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Nurses' Use of Facilitating and Blocking Communication Behaviours in Cancer Care

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Abstract: *This study investigated nurses' use of facilitating and blocking communication behaviours in cancer care and the associated personal and professional factors. Using cross-sectional quantitative descriptive design and researchers-developed observation guide and questionnaire, data were collected by non-participant observation of 47 nurses working as permanent staff in eight wards admitting predominantly cancer patients in four teaching hospitals in South-Eastern Nigeria. Researchers did non-participant, one-hour event observation and recording of nurses' use of facilitating and blocking behaviours in communicating with three categories of admitted cancer patients – newly diagnosed with early disease signs, patients admitted with recurrence, and those admitted for palliative care. Out of the 721 events of communication behaviours observed, 441(61.2%) were facilitating, 280(38.8%) were blocking. Nurses exhibited highest facilitating behaviours for patients with early disease (208) and blocking behaviours mostly for patients on palliative care (139). Statistically significant relationships were noted among length of stay in cancer unit ($p=0.0444$) and exposure to post-basic course in cancer care ($p<0.0001$). Nurses were not good in communicating pains to patients. All nurses caring for cancer patients will most likely benefit from special pre-requisite training in communication and cancer care.*

Keywords: *blocking behaviours, communication behaviours, Cancer care, facilitating behaviours , personal factors*

I. Introduction

Cancer as a disease arouses a feeling of death and dying. Nurses who by nature of their work spend most of the time with patients need to demonstrate wide range of good communication skills with honesty and sensitivity and an ability to discuss delicate issues as death and dying and other nursing-sensitive patient outcomes. These concrete set of behaviours are needed to help patients disclose critical information about their health problems and healthcare providers to disclose difficult information ("bad news") to patients and family in cancer care. However, discussing issues of death and dying with cancer patients can pose challenges for even the most talented and experienced nurse [1].

Delivering "bad news" is an important communication task for oncology nurses [2, 3]. The nurse's communication with cancer patients can constitute a facilitating or blocking behaviour. Facilitating behaviours allow patient to disclose his problems**.** Blocking behaviour occurs when a patient raises a concern and the nurse either fails to respond or redirects the conversations [4]. Duldt [5] used the terms 'humanizing' and 'dehumanizing' to explain similar phenomena. However, it has been observed that staff preferred cancer patients who handle their illness in a way that was not disturbing to them [6].

II. Literature review

Available literature show that care-givers pay little attention to checking how well patients have understood what they have been told [6, 1] and that nurses typically miss the full range of concerns which people with cancer have [7, 8] probably due to lack of prerequisite communication skills. Effective communication is imperative for diagnosing patient's problems. in cancer care, particularly in advanced stages of the illness, it is important for identifying when patients enter the dying phase. Nurses' inability to communicate death and dying may mean failure in delivery of appropriate care

Fallowfield and Jenkins [9] posit that effective communication skills can be taught. The Centre for Health and Social Care Research [10] conducted a two-day pilot training of 10 health practitioners on advanced communication skills. Post training evaluation of participants showed an increase in their level of confidence and improved practice post training.

Lange et al [11] assessed nurses' attitude towards death and caring for dying patients in a comprehensive cancer centre using a convenient sample of 355 oncology nurses and found nursing experience and age as high predictors of nurses' attitude toward death and caring for dying patients. However, Wheatley-Price et al [12] in a similar study noted that comfort in discussing prognosis increased with time, and not age.

Lange et al [11] further observed that the longer the length of time the nurse had been exposed to dying patients, the more positive his/her attitude to death and dying. Dunn et al [13] and Feudtner et al [14] equally noted this in similar studies.

There is generally dearth of literature on nurses' use of facilitating and blocking behaviours in cancer care and factors that influence them. In Nigeria, because oncology nurses are extremely rare, those without any cancer training work in cancer care units and learn on the job. The communication behaviours of these nurses with varying background preparations and experience have not been studied. Furthermore, from some of the researchers' interactions with nurses-on-duty, as well as watching and listening to them, they had the hunch that certain social variables may define how nurses communicate with cancer patients. This study was therefore designed to observe the extent nurses exhibit facilitating and blocking behaviours in communicating with cancer patients at various stages of their illness and how their socio-demographic characteristics impact their communication with various categories of cancer patients. Studies in developing countries using local peculiarities are necessary to enhance effective cancer care in this part of the world as well as contribute to literature in the field. As an observation study, the aim was to see what the nurses actually see [15] and do while caring for cancer patients at various stages of the illness.

