

NURSE-PATIENT COMMUNICATION

WITH THE

ADVANCED CANCER PATIENT

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## CHAPTER I

### DESCRIPTION OF STUDY

#### Introduction

Meaningful communication with the advanced cancer patient is frequently inadequate or absent. Nurses, physicians, and family all tend to withdraw both physically and psychologically when the patient is judged to be dying and "nothing more can be done." This occurs in a number of ways. The physician decreases the number of his visits and the visits he does make are brief. The nurse cuts down to a minimum the number of times she enters the room. When she is in the room she avoids making eye contact with the patient; she avoids touching him; all conversation is on a superficial level. It takes her longer to answer the patient's call light and longer to bring him medication for pain. The family frequently maintains a facade around the patient, behaving as though nothing serious was wrong with him. Often a situation called "pre-mortum burial" is established in which the patient is kept heavily sedated; the windows are covered; the room is kept dark and all conversation is carried on in a whisper.

This lack of communication psychologically isolates the patient, forcing him into withdrawal, depression, dependency or regression. Patients are much more fearful of this isolation than they are of dying itself. There are several apparent elements which are involved in this communication gap. First, society is future-oriented, and the person who is classified as dying has no future. Second, medical personnel are oriented to assisting with the cure of patients. Those who are dying are often seen as examples showing that the nurses and doctors have failed. Third, medical personnel are not adequately prepared in their educational period for meeting the psychosocial needs of the dying patient. Most of them have never examined their own feelings about death. Many people enter the medical field because of a strong fear of death.

Dying patients can make a much more satisfactory adjustment to their situation if meaningful communication can be established. In effect they can continue to live until they die. They can continue to behave in a mature, responsible way, feeling needed, useful and loved.

#### Statement of Problem

The problem of this study was to determine what the advanced cancer patient perceives as meaningful nurse-patient communication.

### Purposes

The purposes of this study were to determine:

1. Whether or not there is a difference in the patient's perception of present nurse-patient communication and the communication which the patient feels would more adequately meet his needs;
2. Whether or not there is a difference in the nurse-patient communication and communication needs as perceived by the hospitalized advanced cancer patient and that perceived by hospitalized patients with other chronic illnesses;
3. What topics the patient would select as important to be free to discuss with the nurse;
4. And whether or not nurse-patient communication is important to the patient.

### Background and Significance

When Kubler-Ross first published her book On Death and Dying [1] it began a stir which has spread in ever widening circles, affecting much of present nursing and medical approaches to caring for the dying patient. The number of articles written on this subject have increased markedly in the past five years. Most of these writings are not research studies, but merely opinions based on personal experiences in working with terminal cancer patients. Psychiatrists, nurses, social workers, and physicians



have attempted to describe what dying cancer patients have expressed to them, what their needs seem to be, and the approach they have taken in attempting to meet these needs.

There are differences of opinion regarding whether to tell the patient he is dying [2, 3, 4, 5] or not to tell him [6], whether the patient wants to talk about death or not, whether it is a healthy, normal reaction of the patient to become depressed and withdraw within himself before death [1, 7] or an unhealthy reaction caused by isolation by society [8]. The opinions about how to meet dying patients needs have changed gradually over the past ten to twenty years. Previously the accepted approach was not to tell the patient anything, to allow all communication about dying to be tacit because it was believed that patients could not cope with the fact of their own death [9, 10]. In more recent years it has become more commonly accepted to be honest and direct with the patient and to give him emotional support in working through his feelings about his death [11]. This approach has been taken because of the growing awareness that the isolation of the patient is more destructive psychologically than the knowledge of impending death [4, 8, 12]. Efforts have been made in isolated areas to alter patient care in accord with the open, direct approach to communication with dying patients [13, 14].

### Hypotheses

1. There is no difference in the level of nurse-patient communication presently occurring and the level of communication needed to meet the patient's perceived communication needs.
2. There is no difference in the nurse-patient communication occurring with hospitalized advanced cancer patients and with hospitalized patients with other chronic illnesses as perceived by patients.
3. There is no difference in the communication needs expressed by the cancer patients and those expressed by the chronically ill patients.
4. The patient rates nurse-patient communication as unimportant.

### Definition of Terms

1. Advanced Cancer--The term was used in this study to indicate those cancer patients who have less than six weeks expected survival.
2. Meaningful communication--The term was used in this study to indicate interactions with the patient rather than reactions to the patient in which the patient experiences genuineness, caring, respect, understanding and trust to the extent that this can be expressed and evaluated by patients. Verbal and nonverbal communication, some degree of touch, eye contact and nearness are involved in meaningful communication.



### Delimitations

This study will be limited to the hospitalized adult advanced cancer patient and the hospitalized adult patient with chronic disease. All patients will know their diagnosis. They will be in sufficient control of their mental faculties to understand and answer a questionnaire. The cancer patients will have less than six weeks expected survival as determined by their physician.

### Assumptions

1. Communication is a basic human need.
2. Each individual, though uniquely different, will have some commonalities with other individuals.
3. The patient will identify what is important to him within a nonthreatening atmosphere.

### Summary and Overview

Beliefs about what constitutes good care of the advanced cancer patient have changed in recent years. Greater emphasis is being placed on meeting their psychosocial needs. Medical and nursing education and practice, though striving to improve psychosocial care of cancer patients are not presently providing optimum care. The present study was designed to determine to what extent the patient perceived a lack in nurse-patient communication, which is essential to meeting the patient's psychosocial needs. The hypotheses were designed to compare current levels of communication with

the patient's desired level of communication and to compare advanced cancer patients with chronically ill patients in their response to questions regarding nurse-patient communication. Chapter two will provide a review of literature in the area of death and dying and care of the advanced cancer patient, discussing patient response to the knowledge of dying, social isolation, the reaction of physicians and nurses to the dying patient, and suggestions for more effectively meeting the communication needs of advanced cancer patients. Chapter three discusses the methodology of the study. Thirty patients, fifteen with cancer from a Chemotherapy Unit and fifteen with a chronic illness from a general medical surgical unit responded to eighteen questions on a questionnaire regarding nurse-patient communication. Chapter four contains the analysis of data from the questionnaire. Chapter five provides a summary, recommendations, implications and conclusions suggesting that the study be repeated with a larger sample size and some alterations in the patients selected for the sample.

## CHAPTER II

### REVIEW OF LITERATURE

#### Introduction

Present knowledge about dying is primarily theoretical and unproved [15]. Little experimental research exploring communication with or emotional reactions of dying patients has been done. Much of the material which has been written on the subject of dying is in the form of descriptions of experiences or observations and insights gained in communicating with the dying [16]. Articles written are filled with emotion-laden words, making it difficult to extract strictly factual information for evaluation. Researchers attempting studies have difficulty maintaining objectivity while examining feelings being expressed by the dying patient [15]. Researchers frequently experience feelings of futility, guilt and hopelessness as they relate to the dying patient [17].

