European Journal of Oncology Nursing 40 (2019) 120–125

Contents lists available at ScienceDirect

European Journal of Oncology Nursing

journal homepage: www.elsevier.com/locate/ejon

Observations of the communication practices between nurses and patients in an oncology outpatient clinic

Anne Prip[a,*], Kathrine H. Pii[a], Kirsten A. Møller[a], Dorte Lisbet Nielsen[b], Sally E. Thorne[c], Mary Jarden[d]

[a] Department of Nursing and Nutrition, University College Copenhagen, Tagensvej 86, 2200 Copenhagen N, Denmark
[b] Department of Oncology, Herlev and Gentofte Hospital, University of Copenhagen, Herlev Ringvej 75, 2730 Herlev, Denmark
[c] School of Nursing, University of British Columbia, Canada
[d] Department of Hematology and Oncology, Copenhagen University Hospital, Rigshospitalet & Department of Public Health, University of Copenhagen, Denmark

ARTICLE INFO

Keywords:
Ambulatory chemotherapy
Communication
Interpretive
Description
Outpatient care
Participant observation
Patient-nurseinteraction
Symbolic interactionism

ABSTRACT

Purpose: Effective communication in cancer care and treatment is linked to better health outcomes, improved treatment adherence, and improved quality of life for cancer patients. While the characteristics of effective communication have been identified, there is sparse knowledge about the current conditions for providing effective communication especially within the outpatient clinical context, where the majority of cancer patients are currently being treated. This study aimed to explore communication practices between nurses and patients undergoing chemotherapy in an outpatient clinic to gain insight into how patients are supported in this setting.
Methods: Data were collected through 70 h of participant observations of nurse-patient interactions supplemented with ad hoc interviews with nurses in an oncology outpatient clinic. The methodology and data analysis are guided by interpretive description, thematic analysis and symbolic interactionism.
Results: Three themes were generated that characterised communication in the outpatient clinic: Treatment-centred communication, efficient communication and spatially-bound communication. While there was good opportunity for patients to learn about treatment and side effects during cancer treatment, psychosocial concerns were rarely addressed.
Conclusions: The outpatient setting influences the type and quality of communication between nurses and patients. Improvement of communication should include not only verbal and written information, but focus on the importance of nonverbal communication in the oncology outpatient clinic. Furthermore, there is a need to make environmental adjustments that can facilitate the opportunity for patients to express their needs and for nurses to respond to them.

1. Introduction

Today, patients with cancer are increasingly and primarily treated in outpatient settings (Bonacchi et al., 2016). This development will continue as the annual number of cancer cases worldwide is expected to increase from 14 million in 2012 to 22 million within the next 20 years (WHO, 2018). Benefits associated with outpatient treatment include better cost control (Bonacchi et al., 2016) and a positive impact on patients' ability to maintain normalcy in everyday life (Hjorleifsdottir et al., 2008; McIlfatrick et al., 2007). However, some patients feel left alone when treated in an outpatient clinic and experience that they do not receive adequate professional support to help them cope with cancer and treatment (McIlfatrick et al., 2007).

The quality of communication between health care professionals (HCPs) and patients influences the quality of cancer care and thereby patients' ability to live with the disease (Epstein and Street Jr., 2007; Prip et al., 2018; Skea et al., 2014; Thorne et al., 2013). Effective communication has been linked to better health outcomes (Epstein and Street Jr., 2007; Street et al., 2009), and improved cancer treatment adherence (Roberts et al., 2005). While effective communication informs, supports and guides patients with cancer (Coolbrandt et al., 2016; McKenzie et al., 2011; Thorne et al., 2013), ineffective communication results in confusion and distress (Thorne et al., 2013). HCPs communication skills are central to the support of cancer patients in

* Corresponding author.
E-mail addresses: anpr@kp.dk (A. Prip), kapi@kp.dk (K.H. Pii), kimo@kp.dk (K.A. Møller), Dorte.Nielsen.01@regionh.dk (D.L. Nielsen), Sally.Thorne@ubc.ca (S.E. Thorne), Mary.Jarden@regionh.dk (M. Jarden).

https://doi.org/10.1016/j.ejon.2019.03.004
Received 21 December 2018; Received in revised form 4 March 2019; Accepted 19 March 2019

their efforts to cope with a potentially life-threatening disease (Botti et al., 2006; Thorne et al., 2013) and maintain hope (Prip et al., 2018; Thorne et al., 2008) while becoming familiar with the disease and treatment (Ekwall et al., 2011).

