Virginia Henderson (1964) stressed the importance of nurses’ understanding of their patient’s needs from the patient’s perspective.

Jean Watson (1979), in her theory of nursing on human science and human care, identifies six themes about the nature of nursing. These themes emphasize core values which create a fertile ground for nurses to create meaningful interactions with patients. The themes include:

1. A view of the person as a valued person to be respected, nurtured and understood;
2. Emphasis on the human relationship;
3. An emphasis on the human transaction between the nurse and the person and how that affects health and healing;
4. An emphasis on the non-medical processes of human care;
5. A concern for health and well-being; and
6. The position that nursing is distinct from but complementary to medical knowledge.

These themes certainly resonate with the work we do with patients and families who are living with a life-threatening illness and experiencing loss, uncertainty, anxiety, loneliness and search for meaning. Oncology nurses are often asked: ‘how can you do this work, it must be so depressing?’ These core values create the foundation for meaningful nurse-patient relationships to develop. It is these relationships that assist the nurse to promote coping, independence and self-determination of the patient and their family during and after the cancer experience. This work is so rewarding for the nurse and so critical to the patient.

The second thought I would like you to consider builds on this notion: while I believe that as oncology nurses, we would all agree the relationship we develop with patients is the foundation to care, I wonder if this essential component gets lost in the busy environments in which we work and the numerous tasks that need to be done. This critical piece of our work appears invisible particularly when nurses are faced with large clinics to run or when the inpatient nurse is challenged to discharge three patients only to admit three more patients who are waiting in emergency.

In a fascinating book entitled “Nursing as Therapy,” (1998), Richard McMahon and Alan Pearson examine the therapeutic potential of nursing and the contribution that is possible if they recognized themselves as therapists. The book begins by asking nurses if professions such as physiotherapists, dieticians, psychologists represent disciplines that provide therapy. When nurses are then asked if they are therapists, many are left perplexed. The hesitation arises when they compare the idea of nursing as a therapy to their own experience of work as nurses, the stereotypes and their instinct about the concept of nursing. Some nurses do report that nursing not only helps people feel better, but actually makes people better. However, all too often nurses express doubt that nursing is a therapy on its own except when undertaking therapy by proxy through following the medical plan of care. I reflect on my interest in the management of dyspnea in the cancer patient. While tremendous work has been done on the medical management of this symptom, how often do we highlight the impact and importance of nursing interventions such as those identified in Jessica Corner’s (1995) research, including presence, counselling, relaxation and the creation of a quiet, calm environment whenever possible? How well do we describe and document these interventions in our work in busy oncology clinics? What outcomes do we measure?

The authors McMahon and Pearson (1998) in “Nursing as Therapy,” appeal to the reader to think about nursing in a different way. Rather than trying to explain our work through the use of growing technology and advancing nursing roles that include traditional medical practices, we should intentionally focus on the core work of nursing. Nursing is not a series of events and tasks. It is about the relationships we have with people. Much of our work needs to focus on how we establish these relationships and to what end. We must clearly articulate the active work we do with our patients, which so often gets lost in the tasks. These authors suggest that perhaps the outcomes of care should be healing and wellness.

Therapeutic nurse-patient relationships

Now turning to the crux of our presentation, throughout our literature review, a number of terms such as caring relationship, helping relationship, purposeful relationship and nurse-patient relationship are used to illustrate the key concept of the interpersonal process that happens between the nurse and his or her patient. Florence Nightingale, in her infinite wisdom, recognized the importance of this interpersonal connection. In one of her writings she urged nurses to keep the patient informed since “apprehension, uncertainty, waiting, expectation, fear of surprise, do a patient more harm than any exertion,”(Nightingale, 1859). Peplau (1991) was perhaps the first to recognize the dynamics of the relationship including the notion that it represents a partnership where both the patient and the nurse benefit and experience growth.

This section describes the elements that create a therapeutic connection, as well as the prerequisites nurses must bring in order to engage with their patients and families in a therapeutic way. In addition to highlighting findings from the literature, we will share a patient’s story with you to illustrate the concepts related to the development and maintenance of a therapeutic relationship.

The therapeutic nurse-patient relationship is developed and maintained through the use of professional nursing knowledge, skill, caring attitudes and behaviours (CNO, 2004). It is based on trust, respect and intimacy. CANO’s standards (2001) stress the importance of maintaining boundaries to these relationships and emphasize that nurses must be willing to take risks, open themselves to vulnerability and know themselves well in order to fully engage in therapeutic relationships. This sounds like a tall order but I believe this is what makes nursing so exciting and challenging. How many people can say their job involves the use of specialized knowledge and skill, respectful courtesy, assurance of human presence and positive connectedness to others and, on top of that an opportunity to get to know oneself better! Joan Edwards, a clinical nurse specialist, wrote in the prologue to Chicken Soup for the Nurse’s Soul (Canfield, Hansen, Mitchell-Autio & Thieman, 2001), “We are not only a blessing, we are blessed!”