Another very real problem is in the area of methodology. It is difficult to develop a tool for use in a study of dying and communication needs since the area being explored is solely within the patient's psychological experience. Since this area is not available to the researcher for

objective examination, the patient must be relied upon to provide the information needed for study. Most of the research conducted has been in the form of open ended interviews. A number of methodological problems are involved in attempting statistical studies using interview techniques.

Research utilizing conventional psychiatric interviewing procedures to investigate the psychological status of cancer patients is open to several criticisms. For one thing the specific questions asked are seldom reported so that it is difficult to evaluate the extent to which suggestion may have influenced the data. In an unstandardized interview situation, the interviewer's preconceived notions may readily affect the data obtained. Further, the frequent absence of normative data makes it difficult, if not impossible, to determine the extent to which the findings are actually specific to cancer patients. [18]

### Literature Review

In 1963 Hinton [16] described a study on the physical and mental distress of the dying. He reports only two previous studies on the subject, Osler in 1906 and Exton-Smith in 1961. His study had three interrelated aims: to assess the amount of mental and physical distress experienced in terminal illness, to seek associations between the distress experienced and the patient's illness and personal life, and to observe any change in the distress as death approached. Patients were selected on the basis of a diagnosis of an illness which was expected to be fatal within six months. On the same day on which each dying patient



was seen, a control patient assigned to the same ward under the care of the same physician was also seen in order to compare persons also affected by hospital admission, physical illness and separation from usual environment. If possible the control patient's illness affected the same body system as the dying patient's illness.

The methods used were a series of nondirective interviews lasting up to thirty minutes each. The first interview concerned the patient's illness, his personal background, and his mental state. The interviews were then conducted weekly as long as the patients were hospitalized. The nondirected interview was designed to encourage the patient to speak of his emotion, problems, hopes and fears within the framework of an accepting relationship with the researcher.

Definitions and rating scales were made for the patient's illness, personal background, and mental state, including the following: duration of illness, amount of physical distress, social class, strength of religious faith, age, sex, marital status, number and age of any children, financial status, depression, anxiety, level of consciousness, and awareness of dying.

A factor analysis was done using the Chi-Square test for comparisons. There was no significant difference in the length of illness between the dying and the control groups and no significant difference in the length of stay

in the hospital. Physical distress of all types was significantly more common in the dying. The most significant type of physical distress occurring was pain. The intensity of physical distress was also found to be greater to a highly significant degree. The dying patients were much more likely to have unrelieved physical distress, and much less likely to have no physical distress. There was no significant difference between the two groups in their personal or social data. There was a high statistical difference in the degree of depression with almost half of the dying patients experiencing a distressing degree of depression.

The dying patients were significantly more anxious. Dying patients showed significant impairment of consciousness.

On the first interview fifty of the 102 dying patients spoke of their awareness of the possible fatal outcome. Illnesses producing symptoms for more than six months were significantly associated with a greater incidence of a distressing degree of anxiety and depression. Depression was more frequent in those with physical discomfort. Awareness of the possibility of death was related to a mood of depression.

Patients who had a high level of physical distress and long term illness were more likely to be aware that they were dying. Mental state was influenced by age, dependent children and religion with dying patients under the age of fifty and with dependent children experiencing more depression than

others. Most of the dying patients were aware of their impending death during the last eight weeks of life.

In 1967 Koenig et al [18] presented a study measuring the emotional status of cancer patients using the Minnesota Multiphasic Personality Inventory (MMPI). The purpose of the study was to evaluate some of the psychological phenomena associated with cancer. All the patients studied had advanced cancer and were aware of their diagnosis. It was hoped that the results of the study would have implications for planning the care and management of cancer patients. The study was done on eighteen men and eighteen women with cancer of the large intestine who were seen in the Oncology Clinic of Henry Ford Hospital. The results indicated that the cancer patients were considerably less emotionally disturbed than a group of patients hospitalized for depressive symptoms. The highest mean scores occurred in the Hypochondriasis, Depression, and Hysteria scales but none of them fell in the pathological range. There was some indication that about one fourth of the patients were experiencing a significant degree of depression. The depression seemed to be associated with the patient's feeling that his situation was hopeless and that control over his life had passed from his hands. Comparison of the means of tuberculosis patients with the cancer patients showed no greater emotional disturbance in the cancer group than in the tuberculosis group.



Depression was rarely seen in those patients who actively aligned themselves with their doctor against the disease. This cooperative alliance was generally sustained as the patient continued to believe that he was actively participating in his treatment and that he still retained some degree of control over his life . . . . An additional factor which appeared to decrease or prevent emotional disturbance was encouragement to maintain usual life activities as long as possible. The patients tended to measure their worth as individuals in terms of their ability to remain useful. . . . Tacit and overt assurance from the physician that the malignancy did not reduce their worth was not only comforting but may have enabled the patients to sustain the highest possible level of functioning throughout the illness . . . . Many patients feared the loss of dignity which may result from becoming totally dependent on relative or medical staff. . . . In conclusion, it appears that however well the patient had come to terms with his disease and its sequelae it can be anticipated that he will be upset and even panicky if he concludes that his case is a "lost cause." Every effort should be made to avoid this as long as the remotest chance for control of the disease remains. [18]

In 1969 Hackett and Weisman [19] reported the results of a study on the presence of denial in patients with heart disease and cancer. It was their opinion that denial could be used more successfully by the cardiac patient than by the cancer patient because the optimistic environment of the cardiac care unit is designed to encourage denial in contrast to the environment of the cancer patient which is "cheerless and constrained." Forty cases were selected with pairs of cancer patients and cardiac patients matched according to age and sex. The cancer patients were followed in daily, weekly, or biweekly visits, depending upon the



needs, until the time of death. The cardiac patients were interviewed two or three times during the first two weeks of their admission and followed until discharge. Twenty questions designed to determine the presence of denial were grouped into five categories: (1) What the patient is told by his doctor, (2) How the patient assimilated this information, (3) Staff-patient relationship, (4) Predominant concerns and orientations toward the future, and (5) Physical discomfort and need for medication.

The cardiac and cancer patients were very similar. Both groups were aware of the actual medical situation regardless of what they had been told by their physicians. Cancer patients who were told little, managed to discover the truth by themselves. Cardiac patients, who were told their condition with a high degree of optimism and behaved as if they believed it, still realized their peril.

In 1969 Sheldon et al [20] reported a study designed to evaluate an integrated, family oriented cancer care program. The concerns which led the authors to attempt this pilot project were the discontinuous medical care for chronic diseases such as cancer, the traditional medical education stressing diagnostic and curative aspects of care, and the attitudes of nurses which caused them to pull away from the patients. It was the opinion of the authors that care of cancer patients was restricted by traditional and limited concepts. The psychological and social needs of cancer patients were not met and there was a lack of effective

communication between physicians and nursing personnel.

There was no recognition of the psychological difficulties of the medical staff in reacting to patient problems. For similar reasons the patient was frequently rejected by his family as well as by the medical staff.