Cancer treatment in an outpatient clinic requires patients to have a good understanding of the side effects of chemotherapy in order to manage symptoms more independently (Coolbrandt et al., 2016; McKenzie et al., 2011). Research shows, however, that patients receiving chemotherapy in outpatient clinics often have unmet needs related to the management of side effects and that these symptoms are the main reason for unplanned hospitalizations (McKenzie et al., 2011). Furthermore, studies find that cancer patients experience concerns and unmet needs related to psycho-emotional issues when treated in an outpatient setting (Bonacchi et al., 2016; Prip et al., 2018). Limited time for communication and brief encounters between patients and HCPs has been identified as a barrier for effective communication in cancer treatment (Banerjee et al., 2016; Hjorleifsdottir et al., 2008).

Although most cancer patients undergo chemotherapy in outpatient clinics, there is little research on communication in this context (Brédart et al., 2015; Hendershot et al., 2005; McIlfatrick et al., 2007; Prip et al., 2018) and how this treatment environment effects communication.

2. Objective

The aim of the study is to explore communication between nurses and patients undergoing chemotherapy in an outpatient clinic to gain insight into how patients are supported in this setting.

3. Methods

3.1. Study design and methodology

This study is based on participant observations of interactions between nurses and patients in an oncology outpatient clinic supplemented with ad hoc interviews with nurses. Interpretive description (ID), a qualitative inductive approach developed to explore clinical problems and phenomena, guided the study (Thorne, 2016; Thorne et al., 2016). ID draws upon established qualitative research traditions and techniques such as phenomenology, grounded theory and ethnography but rejects the “tyranny of method” by encouraging a pragmatic use of methods to suit the specific context of study (Hunt, 2009; Thorne, 2016). ID seeks understanding by exploring natural settings where realities are seen as local and socially experientially generated (Hunt, 2009; Thorne, 2016). As individuals and context are inseparable, it is necessary to observe nurse-patient interactions in the environment in which they take place (Thorne, 2016). In this study, we explored the communicative practice in the clinic including not only verbal communication and the explicit content of their conversations, but also by observing the nonverbal communication of the nurse and patient interactions, their behaviour, activities, and their responses to each other. Symbolic interactionism (SI) guided our understanding of the inherent meaning of the observed communication (Blumer, 1969). SI is a well-established theoretical framework in ID studies and shares the same epistemological foundations (Oliver, 2012), given ID's background in pragmatism and focus on contextualised action (Handberg, 2016; Thorne, 2016). The SI approach rests on three premises: 1) human beings act based on the meanings the phenomena have for them; 2) the meaning of a phenomenon is derived from social interactions with others; and 3) these meanings are handled in, and modified through, an interpretative process (Blumer, 1969). This means that individual actions are both formed by and influence the actions of others (Blumer, 1969). When people interact with each other, they communicate meaning through words and gestures (Blumer, 1969).

3.2. Setting and participants

The study was carried out in an oncology outpatient clinic at a public university hospital in Copenhagen, Denmark in October and November 2014. The participants were patients over 18 years of age with mixed cancer diagnoses: gynaecological cancer, melanoma or cancer in the kidney, bladder or prostate. Sampling patients with different diagnoses can be a useful method when the aim is to describe the general phenomenon regardless of specific conditions, such as gender or tumour site in isolation (Thorne et al., 2016). The nurses involved in the observations performed the same clinical tasks regardless of their clinical oncology experience (varying between < 1 year and > 10 years). These include, besides administering chemotherapy, other nursing tasks such as providing information, changing bandages and collecting blood samples. Each nurse treats approximately five patients depending on the length of treatment. Although the duration of patients' treatment varied from 30 min to 6 h, the interactions between the nurses and patients were predominantly brief, often consisting of 4–7 encounters, each lasting only a few minutes after initiation of treatment. The study was primarily carried out in the 40-m^2 treatment room where most patients received chemotherapy at the outpatient clinic.

3.3. Data generation

Approximately 70 h of participant observation was conducted over a period of two months. Five hours of observation were conducted a day including observations of the nurse-patient interactions, talking with patients and nurses, and participating in practical non-clinical tasks.

We followed the nurses' daily routines, which provided insight into the many encounters and communicative interactions that took place and gave opportunity for short ad hoc interviews (lasting between 2 and 10 min) with the nurses during the day. Questions related to the observations and explored the nurses' reflections about their actions and the observed situations. Approximately six hoc interviews were conducted daily.

Fieldnotes were taken during observations, just as transcripts from conversations between nurses and patients and ad hoc interviews with nurses were documented. Subsequently, the handwritten fieldnotes were transcribed electronically on the same day as the observations according to recommendations of writing ethnographic fieldnotes (Hammersley and Atkinson, 2007).