Before I delve into the various components of this complex relationship, I’d like to share some of my experience with the patient I mentioned to depict how easily a therapeutic relationship can start. I was asked in my role as an advanced practice nurse to see a 35-year-old

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**Figure One.**

- Professional nursing knowledge
- Skill
- Caring attitudes and behaviours
- Trust
- Intimacy
- Power
patient who had just received news that the cause of his rapid three-week physical decline was due to widely-spread cholangiocarcinoma that at this point was incurable. The primary nurse felt he tended to be stoic and that his pain was not well-managed. Our therapeutic bond began by my introducing myself, saying who I was and including a brief description of my role. I acknowledged awareness that that particular day had been a hard one for him, having undergone a failed stent insertion and that I would keep this initial visit brief. I did ask him, however, about his pain and he admitted the medication seemed to wear off in the last half-hour to hour. I talked to him about morphine and its pharmacokinetics so he understood peak effect and duration of action. I suggested we increase the frequency of how often he could ask for the medication, but emphasized that the control still lay with him in that it would only be available at his request. My intent was to share knowledge to increase his sense of mastery and control in one aspect of a situation that he had no control over. As I began to leave, I noticed he was wearing the Lance Armstrong “Live Strong” yellow band. I pulled up my sleeve and showed him that I wore one, too. I could feel the simple connection of the yellow band cement the positive connection of partnership that had been forged in that short five- to 10-minute visit. Whether one is working in a staff nurse role at the bedside, in an outpatient oncology clinic, as an advanced practice nurse, a clinical trials nurse or a homecare nurse, the initiation of the relationship does begin with a courteous introduction to the patient and family.

The therapeutic relationship has three phases, which Peplau (1991) refers to as the orientation, working and resolution phases. The orientation phase includes the introducing of oneself and one’s role to the patient as I described above, getting to understand the patient and family and identifying their goals. The working phase involves the enactment of the care plan and nursing interventions. The resolution phase refers to the closure of the relationship and hopefully involves a celebration of goals that have been met. Every therapeutic relationship has a beginning, middle and an end. However, the duration and intensity varies widely. It may occur over one clinic visit, several months in hospital or intermittent visits over years.

Let us examine the components of the therapeutic relationship. One is caring. There is a general opinion that caring suggests that the patient is in a passive role and the nurse provides comfort measures. This notion can be challenged and caring can be re-conceptualized to include more. Caring is a deliberate nursing act with the goal to empower the patient to achieve their optimum. The development of a caring relationship involves coming to know our patient as an individual as opposed to a diagnosis or a problem, and an acceptance and respect and the development of a care plan that reflects this individuality. Utilizing my story for illustration, in performing a pain assessment I discovered this patient found it difficult to use a number to describe the intensity of his pain. We decided together to use descriptors instead. He described his pain as minimum at best and moderate-to-severe at worst. It was never absent. The key to this patient’s individualized care was that minimal pain was unbearable for him. His goal was no pain. This was communicated in the care plan.

Research looking at caring behaviours ties the concept of caring with that of trust. Larson (1984, 1987) studied cancer patients’ perceptions of what constitutes caring. They identified accessibility of nurses, monitoring of the patients condition and following through on commitments as important caring attributes. One comment this patient and his family made was how horrible the two weeks of exploratory tests had been. They were meeting so many different consult services and yet, felt their questions were not being answered. They began to feel people knew what was wrong, but were not telling them. We set up a team of primary nurses in order to provide consistency and someone they could trust to address their concerns.

The development of a caring relationship depends on knowing and accepting our patients as individuals with unique strengths, weaknesses, fears and goals. The development of a trusting relationship is based on consistency, reliability, honesty and confidentiality. The promotion of trust is closely related to effective communication. This includes providing information but also an opportunity to allow our patients and families to share their feelings, concerns and hopes.

Empathy is also a key concept recognized in the dynamics of the therapeutic relationship and an essential component of good communication. Webster’s dictionary defines empathy as the “intellectual identification with the feelings, thoughts, or attitudes of another”. This is contrasted with sympathy that is defined as the “fact or power of sharing the feelings of another, especially in sorrow or trouble.” Empathy implies a degree of emotional separateness unlike sympathy that implies a kind of fusion with the emotional experience of another.