2.1. Conceptual framework

Humanizing Nursing Communication Theory by Duldt [16] is based on Communication and Humanistic/Existential thought. According to Duldt and Giffin [17], Humanizing Nursing Communication Theory identifies interpersonal communication as "the means by which the nurse becomes increasingly sensitive to and aware of the client's state of being, of the dynamic relationship between the client and his or her environment, and of the client's potential" (p. 9). The theory emphasizes two dimensions of communication: the attitude with which one communicates and skills or patterns of interaction one uses to communicate. It analyzes the interpersonal relationships between the nurse and her patients, peers and colleagues which facilitate compassionate care as well as help her to identify the range of patterns and attitudes to employ in both pleasant and unpleasant relationships. Duldt [16] noted that "humanizing patterns of communication can be learned and can enhance the nurse's awareness of sensitivity to the client's state of being and of becoming" [17, p. 8).

III. Methods

3.1. Design

Cross-sectional descriptive quantitative design was used.

3.2. Setting

Study was carried out in four teaching hospitals in South-Eastern, Nigeria. The hospitals are referral centres where high volume of cancer patients and specialised care are expected. Out of twelve identified wards admitting cancer patients, eight adult wards with the highest volume of cancer patients, two from each hospital (1 adult male, 1 adult female ward) were purposively chosen for inclusion into this study. The study wards were designated as A_1, A_2; B_1, B_2; C_1, C_2 and D_1, D_2. Other inclusion criteria were: the ward must be an open one where predominantly cancer patients are admitted to allow the researchers have free and close observation of the nurses' communication with the patients during data collection. Cancer patients were categorised based on patient's stage in the cancer trajectory course, namely: newly diagnosed patients admitted with early disease stages, patients admitted with recurrence, and patients admitted with advanced disease for palliative care. In each ward, one patient from each patient category (3 in all) was purposively identified for observation during patient-nurse communication/interaction process. Only patients who were conscious and mentally stable were used.

3.3. Sample

All registered nurses working as permanent staff in the study wards and on morning shift duty on data collection days were included in the study. A total of forty-seven (47) eligible nurses were recruited for the study; eleven (11) nurses in hospital A (4 in ward A_1 and 7 in ward A_2), ten (10) nurses in hospital B (4 in ward B_1 and 6 in ward B_2), fifteen (15) nurses in hospital C (8 in ward C_1 and 7 in ward C_2), and eleven (11) nurses in hospital D (6 in ward D_1 and 5 in ward D_2).

3.4. Instruments

Three instruments were used for data collection, namely: 17-item researchers' developed observation guide on use of facilitating and blocking communication behaviours (OGSFBCB), audio-tape recorders and researcher-developed five-item questionnaire. Brown [18] suggested that when communication skills are assessed, these must be defined in observable and identifiable behavioural terms. Also observation is considered a very appropriate means of collecting data in studies aimed at seeing and describing phenomena (such

as verbal and non-verbal communications behaviours including actions and reactions) in their natural setting [19, 20, 20]. The observation guide has two sections. Section A with thirteen items collected data on nurses' behaviours that encourage patients to disclose their problems – facilitating behaviours; while section B with four items was on nurses' behaviours that prevent patients from disclosing their problems – blocking behaviours. The observation guide quantitatively collected data based strictly on the frequency of occurrence of verbal and non-verbal communication behaviours in form of facts or feelings, as specified in the observation guide, and not necessarily on the message contents.

The 5-item questionnaire was used to elicit information on age, years of total nursing experience, length of time the nurse had worked in cancer ward(s) and socio-cultural belief of the participating nurses about life and illness as well as their exposure to post basic course on cancer care. Six (6) socio-cultural beliefs about life and illness were identified; three were beliefs that may elicit facilitating communication behaviours among the nurses (positive attitude), while the remaining three were beliefs that may elicit blocking behaviours (negative attitude) among them.

The tape recorder was used to enhance collection of full range of nurse-patient verbal communication and to validate observations.

3.5. Validation and reliability of instrument

Ten copies of the questionnaire and observation guide were administered to ten nurses on morning duty in two similar wards of a teaching hospital in Imo State, Nigeria, (five nurses from each). Analysis of scores collected from the pilot study yielded a split-half reliability co-efficient values of 0.96 for the questionnaire and an inter-rater Spearman correlation reliability co-efficient of 0.8 for the observation guide, which indicated that the instruments had strong reliabilities.