The goals in revising the medical setting were (1) to provide a medical service to selected patients which recognized and dealt with the social and psychological problems confronting the patient and family; (2) to educate the medical and nursing staff to an awareness of these social and psychological problems; (3) to help staff members increase their skills in handling these problems through a range of in-service educational methods; and (4) to develop a team approach for the delivery of services by utilizing existing professional disciplines and adding appropriate professional staff accordingly. Implementation of these goals was apparently very effective in meeting the psychosocial needs of the cancer patient by providing a source of support for both patient and family.

In 1966 Shands wrote a paper for the Psychiatric Treatment Research Center entitled "The informational impact of cancer on the structure of the human personality" [21]. In this frequently quoted paper he discusses the psychological impact on the patient of being told that he is dying of cancer. He also discusses the psychological problems of the

individual who attempts to care for the dying cancer patient. He believes that the crisis of the cancer patient is primarily an informational crisis. The human being can tolerate severe persistent threats to life when those threats occur in a favoring social situation but because of the isolation which occurs with a diagnosis of cancer, this threat to life is not easily tolerated. "The emotional impact could almost be described as a sudden amputation of the future; the consequence is a major alienation from the self" [21].

In 1973 Pienschke [22] studied the effects of guardedness or openness on the cancer unit. Four approaches were studied in relationship to communicating diagnosis and prognosis to the patient and the effect this communication had on (1) the patient's confidence in their doctors and nurses, (2) the patient's satisfaction with the information received about their illness and their nursing care and (3) the adequacy of the nursing care given. Thirty-two patients were selected to study and an interview-questionnaire used to determine the patient's levels of confidence and satisfaction and patients' and nurses' concepts of adequacy of care. It was found that physicians tended to be open in discussing diagnosis and guarded in discussing prognosis. Patients expressed confidence in both doctors and nurses regardless of approach but expressed greater confidence when a completely open approach was used.



In addition to these studies much has been written on the dying patient (with and without cancer) which has been of significance in changing the approach to communication with cancer patients. The subjects of these articles have revolved around several common concerns: the education of both nursing and medical personnel; the presently existing approach to caring for the dying patient, which results in decreased communication; social isolation and ineffective nursing care; the situational impact of this care on the patient; and discussion of what constitutes a therapeutic milieu for the dying patient.

Studies have shown that neither nurses nor physicians are prepared for their role in communicating with and caring for the dying patient. Attitudes on death and dying remain the same as the general public's attitudes after completion of nursing or medical school. No provisions are made in the curriculum for exploring attitudes toward care for and communicating with the dying or to provide experiences in communicating with the dying [25, 26]. Many physicians enter medical school because of a fear of death [26].

The goal of our present health care system is to cure. When this is not possible both physicians and nurses view it as a failure [23]. The presently existing approach to care of the dying has no theoretical basis and is based primarily on professional defense mechanisms, cultural taboos and hospital rituals which result in withdrawal from the dying

patient [27]. Kennedy states that nurses approach care of the dying patient by either alienating themselves or pretending the patient is not dying [28].

As a result of this failure to communicate, the patient is isolated from the meaningful people in his environment. The nurses consider the dying patient of less value and focus their care on patients who will recover [23]. It takes them twice as long to answer a call from the patient who is dying [29]. If the patient attempts to initiate communication the nurse becomes uncomfortable. Questions about his illness or what he has been told are inclined to be met with awkward silences, a change of subject or encouragement to think about getting well [30].

This situation has a definite impact on the patient's perception of his illness, himself, and his life. In some ways the patient is treated as if he did not exist as a person. His life becomes meaningless [31]. He is treated in some ways as if he were already dead. Responsibilities are removed from him. He is not involved in decisions affecting him, plans affecting him are made without his involvement, he is given shallow reassurances if he asks questions [32].

The patient's reaction to this situation includes a sense of loneliness, depression, introversion, and hopelessness [8]. Because of an increased awareness of this situation by the health care personnel, attempts have been made to

determine the needs of the dying patient and the differences that meeting those needs might make in the quality of patient care. There are implications that patients who can successfully cope with the emotional stress involved in diagnosis and treatment of cancer will live longer and more productive lives. Those who die rapidly seem to have been less able to cope with this stress [33].

Klagsbrun, who has worked as a psychiatric consultant on a cancer unit describes his views of the patient's needs.

This is the time in a person's life when he needs meaningful contact with others and an opportunity to share his reactions in order to adjust to a life-threatening situation . . . The kind of meaningful contact a patient requires at this time must come from a warm, ever present, and sensitive person who offers the patient a sense of security he longs for. This can only come from a person who is strong and secure. . . . A nurse who establishes a trusting and caring relationship with a patient at the moment he enters the hospital can prevent many severe problems from developing in the future. . . . This is the moment when a patient's defenses begin to descend to their lowest level. He can, therefore, be reached, influenced, and helped to readjust more easily at this point than at any other time in his illness. . . . If a patient is allowed to remain overwhelmed by his disease for too long a time in an isolated condition, he may never again regain a sense of his own self. . . . What is needed is an intermediary who has access to the cancer specialist on a regular basis and who is an expert in discerning the meaning behind a patient's communication. I believe this person should be a nurse. [34]

Lamberton, who works as a psychiatric consultant in a terminal care hospital in England, feels that a terminal patient needs to continue to mature, feel a sense of



responsibility, turn his attention away from himself and serve others [35]. McNulty who is a clinical nurse specialist in the care of the dying lists three needs of the dying patient. First, relief from symptoms of illness whenever possible, especially including pain and the fear of pain. Second a caring environment within which the patient can maintain individuality and integrity as a person. Third, time and opportunity to voice his fears, to come to terms with himself and his illness, and to draw closer to his family [23].

The problem of communication with the patient suffering from a terminal illness deserves special considerations . . . The patient wants to talk about many things--the affairs that are common to all living people. How do I live for as long as my life lasts? is the basic problem. Once the patient is assured that he can speak freely and receive honest answers, communication will range from discussion of business matters, relationships with family and friends, to much more personal matters--doubts, fears, fantasies. The most commonly expressed fear is that he will be left to die alone. [36]

There are several views concerning the course this communication should or will take. Abrams [7] believes that communication changes as the patient progresses from the initial stage, to the advancing stage, to the terminal stage. In the initial stage there is direct and truthful communication and an urgency to talk. In the advancing stage the patient seldom confronts his physician for information and the doctor-patient relationship changes because of fear of abandonment, dependency, passivity. In the terminal stage

the patient is in a calm, suspended hopeless state and communication becomes minimal, especially in the area of the patient's anxieties. The patient does not want to talk about death and dying because this brings them closer to the reality and the imminency of death.

Bascue and Krieger [11] divide communication needs of the dying into four areas. First, understanding in which he is allowed to explore and understand his feelings about the dying process itself; second, perspective in which he explores the meaning of death and comes to terms with how this meaning influences him; third, goals, since the dying person needs to find some use for the time he remains alive; and fourth, interpersonal support with a relationship which provides respect and consistency.

