



Quantitative study – other

An evidence-based communication skills training programme for oncology nurses improves patient-centred communication, enhancing empathy, reassurance and discussion of psychosocial needs

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Implications for practice and research

- Communication skills training programmes for oncology nurses may increase patient-centred communication.
- The results showed an increase in empathetic communication by the study participants (eg, reassurance, optimistic utterances), less biomedical talk and longer periods of uninterrupted patient talk after the programme.
- Research in nurse–patient communication should use established communication skills training programmes and coding schemes and also should employ newer analytic techniques such as sequence analysis to understand patterns of communication between nurses and patients.
- Further definition of the roles of oncology nurses and the terms *reciprocity* and *patient centredness* are necessary in future studies.

Context

Given the increasingly complex treatments in cancer care, patient–provider communication may become overly medically focused. The authors highlight the need of oncology providers to understand ‘where the patient stands’ to be patient centred in their communication and to maintain hope in their patients. Today’s oncology nurse provides expert psychosocial and biomedical care to cancer patients but may need support and continuing education to improve communication with patients facing the challenges of a cancer diagnosis and treatment.

The aim of this study was to evaluate the effectiveness of an established communication skills training programme developed by the Swiss Cancer League. It was provided in a 2.5-day seminar and, after 6 months, a 1.5-day ‘booster’ session, an important feature given the known attrition of communication skills after training programmes. Participants were offered telephone consultations (up to five) with a trainer between the two sessions.

Methods

The effect of the training programme on oncology nurse communication was evaluated using a pretest–post-test design. There was no control group. Data were collected between 2002 and 2006 in Switzerland. The authors used video recordings of nurses and simulated patients (actors)

before the communication skills training programme and at 6 months after the programme (before the ‘booster’ session). The authors used the Roter Interaction Analysis System (RIAS, Roter¹) to code communication between the nurses and simulated patients, in a conversation about chemotherapy. The coding process by the raters was described as well as the calculation of inter-rater reliability. In addition, length of uninterrupted speech and a measure of ‘reciprocal communication’ were reported.

Findings

A total of 61 nurses provided the pretest and post-test videotaped interactions with a simulated patient. Communication was coded in 26,135 utterances. A multivariate analysis of the RIAS concluded that there were significant differences between preprogramme and post-programme communication skills, and post hoc *t* tests allowed identification of particular differences. Nurses allowed ‘patients’ more uninterrupted time to talk after training and provided more empathetic responses such as reassurance and optimistic utterances. In addition, the communication between the nurses and simulated patients was less biomedically focused.

Commentary

Improving patient-centred communication is a priority for many organisations. Measuring patient-centred communication is notoriously difficult, and this study used several measures as proxies for patient centredness: empathetic behaviours, ‘reciprocity’, decreased biomedical talk, ‘appropriate responses’ and length of uninterrupted patient talk. They acknowledge that using real patients and assessing their satisfaction with communication may be the ideal.

Strengths of this study include using an established training programme, a well-known coding scheme (RIAS) with high inter-rater reliability confirmed by double-coding and a newer analytic tool (sequence analysis). The authors of this study used video recordings to capture verbal and non-verbal communication. There was low attrition during data collection (70 recruited with 61 providing two recordings). Coders were blind to video in order to reduce bias.

The convenience sample may have included more oncology nurses who value communication skills,

affecting the generalisability of the findings. RIAS codes utterances (one passage with a complete thought) into 1 of 42 discrete categories: although clusters for empathetic behaviours were used in presenting the results, it is unclear which RIAS codes comprised the other categories or whether the clusters were created after coding and preliminary analyses. Often, researchers cluster these coding categories a priori to decrease type I errors. Examples of the dialogue were not presented in the study although RIAS coding for utterances was presented in the description of appropriate responses. The analyses did not include any findings in regards to non-verbal communication, such as eye contact or touch, and its role in patient-centred communication.

The authors of this study also used a newer analytic method – sequence analysis – that explores patient and healthcare provider communication to find patterns and relationships. The numerous statistical analyses, while discussed by the authors, may still dilute the findings of this study.

The impact of training programmes on nursing communication has been called into question by some (Kruijver *et al*²). It may be that nursing researchers need to design communication skills training programmes that include current professional nursing roles on interdisciplinary teams as there may be some overlap in team responsibilities and unique nursing roles.

This study highlights the effectiveness of a training programme to increase empathetic communication and, perhaps, to improve provider delivery of patient-centred communication. It did not measure patient satisfaction. A cautionary note in the discussion reminds us that changing communication style (from a biomedical to a psychosocial focus) *might* be at the expense of clinical care, and our goals need to balance disease and symptom management with patient centredness.

Sequence analysis is increasingly being utilised to analyse patient–provider communication and link behaviours to patient outcomes. The most important finding of this study may actually be a reminder: allowing patients more uninterrupted response time may foster reciprocity and patient centredness in oncology care. While allowing uninterrupted time for patients to talk may not always be a proxy for effective communication, it is wise to remember that listening is also a valuable communication skill.

Competing interests None.

References

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