3.6. Ethical consideration

Bloomer et al [22] observed long existing ethical issues relating to clinical studies using observation and recommend preparatory work with clinicians and managers on how to protect the rights of participants and the vulnerable groups to ensure quality ethical coverage. Ethical clearance for the study was obtained from the Ethics Committee of one the participating teaching hospitals. Administrative permit was also obtained from the appropriate hospital authorities, unit Heads and ward nurse managers. Prior to data collection, prospective patients were approached and purpose of the study carefully explained to them. Only patients who gave their consent after due explanation were used. Also, the patients' medical consultants were approached and informed of the observational study that would necessitate researchers' presence around patients' bedside for specified three-hour period.

3.7. Procedure for data collection

Data collection was by visit of one ward each day and observing the nurses until the eight wards was covered. Only three of the researchers were involved in data collection to ensure consistency of records. The trio visited one study ward at a time to self-administer the instrument. Researchers adopted the non-participant observation mode for this study. The 'outsider' position of this approach prevents the researcher from introducing any known preconceived opinions or attitudes about the participants [23]. To minimize potential Hawthorne effects while maximizing potential benefits of outcome of the study, the mission of the researchers was not disclosed to the nurses under observation *a priori*. Researchers only confided their mission to the Ward Heads who were excluded from the study and requested not to divulge same to the nurses while observation was on.

All nurses on duty were identified physically through the assistance of the Ward Head; assigned numbers by the researcher as they appeared on the duty roster. Then, one patient admitted with newly diagnosed early disease stage, one admitted with recurrence, and one admitted for palliative care were identified with the assistance of the Ward Head. These were designated patients A, B, and C, respectively. These patients were approached by the ward head and the three observers who introduced themselves and the purpose of their visit. The procedure for data collection was duly explained including the information that a tape recorder was to be hidden on the patient's bed locker away from site of the nurses while data collection was going on and that only information needed for purpose of the study would be lifted from interactions as recorded in the tape and used strictly for the same purpose. Only patients who met inclusion criteria and who gave their consent after due explanations were used for data collection.

A powered tape recorder was placed on bed locker of each of the designated patients near his/her bed and concealed with decoration flowers. One observer was randomly assigned to one patient at a time. Each sat at a distance of about six feet away from the patient to observe (around the bedside of the patient's neighbour whom the researcher disguised as visitor to) which allowed her to observe the nurses while attending to that particular patient. Prior to observation, these patients' neighbours were privately approached and informed that a 3- hour

observation of the nurses while caring for the next patient would be done by one researcher for every one hour while sitting at their bedside and that they were not in any way involved in the study.

The three researchers independently observed and recorded the nurses' exhibition of facilitating behaviours and blocking behaviours at each patient contact, noting the frequency of visits to the patient's bed side, purpose and verbal and non-verbal communication behaviours exhibited while interacting with the patient and/or patient relations as stipulated in the observation guide. The observation of communication events around each patient lasted for only one hour. The ward environment was not manipulated. However, all interactions with other patients, family members and clinicians who pass through the observation field while observation lasted were considered irrelevant. After the one hour, observers rotated their positions to another patient. The observers rotated thrice, spent a total of three hours in each ward with each observer having spent one hour observing nurses' communication with each of the three patient groups. The tape recorder was used to collect audio details of the communication that might have been missed by the observers. The data collection was done between 9.00am and 1.00pm in each ward to control for the effect of procedure timing on the communication process, since there are certain procedures performed specifically within this time for each of the wards such as bed bathing, wound dressing, and oral medication rounds.

After the life observations, each nurse-participant was approached by either of the researchers to disclose the purpose of the researchers' visit and the demands of the study. They were informed that although they had already been observed, participation was still voluntary. Only the observation guide of those who agreed to participate would be used subsequently for analysis. They were assured of anonymity and confidentiality of information given and all gave their informed consent.

The questionnaire on personal profile was then administered to the nurse participants. This was completed and returned to researchers on the day of observation of each nurse. Data collection took eight days.