Many believe that the nurse is in a unique position to meet the communication needs of the dying patient [34, 36, 37]. Nurses who have entered the field of cancer nursing have established some approaches to communicating with the dying which have proved successful in meeting patient needs. Benol-eil [27] suggests that nurses must adjust to relating to patients with frequently changing moods. She points out that in order to communicate with the patient, the nurse must be willing to risk being confronted with her own feelings of discomfort and dismay and find positive ways of coping with her own negative feelings. The nurse must choose whether she



will stay and risk discomfort, walk out or change the subject when patients attempt to discuss their feelings.

### Summary

We have found from research that a large percent of cancer patients experience depression but they are not more inclined than other seriously ill patients to use denial. Patients who are told their diagnosis but encouraged to participate with their doctor in fighting the disease seldom experience depression. It has been shown that it is possible to alter the patient care setting to meet more effectively the patient's needs and the needs of the medical staff. Patients evaluate their care as better in an environment of open communication. Present education of nurses and physicians does not prepare them intellectually or emotionally for caring for the dying patient. The presently existing approach to care of the dying results in decreased communication with the patient, social isolation and inadequate nursing care. Given the opportunity to relate to others in a caring relationship, express and explore feelings, and establish personal goals the dying patient can continue to live for as long as his life lasts.

## CHAPTER III

### PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

#### Introduction

In this chapter the following things will be discussed: the sources of data for a cancer sample and a chronic illness sample, the procedure for collection of data, and procedure for treatment of data. A description of the questionnaire used to collect data will be included.

#### Sources of Data

Respondents consisted of fifteen cancer patients and fifteen patients with chronic illnesses who were hospitalized at St. Joseph Hospital in Fort Worth, Texas during the period of the study. All patients who met the criteria of the study were asked to participate until the quota for that group had been reached. No patient approached refused to participate.

#### Cancer Patient Sample

This group of fifteen patients consisted of thirteen women and two men admitted to the Chemotherapy Unit at St. Joseph's Hospital during the month of June, 1974 who met

the following criteria:

1. under the care of an Oncologist who had agreed to allow his patients to participate in the study
2. had a confirmed diagnosis of cancer
3. had less than six weeks expected survival
4. had known their diagnosis for at least two months
5. were over twenty-one years of age
6. were able to comprehend and answer questions on a questionnaire

#### Chronic Illness Patient Sample

This group of fifteen patients consisted of nine women and six men admitted to St. Joseph Hospital during the month of June, 1974 who met the following criteria:

1. under the care of a group of internists who had agreed to allow their patients to participate in the study
2. had a chronic illness with frequent hospitalizations which gave them repeated experiences with nurse-patient communications
3. were over twenty-one years of age
4. were able to comprehend and answer questions on a questionnaire

#### Description of the Instrument

A questionnaire with closed questions was selected as the tool for measuring the hypotheses of the study. Since it

was the patient's perception which was being measured, a self-report measure was necessary. The questionnaire method was selected because the subjects being studied could easily be threatened by more direct methods of self-report. Also there is less risk of interviewer bias when using closed question technique.

The closed question is an efficient and economic way of getting a limited amount of information and requires no inference or interpretation by the interviewer. It is appropriate since the intent is to classify the respondent's perception. Less effort or motivation is required to answer closed questions which, because of the level of illness of the respondent, is important. The respondents will have similar situational factors such as level of information about the topic which is communication and a similar reality situation making it appropriate to use this method.

Multiple questions were used to measure hypotheses one, two and three, increasing the accuracy and reliability of the responses. Ascertaining attitudes requires more questions than measuring factual data. Each question measures a sub-area of the total area involved in nurse-patient communication.

A funnel sequence of questions was used in the questionnaire-asking the most unrestricted questions first to avoid earlier questions from conditioning the responses to



later questions. Questions were arranged to follow a logical sequence in the view of the respondent.

There are some disadvantages to the use of a closed question questionnaire. The amount of information received is markedly limited. The closed question carries a greater risk of a biased response particularly if it is apparent which answers are preferred by the researcher. Interpreting the respondents' answers to closed questions requires that the researcher assume the frame of reference used by the respondent to some degree. This can result in incorrect interpretations [39].

The questionnaire used (see Appendix) consisted of eighteen questions designed to measure the patient's perception of presently occurring nurse-patient communication, the patient's preference in nurse-patient communication, the value that the patient places on nurse-patient communication and topics the patient wishes to discuss with the nurse. The first sixteen questions are paired. The first question of each pair measures what the patient perceives as occurring and the second question of each pair asks what the patient would like to occur. Responses to the questions were scaled with response (a) indicating a low level of communication and responses increasing in level of communication to (d) which indicated the highest level of communication measured. Questions one and two discuss the frequency of nurse visits. Questions three and four measure the extent

to which nurse-patient conversation is patient centered. Questions five and six indicate the patient's perception of the interest of the nurse during conversation. Questions seven and eight measure social distance. Questions eleven and twelve evaluate the frequency with which the nurse is willing to discuss important concerns of the patient with him. Questions thirteen and fourteen measure frequency of eye contact and questions fifteen and sixteen measure the frequency of touch. Question seventeen is designed to determine the importance of nurse-patient communication to the patient. Question eighteen elicits some of the topics which the patient considers important to discuss with the nurse. The term nurse was purposely not defined to the patient answering the questionnaire since the questionnaire was strictly patient centered. It was not the purpose of the study to determine the quality of communication of various levels of nursing personnel or even who on the nursing team the patient classified as a nurse. Rather the purpose was to determine if the patient's communication needs were being met by anyone whom the patient classified as nurse. The rationale for the questionnaire was based on the following communication theories.

Verbal and nonverbal communications are both important in the patient's assessment of the nurse's attitude toward him. Frequently what the nurse does not say and her nonverbal

behavior speaks so loudly her words cannot be heard. This is true also of the frequency of visits to the patient's room. Within the nurse-patient relationship the nurse is tempted to escape difficult situations by avoidance. She may avoid the patient completely or disguise the real problem by irrelevant conversation or a frivolous tone of voice. Effective listening as well as meaningful conversation is essential to significant nurse-patient communication [41].

Eye contact, body posture, gestures and the distance between the nurse and the patient during the conversation communicates to the patient how the nurse feels about him. Lack of eye contact communicates disinterest. Touching privileges are given to the nurse beyond the usual social acceptance but touch is still limited. Although touch has many positive and negative connotations [40], patients who are dying seem to be touched less as a result of the social isolation which occurs [41].

The amount of sharing which can occur will be determined by the level of communication. There are five levels of communication in which people engage: level five--cliche conversation, level four--reporting facts, level three--ideas and judgments, level two--feelings and emotions and level one--peak communications [41].

Terminally ill patients find it important to discuss their individual life situation and their health care. They

often experience rapidly changing emotions and question the meaning of existence. They have a felt need to express these feelings to a caring person [41].