I’d like to pause and reflect here as I believe this distinction is central to our emotional health and ability to work in oncology. Our ability to empathize with our patients involves an ability to understand the world in which they find themselves. It is important to share our perceptions in order to validate our understanding. It does not involve absorbing their pain and suffering but recognizing and identifying it. This is an important distinction. Nurses must be aware of their reactions and ensure they are responding to the patient’s emotions and not their own emotions evoked by the situation. As one patient put it, “I don’t want people feeling sorry for me. I don’t need their sympathy. I need them to try to understand what I’m going through.”

This can be one of the greatest challenges in oncology nursing. So many nurses share stories of pain, guilt, and helplessness in caring for patients and more often than not, they are experiencing emotion or sadness for the patient’s situation. They need to step back and recognize where their emotion is coming from and focus on their vital role of helping this person cope and live with their situation. This is accomplished by being present, listening, sharing knowledge and engaging.

Self-reflection is extremely important. Nurses need to understand themselves, recognizing their own values and potential biases. This is essential in order to ensure we are functioning as advocates of our patient’s agenda and not our own.

The Registered Nurses Association of Ontario’s best practice guidelines (2002) for the therapeutic relationship emphasizes that reflective practice includes self awareness, self knowledge, empathy, awareness of boundaries and limits of the professional role. In my work with this patient and family, reflecting on boundaries became extremely important. I think it was important for everyone involved in his care. Many of us had strong emotional reactions to this family’s story. They were young with a beautiful three-year-old daughter, and were at an exciting crossroad in their life adventure, having had just relocated to Toronto after spending a year in Saudi Arabia when he became ill so suddenly. He lived a balanced, healthy lifestyle. It seemed so unfair to all of us that this should happen.

Boundaries in a therapeutic relationship represent the point at which a professional and therapeutic relationship changes to a non-professional and personal one. The therapeutic relationship differs from a social relationship or friendship in that the needs of the client always come first. There are a number of the warning signs found in the literature to show that one may be crossing boundaries from a therapeutic to a social relationship. These include spending extra time with one client beyond therapeutic needs; feeling other members of the team do not understand the patient as well as you do; disclosing personal problems; thinking about the client frequently when away.

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**Figure Two.**

- Importance of boundaries
- Risk-taking
- Vulnerability
- Self-reflection

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from work; being guarded or defensive when someone questions your interactions with the client; or giving out your home phone number unless it is required as part of the nursing role. It is not always easy to know when one is crossing boundaries. There are times when we genuinely connect and like the people we are partnering with and there is reciprocity in these relationships. We share an intimacy with our patients and families. It often feels as if we are given a gift when they share their stories, including their successes, troubles, goals and fears.

When I was a new nurse embarking on my career, I remember feeling extremely guilty at times because I was having so much fun with a patient and/or family. I would think I shouldn’t be laughing and having fun. I should be working. I came to realize that the use of humour is very therapeutic to patients and those engaging moments are part of nursing therapy.

I’d like to speak more on boundaries because as with empathy, I think this is one of the most challenging and can be the most painful learning associated with engaging in therapeutic relationships, particularly in oncology nursing. I will use this story again as I found myself reflecting on numerous occasions. There were times where I did ‘take this patient home with me’. For example, when I first met him, I made suggestions regarding his pain management on a Friday and thus found myself calling the unit over the weekend to inquire about his pain management. Upon reflection, this behaviour most likely was associated with the working phase of the relationship and the importance of establishing trust in the plan of care.

Self-reflection is a constant requirement in our work as oncology nurses and so is debriefing. In order to care for ourselves we need to find opportunities to talk with colleagues and mentors about these evoked emotions. Story-telling is a wonderful tool for nurses to share knowledge, experience and validate feelings, and gain insight. Many nurses do this informally, which is not only therapeutic for the nurse but essential for ongoing growth in this area. Doris Howell utilized a framework based on Carper’s fundamental ways of knowing for the Interlink nurses in Toronto who work with cancer patients in the community as a way for them to engage in reflective practice. The exercise includes steps leading to awareness, critical analysis and transforming knowledge (Johns, C., 1995).

The other part of reflective practice is recognizing one’s limitations. There are certainly times when we need to bring in other health professionals and expertise to assist our patients. I had such a moment with this patient. His wife and mother were having difficulty relating to each other under the stress of living through such a crisis. This was new territory for them and they asked if I would be able to help them work through their issues. I questioned whether I had the expertise to act as a mediator. Was I the best person for this task? In speaking to a colleague, I discovered that our bioethicist was a professionally trained mediator. So I accessed his expertise and participated with him through the dialogue. It was a wonderful learning experience for me. It truly made a difference to bring in a neutral person for this type of work. I recognized that I had a relationship with this family, which may have interfered with my objectivity. It also affirmed for me that I had healthy boundaries in this relationship. I did not feel possessive in that I was the only one to help this family. I also reflected on the amount of time I was spending with this one family and realized it was just a reflection of the complexity of the crisis situation in which they found themselves.