Observations were scored nominally by counting and awarding 1 (one) point to any of the specified behaviours exhibited by a particular nurse each time she/he visited a specified patient's bedside. Additional information from the audio-tape recorder were coded; the contents were transcribed and converted to scores using the items in the observation guide through inter-coder agreements. These scores were subsequently summated and analysed descriptively. Chi square test at 0.05 level of significance was applied to test for association between communication patterns and the nurses' age, years of total nursing experience, socio-cultural beliefs about life and illness and exposure to post basic course in cancer care using GraphPad Prism version 5.20.

IV. Results

4.1 Personal profile of study participants

Table 1: Summary of personal profile of study participants

Personal profile		f	%
Age	21-25	3	6.4
	26-30	8	17.0
	31-35	15	31.9
	36-40	16	34.0
	>40	5	10.7
	$\bar{x}$(SD)	33.18($\pm$40.15)	
Years of total nursing experience	1-5	16	34.0
	6-10	11	23.4
	11-15	13	27.7
	$\geq$16	7	14.9
	$\bar{x}$(SD)	9.17($\pm$12.73)	
Length of time in cancer ward	Less than one month	10	21.3
	1 – 6 months	18	38.3
	7 months – 2 years	9	19.1
	2 – 5 years	6	12.8
	> 5 years	4	8.5

Table I shows that majority of the nurses were between the ages 31 and 40 years (16 + 15 =31). Mean (and standard deviation) of the nurses' age was 33.18 (S.D±40.15) years. Many (16, that is 34.0%) were still under 5 years on the nursing job while only 7 had working experience above 16 years; $x^2 = 9.17$, S.D$\pm$12.73 years. It appeared that majority had spent less than 6 months put together caring for cancer patients: 1-6 months = 18 (38.3%); <1 month = 10 (21.3%). Only 4 (8.5%) had nursed cancer patients for more than 5 years.

2 Nurses' communication with patients noting facilitating and blocking behaviours

Table 2: Summary of observations on nurses' communication with patients noting facilitating and blocking behaviours

Communication Behaviours	Patient A	Patient B	Patient C	Total
Section A – Facilitating behaviours				
Visits patient's bedside	37	21	12	70
Addresses patient using his/her appropriate name	27	24	16	67
Initiates verbal communication	12	9	6	27
Touches patient gently	9	12	7	28
Asks patient how he feels	32	22	7	61
Uses warn, friendly voice tone to talk to patient	11	7	2	20
Encourages patients to verbalize problem	3	0	1	4
Maintains eye contacts while talking to patient	16	13	10	39
Answers questions raised by patient	5	3	1	9
Smiles to patient	18	12	5	35
Comforts patient	5	5	2	12
Explains procedure to patient	19	12	11	42
Listens actively to clarify patient's concerns	6	4	0	10
Summarises information to show patient he was heard	4	1	0	5
Finds out patient's satisfaction before leaving	2	0	1	3
Ignores patient's unfriendly and inappropriate behaviour	2	5	2	9
Total	**208**	**150**	**83**	**441**
(%)	**(47.2)**	**(34.0)**	**(18.8)**	**(61.2)**
Section B – Blocking behaviours				
Uses command to speak to patient	2	9	7	18
Addresses patient inappropriately	8	11	19	38
Avoids touching the patient	3	7	14	24
Speaks to patient in cold tone	6	13	19	38
Performs procedure without explaining	4	11	24	39
Limits eye contact with patient	4	9	16	29
Handles patient carelessly	6	10	18	34
Gives incomplete or incorrect facts	8	5	17	30
Switches topic to avoid critical question	14	11	5	30
Total	**55**	**86**	**139**	**280**
%	**(19.6)**	**(30.7)**	**(49.7)**	**(38.8)**
Grand Total				**721**

Note: **Patient A =** Patients admitted with newly diagnosed early signs
Patient B = Patients admitted with recurrence
Patient C = Patients admitted for palliative care

A total of 721 nurse-patient communication events were observed; 441 (61.2%) of these were facilitating, while 280 (38.8%) were blocking. Generally, newly diagnosed patients admitted with early disease received the highest facilitating behaviours (208) while those admitted for palliative care were least favoured (83). The most frequently exhibited behaviour was visit to patient's bedside (70), followed closely by **a**ddressing patient using his/her appropriate name (67). Thirty-seven of these visits were made to the bedside of newly diagnosed patients admitted with early disease. Patients for palliative care were visited only 12 times put together. Very few nurses attempted finding out patient's satisfaction before leaving (3) or summarised information obtained to show patient was heard (5).