In the process of designing the questionnaire the assistance and advice of the following experts was sought: Dr. Schwen Helge who is the department head of the Counseling and Testing Center at TCU, Mr. Gary Lype who is an expert in test construction and research at TCU, Dr. Ann Richards who is a clinical psychologist, a nursing researcher and on the nursing faculty at TCU and Dr. Rhett Fredric who is an Oncologist practicing at St. Joseph Hospital in Fort Worth. The questionnaire was then given to a test sample of six patients who were attending the out-patient Oncology Clinic at St. Joseph for the purpose of determining the clarity of written instructions to the questionnaire and the patient's interpretation of the meaning of each question and each of the four answers given. It was determined at this time that it would be necessary to give verbal directions as well as written instructions. The wording of two questions was changed. The questionnaire was then administered to the research sample.

#### Procedure for Collection of Data

When it was determined that a patient met the criteria of the study the researcher took a questionnaire to the



patient's room, introduced herself explaining that she was a nurse and was conducting a study for the purpose of writing a thesis for a master's degree. The patient was asked if he/she would be willing to answer a questionnaire which would take about five to ten minutes to complete. When the patient agreed, the researcher read the written instructions to her/him and explained that the questions were paired with the first question asking what was presently occurring and the second question asking what the patient preferred in nurse-patient communication.

#### Procedure for Treatment of Data

Hypothesis one: There is no difference in the level of nurse-patient communication presently occurring and the level of communication needed to meet the patient's perceived communication needs which was tested by using the Wilcoxon Matched-Pairs Signed-Ranks Test [42] on the paired questions one through sixteen, comparing the present level of communication with the desired level and the cancer sample with the chronically ill sample.

Hypothesis two: There is no difference in the nurse-patient communication occurring with hospitalized advanced cancer patients and with hospitalized patients with other chronic illnesses as perceived by patients which was tested using the Kolmogorov-Smirnov Two-Sample Test [43] compared answers by cancer patients and chronically ill patients to

the questions which asked about presently occurring levels of communication.

Hypothesis three: There is no difference in the communication needs expressed by the cancer patients and those expressed by the chronically ill patients which was also tested using the Kilmogorov-Smirnov Two-Sample Test [43] compared answers by cancer patients and chronically ill patients to questions which asked about preferred levels of communication.

Hypothesis four: The patient rates nurse-patient communication as unimportant was tested by using Chi-Square [44]. This measure demonstrates the difference of responses by cancer patients and then chronically ill patients to question seventeen.

Chi-Square was also used to measure responses to question eighteen which asked the patient to select items he felt were important to discuss with the nurse.

#### Summary

A study of nurse-patient communication was conducted in which a questionnaire was administered to fifteen cancer patients and fifteen chronically ill patients. The questionnaire was designed to measure the patient's perception of present nurse-patient communication, the value he places on communication, topics he considers important to discuss,

and level of communication he would prefer. The questionnaire was designed with the advice of a panel of experts and pretested on a pilot sample of patients for clarity of meaning and validity before being administered to the study patients. Each hypothesis was measured separately using the Wilcoxon Matched-Pairs Signed-Ranks Test, the Kolmogorov-Smirnov Two-Sample Test and Chi-Square.

## CHAPTER IV

### ANALYSIS OF DATA

#### Introduction

In the following chapter statistical analysis of the data received from the questionnaire will be discussed. Comparisons of responses of the cancer sample and the chronically ill sample and comparisons of present communication and desired communication will be made using the Wilcoxon Matched-Pairs Signed-Ranks Test, the Kolmogorov-Smirnov Two Sample Test and Chi-Square. Findings are presented in the order of the questions asked in the questionnaire.

#### Responses to Questions

Question one asked how often the nurse came into the patient's room. Of the cancer group none answered rarely, none answered sometimes, five answered "whenever I call them" and ten answered "frequently just to speak or check me." Of the chronically ill group none answered rarely, one answered sometimes, three answered "whenever I call them" and eleven answered "frequently just to speak or check me." Question two asked how often the patient would like the nurse to come



into his room. Of the cancer group none answered rarely, one answered sometimes, three answered "whenever I call them" and eleven answered "frequently just to speak or check me." Of the chronically ill group none answered rarely; three answered sometimes; one answered "whenever I call them;" and eleven answered "frequently just to speak or check me." Of the chronically ill group twelve patients indicated that the frequency of nurse visits was satisfactory, one preferred an increase in frequency of visits and two preferred fewer visits than were presently occurring. In the cancer group eleven indicated that the frequency of nurse visits was satisfactory, two preferred an increase in frequency of visits and two preferred fewer visits than were presently occurring.

Table 1. Frequency responses to questions one and two.

Level of relating	Responses of Cancer Patients				Responses of Chronically Ill Patients			
	a	b	c	d	a	b	c	d
#1	0	0	5	10	0	1	3	11
#2	0	1	3	11	0	3	1	11

a. low b. moderately low c. moderately high d. high

Question three asked the extent to which nurse-patient conversation was patient centered. Of the cancer group one

answered "talks very little;" none answered "trys to talk about things I do not wish to discuss;" one answered "talks only about casual things;" and thirteen answered "is willing to listen or discuss what concerns me." Of the chronically ill group, two answered "talks very little;" one answered "trys to talk about things I do not wish to discuss;" three answered "talks only about casual things;" and nine answered "is willing to listen or discuss what concerns me." Question four measured the degree to which the patient preferred patient centered conversation. Of the cancer group one answered "talks very little;" none answered talks only when necessary;" one answered "talks only about casual things;" and thirteen answered "be willing to listen or discuss what concerns me." Of the chronically ill group one answered "talks very little;" one answered "talks only when necessary;" three answered "talks only about casual things;" and ten answered "be willing to listen or discuss what concerns me." In the cancer group thirteen indicated that the nurse-patient conversation was sufficiently patient centered, one patient indicated a preference for more patient centered conversation and one patient indicated a preference for less patient centered conversation. Of the chronically ill patients ten indicated that the nurse-patient conversation was sufficiently patient centered, three indicated a preference for more patient centered conversation and two a preference for less patient centered conversation.

Table 2. Frequency responses to questions three and four.

	Responses of Cancer Patients				Responses of Chronically Ill Patients			
Level of relating	a	b	c	d	a	b	c	d
#3	1	0	1	13	2	1	3	9
#4	1	0	1	13	1	1	3	10

a. low b. moderately low c. moderately high d. high

Question five indicates the patient's perception of the interest of the nurse during conversation. Of the cancer group none indicated that the nurse was "not interested;" one indicated that the nurse seemed "in a hurry;" none indicated that the nurse was "polite but distant;" and fourteen indicated that the nurse seemed to "care for me as a person." Of the chronically ill group none indicated that the nurse seemed to be "in a hurry;" two indicated that the nurse was "polite but distant" and ten indicated that the nurse seemed to "care for me as a person." Question six measured the patient's preference as to the level of nurse interest. Of the cancer group one indicated a preference that the nurse be "not interested;" none preferred that the nurse be "in a hurry;" none preferred that the nurse be polite but distant and fourteen preferred that the nurse be "caring for me as a

person." Of the chronically ill group none preferred that the nurse be "not interested;" none preferred that the nurse be "in a hurry;" two preferred that the nurse be "polite but distant" and thirteen preferred that the nurse be "caring for me as a person." In the cancer group fourteen indicated satisfaction with the level of nurse interest and one indicated a preference for less nurse interest. Of the chronically ill group ten indicated satisfaction with the level of nurse interest, four indicated a preference for greater nurse interest and one indicated a preference for less nurse interest.