Anne Prip (AP) and Kirsten Alling Møller (KAM), both registered nurses, collected the data individually. AP has extensive oncology experience and Kirsten Alling Møller (KAM), who had no prior clinical oncology experience has broad experience with ethnographic fieldwork. Their different clinical experiences enabled a variety of perspectives on the data generation and analyses. AP, KAM and Kathrine Hoffmann Pii (KHP), a trained anthropologist, collaboratively developed the fieldwork strategy and methods. All the observations were carried out individually on different days and discussed among AP, KAM and KHP three times during the observation period to review methodological aspects and identify patterns and variations in the data. For example, the three researchers met after two days of observations to develop an observation strategy which included selection of specific activities to follow (Hammersley and Atkinson, 2007). Investigator triangulation was conducted to ensure study credibility and methodological reflection (Malterud, 2001).

3.4. Data analysis

Data analysis was inductively driven and carried out as a thematic analysis (Braun and Clarke, 2006) involving the author group at different stages to ensure credibility (Malterud, 2001). NVivo 10™ software (Edhlund and McDougall, 2012) was used to organise and manage the data. The first step was to become familiar with the data through

repeated readings of the transcripts and by noting initial ideas (AP, KAM). The data were then coded, and the transcripts re-read according to the initial codes, after which the data were repeatedly coded and recoded. Next, patterns and variations in the data were identified and discussed as potential themes (AP, KAM, MJ, KHP). The final coding and analysis were discussed in the entire author group. SI inspired the analysis of the observed communication by drawing attention to the nonverbal communication in interactions and the inherent symbolic meaning of nurses and patients' actions.

3.5. Ethics statement

The study was carried out in accordance to the Helsinki Declaration (WMA, 1974) and approved by the Danish Data Protection Agency (no. 2018-521-0054) and Research Ethics Committee of the Capital Region of Denmark (no. H-4-2014-FSP).

HCPs at the outpatient clinic were informed about the study, including principles of voluntary participation and anonymity. Information posters about the project and the involved researchers were placed in the reception area, hallways and treatment rooms. Researchers introduced themselves when possible during the observations to give patients the opportunity to decline participation, and inform them about the principles of voluntary participation and anonymity. No patients or nurses declined participation.

4. Results

The analytical process led to the identification of three main themes that characterised the communication in the outpatient clinic in terms of its content, form and setting: treatment-centred communication, efficient communication and spatially-bound communication. Although presented separately, the themes are interrelated and mutually influence each other, as illustrated in Fig. 1.

4.1. Communication content: treatment-centred communication

Communication between nurses and patients primarily focused on aspects of treatment. Often, communication was initiated by the nurse, who explained the physiological effects of chemotherapy and the side effects that the patient needed to be aware of, e.g. how chemotherapy affects the bone marrow, stomach and intestines. Patients responded by listening or asking questions, accepting that the nurses set the agenda for the conservation. A treatment appointment typically started with the nurse accompanying the patient from the waiting room to the treatment room. To start treatment promptly, the nurse had prepared the patient's chemotherapy in advance and inserted the intravenous catheter (IV catheter) as soon as the patient was seated. When the patient asked questions during this procedure, the nurse sometimes answered and other times she waited until the IV catheter was in place, signaling through her actions that treatment had to be started before engaging in conversation. Thereby, the nurse communicated verbally and nonverbally a priority order, i.e. that treatment took precedence over dialogue. We observed that the patients responded to this symbolic action (insertion of the IV catheter as the initial action) by either waiting to ask questions until the nurse was ready to converse or by asking questions directly related to the treatment or side effects. In this regard, nurses initiated a line of activity and shaped patients communication in terms of how they responded and which types of questions they asked.

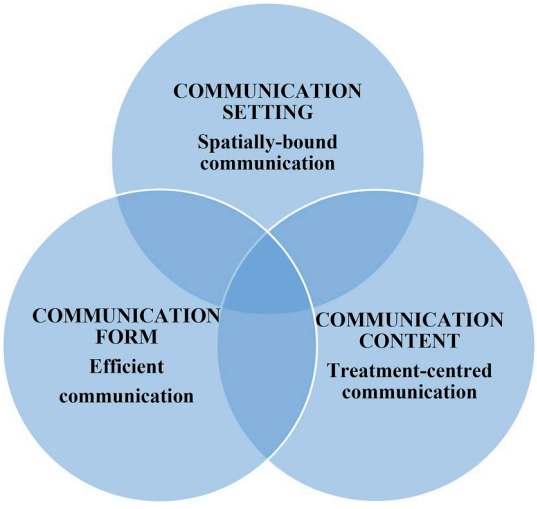

Fig. 1. Themes characterising communication in the outpatient clinic.