Blocking behaviours were most exhibited in dealing with patients for palliative care (139) except for switching topic to avoid critical question (5). Patients admitted with early disease had the least blocking behaviours (55).

4.3 Age and use of facilitating and blocking behaviours

Table 3: Nurses' age and use of facilitating and blocking behaviours

Age in years (n)	Patient A		Patient B		Patient C		Total	
	FB	BB	FB	BB	FB	BB	FB	BB
21-25 (3)	52	11	32	16	19	36	103	63
26-30 (8)	40	13	35	19	17	25	92	57
31-35 (15)	46	8	27	17	17	26	90	51
36-40 (16)	33	10	22	16	13	21	68	47
>40 (5)	37	13	34	18	16	29	87	60

Summary of ANOVA result	
F	0.7839
df	5
Mean square	183.9
Significance	0.5839>p0.05

Note: **FB:** Facilitating behaviours
BB: Blocking behaviours

Participants aged 21-25years although very few (3), communicated most often with the patients (facilitating behaviours=103, blocking behaviours=63), but most often with patients admitted with newly diagnosed early signs (facilitating = 52). Those aged 31-35 and 36-40 years were in the majority (15 and 16, respectively) yet, had the least communication with the patients. Generally, facilitating and blocking behaviours exhibited seemed to decrease as the age increase. Statistically, there was no significant difference in the use of facilitating and blocking behaviours based on age as indicated by the ANOVA result, thus: (F = 0.7839, df = 5, p value = 0.5839>p0.05).

4.4 Years of total nursing experience and use of facilitating and blocking behaviours.

Table 4: Nurses' years of total nursing experience and use of facilitating and blocking behaviours

Years of nursing experience (n)	Patient A		Patient B		Patient C		Total	
	FB	BB	FB	BB	FB	BB	FB	BB
1-5 (16)	64	18	41	23	29	39	134	80
6-10 (11)	44	10	28	19	17	28	89	57
11-15 (28)	47	13	30	21	19	34	96	68
≥16 (7)	53	20	51	23	18	38	122	81
Summary of ANOVA result								
F	0.7766							
df	4							
Mean square	266.9							
Significance	0.5703>p0.05							

The 16 nurses with 1 – 5 years demonstrated interestingly high facilitating behaviours (134) when compared with those 6 – 15 years, although the former equally recorded high blocking behaviours (80). Although nurses who had been working for ≥16 years were few (7), they exhibited facilitating behaviours up to 122 times but also with equally high blocking behaviours (81). However, this was mainly with patients admitted with newly diagnosed early signs (53) and admitted with recurrence (51). The rest showed facilitating behaviours almost as often as they demonstrated blocking behaviours. However, the result of two-way analysis of variance (ANOVA) of the observations at df = 4, showed no statistically significant difference in the use of facilitating and blocking behaviours among the subjects. (F=0.7766; p value=0.5703>p0.05). Nurses' exhibition of facilitating and blocking behaviours was not defined by their years of total nursing experience.

4.5 Length of time the nurse had worked in cancer ward

Table 5: Length of time the nurse had worked in cancer ward

Length of time in cancer ward (n)	Patient A		Patient B		Patient C		Total	
	FB	BB	FB	BB	FB	BB	FB	BB
<1 month (10)	16	11	17	24	6	41	50	55
1 – 6 months (18)	47	19	21	20	9	32	53	52
7 months – 2 years (9)	21	8	26	22	16	29	91	58
2 – 5 years (6)	54	8	37	12	20	17	102	55
> 5 years (4)	70	10	49	8	31	10	144	50
Summary of ANOVA result								
F	3.475							
df	5							
Mean square	726.0							
Significance	0.0444<p0.05*							

* Statistically Significant

The use of facilitating communication behaviour by the nurse seemed to improve as the total amount if time they spend caring for cancer patients increased. Though only 4 of the subjects had nursed cancer patients for more than 5 years put together, they demonstrated high facilitating communication behaviour (144) with 50 blocking behaviours. Those with total stay of 7 months – 2 years (9) and 2 – 5 years (6) were very similar in their use of both facilitating (91 and 102, respectively) and blocking (58 and 55, respectively) behaviours. Nurses newly introduced to cancer (< 1 month) though up to 10 in number had the least to do with the cancer patient. Their communication was mainly with patients admitted with newly diagnosed early signs (16) and those admitted with recurrence (17). These differences were reflected on the ANOVA result of the observations which was slightly statistically significant (F = 3.475; p value = 0.0444<p0.05). The length of time nurses spend

in a ward where cancer patients are admitted significantly influences his/her use of facilitating and blocking communication behaviours in cancer care.