Table 3. Frequency responses to questions five and six.

	Responses of Cancer Patients				Responses of Chronically Ill Patients			
	a	b	c	d	a	b	c	d
#5	0	1	0	14	0	3	2	10
#6	1	0	0	14	0	0	2	13

a. low b. moderately low. c. moderately high d. high

Question seven measures the social distance of the nurse during conversation. Of the cancer group none indicated that



the nurse stood in the doorway, none indicated that the nurse stood at the foot of the bed, eleven indicated that the nurse sat by the side of the bed. Of the chronically ill group one indicated that the nurse stood in the doorway, one indicated that the nurse stood at the foot of the bed, twelve indicated that the nurse stood at the side of the bed and one indicated that the nurse sat by the side of the bed. Question eight asks what social distance the patient would prefer during nurse-patient conversation. Of the cancer group none preferred that the nurse stand in the doorway, none preferred that the nurse stand at the foot of the bed. Twelve preferred that the nurse stand by the side of the bed and three preferred that the nurse sit beside the bed. Of the chronically ill group, none preferred that the nurse stand at the foot of the bed, twelve preferred that the nurse stand beside the bed and one preferred that the nurse sit beside the bed. Of the cancer group fourteen were satisfied with the present social distance of the nurse, one preferred a greater social distance. Of the Chronically ill group nine were satisfied with the present social distance of the nurse, three preferred less social distance and three preferred greater social distance.

Table 4. Frequency responses to questions seven and eight.

Level of relating	Responses of Cancer Patients				Responses of Chronically Ill Patients			
	a	b	c	d	a	b	c	d
#7	0	0	11	4	1	1	12	1
#8	0	0	12	3	0	2	12	1

a. low b. moderately low c. moderately high d. high

Question nine measures the level of nurse-patient conversation. Of the cancer group three indicated that conversation was "strictly business;" one indicated that the conversation was "casual;" one indicated that the conversation was "friendly but not talking about feelings;" and ten indicated that the conversation was "open to talk about things I worry or think about." Of the chronically ill group six indicated that the conversation was "strictly business;" two indicated that the conversation was "casual;" four indicated that the conversation was "friendly but not talking about feelings;" and three indicated that the conversation was "open to talk about things I worry or think about."

Question ten measures the level of conversation the patient

prefers. Of the cancer group none indicated that they preferred to keep the conversation "strictly business;" two preferred that the conversation remain "casual;" none preferred that the conversation be "friendly but not talking about feelings" and thirteen preferred that the conversation be "open to talk about things I worry or think about." Of the chronically ill group none preferred that the conversation be "strictly business;" two preferred that the conversation remain "casual;" seven preferred that the conversation remain "friendly but not talking about feelings;" and six preferred that the conversation be "open to talk about things I worry or think about." Of the cancer group nine were satisfied with the level of conversation, five preferred a deeper level of conversation and one preferred a more shallow level of conversation. Of the chronically ill group seven were satisfied with the level of conversation, seven preferred

Table 5. Frequency responses to questions nine and ten.

	Responses of Cancer Patients				Responses Chronically Ill Patients			
	a	b	c	d	a	b	c	d
Level of relating								
#9	3	1	1	10	6	2	4	3
#10	0	2	0	13	0	2	7	6

a. low b. moderately low c. moderately high d. high

a deeper level of conversation and one preferred a more shallow level of conversation.

Question eleven measures the frequency with which the nurse discusses subjects important to the patient. Of the cancer group one patient indicated that this occurred rarely, one indicated that this occurred sometimes, three indicated that this occurred frequently and ten indicated that this occurred "as often as I need to talk." Of the chronically ill group two indicated that this occurred rarely, three indicated that this occurred sometimes, five indicated that this occurred frequently and five indicated that this occurred "as often as I need to talk." Question twelve measures how frequently the patient prefers to discuss important subjects with the nurse. Of the cancer group none indicated rarely, three indicated "sometimes;" two indicated "frequently;" and ten indicated "as often as I need to talk." Of the chronically ill group one indicated rarely, three indicated "sometimes;" one indicated "frequently" and ten indicated "as often as I need to talk." In the cancer group ten indicated satisfaction with the frequency with which the nurse discusses important matters, three preferred an increase in frequency and two preferred a decrease in frequency. Of the chronically ill group, four were satisfied with the present level of discussion, eight preferred an increased frequency of discussion, and three preferred a decrease in frequency of discussion.



Table 6. Frequency responses to questions eleven and twelve.

Level of relating	Responses of Cancer Patients				Responses of Chronically Ill Patients			
	a	b	c	d	a	b	c	d
#11	1	1	3	10	2	3	5	5
#12	0	3	2	10	1	3	1	10

a. low b. moderately low c. moderately high d. high

Question thirteen measures frequency of eye contact. Of the cancer group one indicated that eye contact occurred rarely, none indicated that eye contact occurred sometimes, seven indicated that eye contact occurred frequently and seven indicated that eye contact occurred very frequently. Of the chronically ill group three indicated that eye contact occurred rarely, five indicated that eye contact occurred sometimes, three indicated that eye contact occurred frequently and four indicated that eye contact occurred very frequently. Question fourteen measured patient preference in regard to eye contact frequency. Of the cancer group none preferred that eye contact occur rarely, two preferred that eye contact occur sometimes, six preferred that eye contact occur frequently and seven preferred that eye contact occur very frequently. Of the chronically ill group one preferred that eye contact

occur rarely, three preferred that eye contact occur sometimes, three preferred that eye contact occur frequently and eight preferred that eye contact occur very frequently. In the cancer group eight indicated satisfaction with the present level of eye contact, three preferred less eye contact. Of the chronically ill group ten were satisfied with the present level of eye contact, and five preferred increased eye contact.

Table 7. Frequency responses to questions thirteen and fourteen.

Level of relating	Responses of Cancer Patients				Responses of Chronically Ill Patients			
	a	b	c	d	a	b	c	d
#13	1	0	7	7	3	5	3	4
#14	0	2	6	7	1	3	3	8

a. low b. moderately low c. moderately high d. high

Question fifteen measured the amount of touch during nurse-patient communication. Of the cancer group two indicated that the nurse touched them rarely, seven indicated that the nurse touched them sometimes, five indicated that the nurse touched them very frequently. Of the chronically

ill group six indicated that the nurse touched them rarely, seven indicated that the nurse touched them sometimes, one indicated that the nurse touched them frequently, and one indicated that the nurse touched them very frequently.