Another crucial dimension of the therapeutic relationship to recognize is the presence of a power differential. Our patients are vulnerable. They look to us for information, support, guidance and advocacy. We hold specialized knowledge, access to privileged information and influence on other health care team members. It is important that we utilize this power to advocate for our patients and empower them as opposed to making them dependent and even more vulnerable.

Engaging in therapeutic relationships is a skill we develop over time. Using Benner’s terminology (1984), we start as novices and work to becoming experts. It is by far the most complex and challenging skill to develop as a nurse but when we allow ourselves to engage and partner with our patients in this way it makes our work so much more fulfilling.

Research findings indicate that the patient’s perception of quality of care is directly related to the interpersonal relationship between caregivers and patients, (Fosbinder, 1994). The patient’s voice should be central to our understanding of patient needs. However, the majority of the research looking at the nurse-patient relationship comes from caregivers and we know less about the patient’s experience. Understanding more about the patient’s perspective and their needs can lend insight into desired outcomes of care as it relates to this relationship.

Several authors have investigated elements of the therapeutic relationship from the patient’s perspective in the area of oncology nursing (Fosbinder, 1994; Radwin, 2000, 2003, 2005). In one of Radwin’s studies (2000), she concluded that two broad outcomes resulted from quality nursing care: 1) a sense of well-being, which referred to trust, optimism and authenticity and, 2) increased fortitude, which was described as the nursing care patients received which helped make the treatment more tolerable. In this study, the patients described how outcomes were the result of specific quality nursing care attributes as described in the nurse-patient relationship literature. They were not simply a series of nursing interventions.

In a later study (2005), Radwin sought to determine cancer patient’s descriptions of their nurses. The results indicated that patients held nurses in high esteem. Some of the descriptions used by these patients included positive regard, supportive, empathic, sensitive, comforting, feel comforted and cared for. Outcomes of quality care identified by patients were “feeling comforted and cared for” and a “sense of healing and recovery”. One respondent said, “Nurses are the key to lowering anxiety and helping one to feel cared for and respected.” Another notable comment was: “My own oncology nurse made a tremendous difference on my recovery.”

Both these studies underscore the relationship with patients as central to the nursing role and perceived as such by the recipients of nursing care. These studies emphasize and make the invisible aspect of nursing visible.

**Conclusion**

Returning to our opening comments from the book: “Nursing as Therapy” (McMahon & Pearson, 1998), I am struck by the close connection between what individuals in Radwin’s research identified as positive outcomes and what McMahon and Pearson challenge nurses to consider as the core of their work. Therapeutic nursing can be broadly defined as nursing that deliberately leads to beneficial patient outcomes such as wellness.

As a clinical nurse specialist working directly with nurses and patients day to day, I am often the recipient of patient and nursing sharing stories of their interactions. Many times I’ve had patients comment, “My nurse was wonderful today” or “I really like the nurse looking after me today.” I rarely let those comments go by without exploring more with the patient. When asked what makes your nurse so wonderful, I receive comments such as “she treated me like a person” or “she spent time talking to me, she listened and supported me.” One comment will stay with me for a long time. “I know the unit is busy, but when my nurse is with me I feel I am the only person at that moment who matters. She gives her complete attention to me, answering my questions, supporting me and giving me encouragement and I feel so cared for. That helps me to feel better!”

I am often struck by both the complexity and the simplicity of the nurse-patient relationship. For example, in contrast to the earlier story which speaks about the depth of some relationships, simple nursing interactions such as eye contact, a touch, a moment of silence to acknowledge a concern, or a smile showing acceptance and warmth can also have a lasting and profound impact on the patient experience.

A very recent experience comes to mind where a patient shared with her primary nurse about her love of the east coast and she described...
Many forks in the road to ponder
Which way to turn? Which path to take?
So many choices have I…or do I?

Come with me...
Comfort me and my comfort will comfort you
Listen to me and my gratefulness will touch your soul
Touch me kindly and I will warm your heart
Respect me and you will gain respect
Show me care as you desire for your own family.

Explain with small words so I understand
My choices are many but my plan is clear
I know my destination but how I get there is my decision
Tell me the good and the bad; I want to hear it all
How else can I decide if I don’t know?

Hold my hand, please take one minute…
Reassure me that someone will ask me how I feel
Be tuned into my facial expressions,
Hear the words that I may not say
Help me move with dignity and pride,
Celebrate my progress in my journey
Smile to me so I can smile to you

For an indefinite period of time, we journey together
Do you know my name?

References