4.6 Exposure to post basic course in cancer care and use of facilitating and blocking behaviours

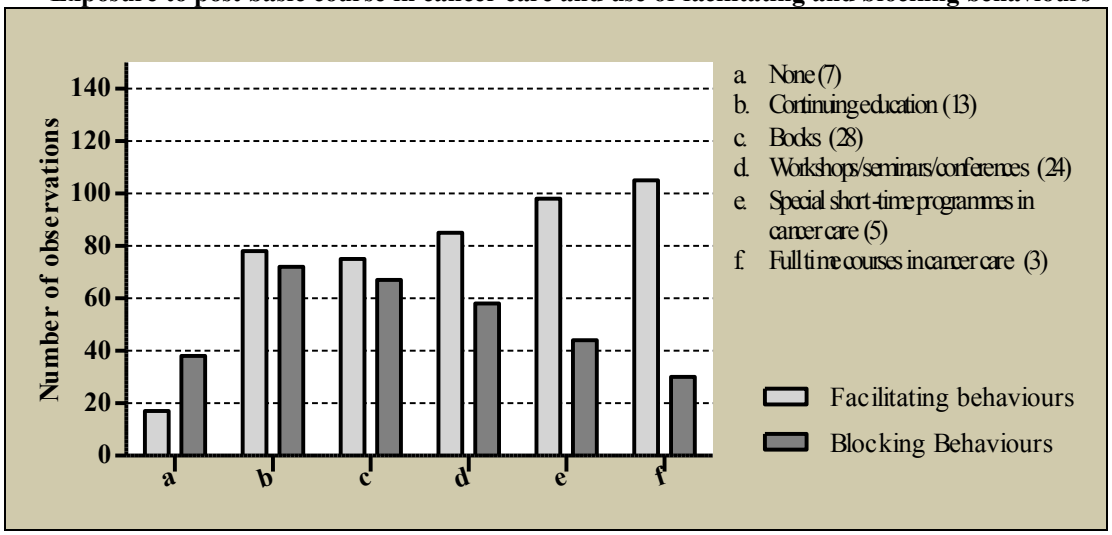

Figure 1: Use of facilitating and blocking behaviours based on exposure to post basic course in cancer care

Twenty-eight of the nurses had read about cancer care in books. These demonstrated 75 facilitating communication behaviours and 67 blocking communication behaviours. Seven (7) nurses who never had any course on cancer care showed more blocking behaviours (38) than facilitating behaviours (17). For those who had formal courses, whether short-time (5) or full-time (3), facilitating behaviours were far more frequent (short-time = 98 times, full-time = 105 times) than blocking behaviours (short-time = 44 times, full-time = 30 times). Attendance to courses in cancer care strongly influenced the nurses' use of facilitating and blocking behaviours as $x^2_{cal} = 48.91$, x^2_{crit} at 0.05 level of significance was <0.0001. (Table 6).

Table 6: Summary table of chi square for nurses' exposure to post basic course in cancer care and their use of facilitating and blocking behaviours

No of rows	No of columns	df	x^2cal	α	x^2crit	p
6	2	5	48.91	0.05	<0.0001	***

V. Discussion

5.1 Use of Facilitating and blocking behaviours

Although findings showed that this cohort of nurses exhibited facilitating behaviours (441 times) more than blocking behaviours (280 times), the magnitude of blocking behaviours is worrisome considering that it depicts inadequacy in communication and poor quality of care. Equity and holistic care seem to be missing in this aspect of nursing practice since the very ill patients admitted for palliative care received the least attention. Most facilitating behaviours were around newly diagnosed patients admitted with early disease stage, probably because these patients have normal activity scale and as such were less disturbing to the staff. In line with Quint's [5] patients with early signs (and possibly, normal activity scale) were mostly attended to. The few nurses who went to these patients' bedside had specific mission which they did almost exclusively, e.g.: to ask patient about his drugs or perform procedures, like to make bed, serve drug, give injection, change infusion, etc.