Question sixteen measured the patient's preference regarding touch. Of the cancer group two preferred to be touched rarely, six preferred to be touched sometimes, four preferred to be touched very frequently. Of the chronically ill group five preferred to be touched rarely, seven preferred to be touched sometimes, three preferred to be touched frequently and none preferred to be touched very frequently. In the cancer group eight were satisfied with the present level of touch, five preferred an increase in touch and two preferred a decrease in touch. Of the chronically ill patients eight were satisfied with the present level of touch, four preferred an increase in touch and three preferred a decrease in touch.

Table 8. Frequency responses to questions fifteen and sixteen.

Level of relating	Responses of Cancer Patients				Responses of Chronically Ill Patients			
	a	b	c	d	a	b	c	d
#15	2	7	5	1	6	7	1	1
#16	2	6	4	3	5	7	3	0

a. low b. moderately low c. moderately high d. high

Question seventeen measured the value the patient placed on nurse-patient communication. Of the cancer group none indicated that "they should do their work well and otherwise leave me alone;" one indicated that "they may talk if they need to; it does not bother me;" one indicated that "I enjoy talking with the nurses;" thirteen indicated "when the nurse lets me talk with her about things important to me, I feel that she cares for me as a person." Of the chronically ill group none indicated that "they should do their work well and otherwise leave me alone." Two indicated that "they may talk if they want to; it does not bother me;" seven indicated "I enjoy talking with the nurses;" six selected "when the nurse lets me talk with her about things important to me I feel that she cares for me as a person."

Question eighteen is a list of items from which the patient could select topics he would like to feel free to discuss with the nurse. Of the cancer group eleven wished to discuss their illness, eight wished to discuss their future, two wished to discuss financial problems, eight wished to discuss their feelings about themselves, six wished to discuss their feelings about their families, and seven wished to discuss their life up to this time. A total of forty-two items were marked. Of the chronically ill patients eight wished to discuss their illness, two wished to discuss their future, one wished to discuss financial problems, seven wished to discuss their feelings about themselves, three wished to



discuss their feelings about their family and five wished to discuss their life up to this time. A total of twenty-six items were selected.

### Statistical Analysis

The Wilcoxon Matched-Pairs Signed-Ranks Test was performed on responses to questions one through sixteen, matching present and desired levels of communication. Responses of the cancer group and chronically ill group were evaluated separately. For the cancer group the results were  $T=30$  which is not significant at the .05 level. For the chronically ill group the results were  $T=28.5$  which is not significant at the .05 level. These results retain null hypotheses one which states there is no difference in the level of nurse-patient communication presently occurring and the level of communication needed to meet the patient's perceived communication needs.

The Kolmogorov-Smirnov Two-Sample Test was performed to test hypothesis two and three. The responses of the cancer group and the chronically ill group to questions one, three, five, seven, nine, eleven, thirteen and fifteen were calculated. The resulting score was five which is not significant at the .05 level. Tabulation of questions two, four, six, eight, ten, twelve, fourteen and sixteen resulted in a score of three which is not significant at the .05 level. These results retain hypotheses two which states there is no

difference in the nurse-patient communication occurring with hospitalized advanced cancer patients than with hospitalized patients with other chronic illnesses as perceived by patients. These results also confirm hypothesis three which states there is no difference in the communication needs expressed by the cancer patients and those expressed by the chronically ill patients.

Chi-Square was performed on the responses to question seventeen resulting in a score of 7.42 which is significant at the .05 level. A score of 7.82 is significant at the .02 level. These results reject hypothesis four which states that the patient rates nurse-patient communication as unimportant. The cancer group rated nurse-patient communication considerably higher than the chronic illness group.

Chi-Square was also performed on question eighteen resulting in a score of 2.1 which is not significant at the .05 level. This indicated that there was no difference in the selection of topics for discussion by the cancer group and the chronically ill group. There was however a larger number of topics selected by the cancer group. The cancer group selected forty-two topics. The chronically ill group selected twenty-six.

#### Summary

Responses to each question of the questionnaire were itemized and comparisons made of present and desirable levels

of communication by both cancer and chronically ill groups. No statistical differences were found in comparing responses of the cancer group and the chronically ill group. No statistical differences were found in comparing responses to present levels of nurse-patient communication and desired levels of nurse-patient communication. Null hypothesis one: there is no difference in the level of nurse-patient communication presently occurring and the level of communication needed to meet the patient's perceived communication needs was retained. Null hypothesis two: there is no difference in the nurse-patient communication occurring with hospitalized advanced cancer patients and with hospitalized patients with other chronic illnesses as perceived by patients was retained. Null hypothesis three: there is no difference in the communication needs expressed by the cancer patients and those expressed by the chronically ill patients was retained. Null hypothesis four: the patient rates nurse-patient communication as unimportant was rejected at the .05 level. This indicated that cancer patients place a much higher value on nurse-patient communication than do chronically ill patients.

## CHAPTER V

### SUMMARY, RECOMMENDATION, IMPLICATIONS AND CONCLUSIONS

#### Introduction

In the following chapter the process and findings of the study will be summarized, discussing the one significant finding in the study which was that cancer patients placed a much higher value on nurse-patient communication than chronically ill patients. The recommendations will also be discussed, suggesting the possibilities for further study in the area of nurse-patient communications and use of communication with cancer patients to provide quality patient care. Implications for both nursing education and nursing practice in the area of patient communication will be considered. Finally, conclusions reached as a result of the study will be expressed.

#### Summary

Thirty patients, fifteen with a diagnosis of cancer and an expected survival of less than six weeks who were admitted to the Chemotherapy Unit and fifteen with a chronic illness and repeated hospitalizations who were admitted to a general medical-surgical unit of St. Joseph Hospital in Fort Worth,



Texas in June, 1974 were asked to participate in a study of nurse-patient communications. Each patient marked responses to a questionnaire designed to evaluate present levels of nurse-patient interaction and patient preference of levels of nurse-patient interaction. Factors which were considered to be important components of nurse-patient interaction were frequency of nurse visits, degree of which conversation is patient-centered, interest of nurse in conversation, social distance, level of communication, eye contact, and touch.

Patients were also asked what value they placed on nurse-patient communication and what topics they wished to discuss. Responses to the questions were tabulated and analyzed comparing cancer patients to chronically ill patients, and presently occurring communication to preferred communication. No statistical differences were found in the responses of cancer patients as opposed to chronically ill patients with the exception of the value the patients placed on communication.

The cancer patients considered the caring level of nurse-patient communication to be of significantly greater importance than the chronically ill group. No significant difference was found in comparing the present level of communication with the preferred level of communications.

Trends in the data indicated that cancer patients generally rated both present level and preferred level of

communication higher than the chronically ill group however the small sample size made statistical significance difficult to achieve. These trends were in the reverse direction to the expected results. This reverse trend may have occurred because of the special nursing unit from which the cancer patient sample was taken. This unit functions within an open awareness setting. The nurses practicing on the unit are recognized by nursing administration to be providing a different level of care than general patient care. All patients admitted to the unit have a diagnosis of cancer and are being treated with Chemotherapy. From the response of the cancer patients it would seem that the nurses are meeting many of these patients' communication needs.

#### Recommendations

On the basis of the results of this study the following recommendations are made.

1. That the study be repeated using a larger sample size and more control of variables. It is suggested that the sample include cancer patients being cared for on a general medical-surgical unit and patients with acute rather than chronic illnesses admitted to a general medical-surgical unit.
2. That a study be conducted of nurses' perception of the communication occurring between themselves and the patient, administering a test to both the nurse and the patient.

3. That a study be conducted to determine if there are differences in the level of communication occurring between the patient and various levels of nursing personnel such as nurse aide, vocational nurse, staff nurse, head nurse, in an attempt to determine what level of nursing personnel the patient sees as most effectively meeting his communication needs.
4. That a study be conducted to compare the patient's perception of communication patterns of the physician as compared to the nurse.
5. That a study be conducted using interview methods and open ended questions to explore more thoroughly the patient's perception of presently occurring and desirable levels of nurse-patient communication.
6. Nurses working with cancer patients should have some assistance both through inservice programs and individual counseling in meeting the communication needs of their patients.
7. That a theoretical framework be developed for providing nursing care of the advanced cancer patient.

#### Implications

This study has implications for nursing education in the area of communication. Communication is a skill and can be acquired. This skill should be developed from the beginning of nursing education. Since it is a skill, learning

communication theory is not sufficient unto itself. The student will require carefully guided experiences in effective communication with others. Communicating with the dying is a specific communication skill which cannot be expected to develop automatically because the student is an effective communicator in other areas. The student will require some support in exploring his own feelings in this area and in giving the patient permission to express his feelings.

The study also has important implications for nursing practice. Although cancer patients were much higher in the value they placed on communication, both groups placed importance on communication. If this is important to the patient it will need to be important to the nurse practitioner in her endeavor to provide quality care. At this point in nursing practice, communication is in a gray area whereby individual nurses are not held responsible for quality or quantity of communication with the patient. Meeting the patient's communication needs are not planned for, they just happen--if indeed it happens at all.

In order to meet effectively the patient's communication needs, these needs must be planned for by inclusion within the nursing care plan and team conferences. Interactions with patients need to be discussed and communication approaches continually reevaluated. The most frequent reaction to suggestions in these areas is that nurses do not have time for this type of care. It is a truism that people usually



find time to do what they consider important. The amount of time spent talking is not merely as important as how that time is used. If nurses were encouraged, supported and praised for meeting communication needs of patients, more patients would have their needs met. This support could come from nursing administration or head nurses or from the nursing team on a specific unit.

### Conclusions

It was determined from the study that cancer patients place a significantly higher value on nurse-patient communication than do chronically ill patients. However, both groups considered nurse-patient communication to be important. Cancer patients considered more topics important to feel free to discuss with the nurse than did chronically ill patients. No significant differences were found in present levels of communication and desired levels of communication. No significant differences were found in responses of cancer and chronically ill groups except in the value they placed on communication.

### Summary

A summary of the study and its results was presented. Recommendations were made to repeat the study with a larger sample and more controlled variables and that related studies be done comparing the patient's perception of communication skills of various levels of nurses and of physicians. It was

suggested that greater emphasis be placed on nurse-patient communication in nursing practice and that this emphasis be supported by continuing education programs and by providing greater psychological rewards to the nurse for effective communication. It was also suggested that communication skills be more effectively included in basic nursing education with planned experiences in communication provided. The conclusion was reached that communication was more important to the cancer patient than the chronically ill patient.

## APPENDIX I

### QUESTIONNAIRE

The following questionnaire is being given as part of a thesis for a masters degree in nursing in an attempt to learn how patients feel about conversations between nurses and patients.

Your doctor has given permission for you to participate in this study with your consent.

Please circle one answer for each question. If the answers do not seem to express how you feel, please select the answer which comes nearest. If one answer occurs part of the time, and another occurs part of the time, select the answer which occurs most frequently.

## QUESTIONNAIRE

1. Nurses come into my room
  - a. rarely
  - b. sometimes
  - c. whenever I call them
  - d. frequently just to speak or check me
2. I would like nurses to come into my room
  - a. rarely
  - b. sometimes
  - c. whenever I call them
  - d. frequently just to speak or check me
3. When a nurse enters my room, she usually
  - a. talks very little
  - b. tries to talk about things I do not wish to discuss
  - c. talks only about casual things
  - d. is willing to listen or discuss what concerns me
4. When a nurse enters my room, I would prefer that she
  - a. talk very little
  - b. talk only when necessary
  - c. talk only about casual things
  - d. be willing to listen or discuss what concerns me
5. When a nurse talks with me she usually seems
  - a. not interested
  - b. in a hurry
  - c. polite but distant
  - d. to care for me as a person
6. When a nurse talks with me, I would prefer that she be
  - a. not interested
  - b. in a hurry
  - c. polite but distant
  - d. caring for me as a person
7. When a nurse talks with me she usually
  - a. stands in the doorway
  - b. stands at the foot of the bed
  - c. stands at the side of the bed
  - d. sits beside the bed
8. When a nurse talks with me I would prefer that she
  - a. stand in the doorway
  - b. stand at the foot of the bed
  - c. stand at the side of the bed
  - d. sit beside the bed



9. When a nurse talks with me, she is
  - a. strictly business
  - b. casual
  - c. friendly but not talking about feelings
  - d. open to talk about things I worry or think about
10. When a nurse talks with me, I would prefer that she keep the conversation
  - a. strictly business
  - b. casual
  - c. friendly but not talking about feelings
  - d. open to talk about things I worry or think about
11. Nurses talk with me about things important to me
  - a. rarely
  - b. sometimes
  - c. frequently
  - d. as often as I need to talk
12. I would like for the nurse to talk with me about things important to me
  - a. rarely
  - b. sometimes
  - c. frequently
  - d. as often as I need to talk
13. The nurse looks me in the eye when she talks with me
  - a. rarely
  - b. sometimes
  - c. frequently
  - d. very frequently
14. I would prefer that the nurse look me in the eye when she talks with me
  - a. rarely
  - b. sometimes
  - c. frequently
  - d. very frequently
15. When a nurse talks to me, she touches me
  - a. rarely
  - b. sometimes
  - c. frequently
  - d. very frequently
16. When a nurse talks with me I would prefer that she touch me
  - a. rarely
  - b. occasionally
  - c. frequently
  - d. very frequently

17. My feelings about nurses talking with me are
- a. They should do their work well and otherwise leave me alone.
  - b. They may talk if they need to; it does not bother me.
  - c. I enjoy talking with the nurses.
  - d. When the nurse lets me talk with her about things important to me, I feel that she cares for me as a person.

ON QUESTION 18 PLEASE MARK AS MANY ANSWERS AS YOU WISH

18. I would like to feel free to talk with the nurse about my
- a. illness
  - b. future
  - c. financial problems
  - d. feelings about myself
  - e. feelings about my family
  - f. life up to this time

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