It appears that the nurses were not comfortable discussing issues about patients' pains which is very crucial to cancer patients. As recorded (28 times), any discussion initiated by the patient concerning pain was hurriedly concluded by the attending nurse by changing the topic to avoid critical question – asking why the patient wanted to 'know', giving empty responses or leaving the bedside entirely while keeping silence, all in a bid to avoid the 'nut too had to crack'. This finding was not in agreement with Lange et al [11] since even the long serving nurses did not make a difference. Nurses will likely ignore what individual patients wish to know and pay little attention to checking how well patients have understood what they have been told, probably because they lack the skill necessary for good communication behaviour.

5.2 Age

Nurses' use of facilitating and blocking behaviours was not influenced by their age (F = 0.7839, p value = 0.5839). Although Lange et al [11] earlier observed that age was most likely to predict nurses' attitude to caring for dying patients, this present finding was in line with Wheatley-Price et al [12] indicating that ability to discuss patient prognosis does not increase with age. The older one gets, the more experiences the person should have, but that depends on the amount of contacts one has with the phenomenon to be learnt. No nurse, therefore, should be regarded as inadequate based on age provided the person possesses the pre-requisite knowledge and skills needed to practice effectively.

5.3 Years of total nursing experience

Mere number of years of total nursing experience was not a predictor of use quality of communication behaviour the nurse exhibits (F=0.7766; p value=0.5703>p0.05). Proficiency improves with exposure and practice, which is qualitative increment, as well as in number of years – quantitative increment. Again, the finding is not in line with Lange et al [11].

Furthermore, the result supports Gauthier's [7] discovery that communicating death to the 'near death' patient poses challenge for even the most talented and experienced nurse. Commonsense-wise, since repetition enhances mastery, nurses who have been in contact with various categories of patients over a period of time should have demonstrated reduced anxiety levels in patient care and demonstrate proficiency in communicating with patients. Failure in this regard may be related to lack of commitment; a defence mechanism against their vulnerability; or inadequate preparation on how to handle the situation.

5.4 Length of time spent in cancer ward

The findings of the present study confirm earlier findings of Dunn et al [13], Feudtner et al [14] and Lange et al [11] that used even larger samples. Frequent exposure will tend to reduce the anxiety level of the nurse while attending to the critically sick patient and his family. It will also improve nursing-sensitive patient outcomes. The new nurse on the other hand may be scared particularly if he/she equally lacks the necessary training in oncology care. This finding may be implicated in the length of time each nurse is assigned to a ward or unit. Frequent rotation will most likely reduce the nurse's effectiveness because it means the nurse working under continuous adjustment state.

5.5 Exposure to post basic course in cancer care

Whether or not nurses had undertaken courses in cancer care was a highly significant clear determinant of how they communicate with cancer patients (x^2_{cal} = 48.91, p value at 0.05 = <0.0001). It is, however, regretted that all the respondents (except 3) did not receive any formal full-time training in oncology nursing. Fallowfield and Jenkins [9] and Wheatley-Price et al[12] already demonstrated in their studies that quality of nursing care improved after such extra courses. Also, the findings have implication for the educational qualification of the nurses that must care for cancer patients irrespective of the stage of the illness. Additional courses will enhance nurse's knowledge acquisition; improve communication skills; increase confidence in handling difficult areas such as patient's feelings regarding their diagnosis and prognosis; and ultimately result in improved care. In particular, courses in oncology will most likely help to improve communication among nurses as well as offer them the opportunity to internalise an ability to cope with the emotional factors cancer nursing involves. Special programmes in cancer care should therefore be regarded as *sine qua non* to effective communication behaviours.

VI. Conclusion

The conclusions from findings are that some (38.8%) nurses were unable to communicate openly with cancer patients. All nurses involved in cancer care should as a matter of necessity be exposed to post basic oncology nursing education to enhance their practice. Where it is not realistic to get all nurses working in these units to receive this training due to limited finance and staff, at least a potential ward head in these units should receive this training and subsequently help in on-the-job training for other nurses. The authors would like to recommend that communication in palliative care be included as a course in the basic nursing education programme, particularly in this part of the world, so that all prospective nurses would begin to learn this from the cradle.

Paucity of literature at the local level to enrich the literature limited comparability of findings. Physical nearness necessary for full range observation of these subjects during data collection so as to elicit information through facial expressions and certain other non-verbal cue including those behind the screen was not possible as researchers needed to make the data collecting process anonymous. This, therefore, limits a wide application of the findings. Also, this study was limited to facilitating and blocking communication behaviours. Other important aspects of nurse-patient communication were not included.

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