Patients' actions were also a reflection of the priority of treatment in the clinic, especially those patients who were familiar with the clinical routines of chemotherapy. Often they initiated communication with the nurse by asking the nurse *which hand she would like [for the IV catheter]* (Observation day 9), indicating that the patients had been socialized to the treatment-practice and had learned the clinic's priorities, i.e. that treatment was the primary focus in their interaction. The following field notes present an example of the situation:

> *After the initial greeting, the patient gets comfortable in the chair. It doesn't seem as if the patient and nurse know one another, but the patient seems familiar with the procedure. The nurse inspects the patient's veins on both arms right away and asks while she inspects: "Are you feeling well?" The patient answers that he has stomach problems. The nurse moves away from the patient, fetches the IV equipment, pulls out a chair and sits down in front of the patient. The IV catheter is inserted on the first try. No words are spoken, but the patient looks on with curiosity. The nurse inspects the IV chemotherapy connected to the patient, and says after reading from the flowchart: "I can see that the dose has been lowered slightly since the last time."Patient: "Has it … ?" Once the treatment begins the nurse sits down, looks at the patient and asks about his stomach problems* (Observation day 5, large treatment room).

For the most part, the nurse returned to the patient's questions after the chemotherapy had been started. However, at times supportive needs were unmet as questions were left hovering in the air unanswered.

Although treatment was pivotal for their interaction, we also observed variations where patients sometimes shared their concerns. The following nurse-patient interaction lasted no longer than 2 min while the nurse was removing the IV catheter:

> *The patient is reading a magazine but puts it away as the nurse enters.*
> *Nurse: "You're sighing?"*
> *Patient: "Yes, you get sad when you read this."*
> *Nurse: "Yeah, we're being blitzed at the moment [a particular TV channel has been focusing on cancer all week]… but you could turn it off."*
> *Patient: "I have children and grandchildren … I imagined that I would live to be 90 … but then again, I won't."*
> *Nurse: "No, you probably won't … but let's see how the treatment works for you."*
> *Patient: "Yeah, but then again, I'd like to feel good … otherwise there wouldn't be much to it … "*
> *Nurse: (short silence) "Did you get your new appointment?"* (Observation, day 5).

In this situation, the nurse noticed and responded to the patient's initiation of communication (the sigh). The dialogue illustrates that it is possible to engage in conversations about existential issues even in a very short period of time. However, it underpins our general observations, that the nurses rarely explored patients' concerns, especially existential issues as death. As the fieldnotes illustrate, the nurses could either open or close the dialogue with the patient by pursuing or avoiding questions that the patient posed, for instance, by changing the

subject, and in this case, by asking about the patient's next appointment.

4.2. Communication form: efficient communication

We observed that the interactions between the nurses and the patients were brief and used efficiently. The nurses' actions were often multitasked, informing the patient about side effects while moving around or engaging in other tasks such as placing the IV catheter and checking the progress of the chemotherapy.

An example of efficient communication was observed when nurses accompanied the patient from the waiting room to the treatment room. During this short walk, the nurse often asked how they had been since the last treatment. By making this enquiry already before arriving to the treatment room, the nurse communicated that time was brief and needed to be used efficiently. This was also confirmed in an ad hoc interview with a nurse about her reflections on the depth of the conversations in the outpatient clinic. She said: *"The patients know that there's only a limited amount of time, so they need to get to the point quickly"* (Informal interview with a nurse, day 3).

Aside from the communication form being brief, much of the meaning was implied. This inherent meaning nevertheless appeared to be understood by the patients who were familiar with the outpatient clinic. These patients used either more direct communication and fewer words to make themselves understood or communicated nonverbally e.g. by extending an arm for the IV catheter.

Although the nurse-patient interactions were brief, we also observed variations where the nurses spent more time with patients who were at risk of developing an allergic reaction during treatment. The nurses also provided more detailed information about the treatment and side effects to patients receiving treatment for the first time. We also observed situations where nurses broke the rapid work pace and took time for a longer dialogue with the patient, e.g. to make sure that a patient understood the information or if a patient showed signs of emotional distress. In certain situations, the nurses thus compensated for the restricted amount of time available in the clinic and created a new line of activity in the busy clinic.

4.3. Communication setting: spatially-bound communication

The clinical setting influenced the interactions between the patient and nurses in terms of how they communicated and the content of the communication. The outpatient clinic had a steady flow of patients arriving, exchanging treatment chairs and departing. This flow created a constant high activity level among the nurses as they prepared for new patients.

The physical environment influenced the content of the verbal communication. We observed a difference in the content of the conversations depending on whether the patients were treated in the large or small treatment room. Especially the large treatment room where most patients were treated, offered poor conditions for sensitive conversations. Patients chose the small rooms when it was an option and sometimes requested one.

As described earlier, existential, psychosocial and sexual issues were rarely brought up in conversations during treatment. One reason for the absence of these issues could, besides from the restricted time to communicate, be related to the lack of privacy in the outpatient clinic making it difficult to have confidential conversations. This challenge was also discussed among the nurses:

> *At the nurses' office, one of the nurses tells another nurse about a newly diagnosed patient with malignant myeloma that she treated the day before. The nurse had never met the patient before and had asked him to sit in the small treatment room. When she asked how he was doing, he broke down in tears. She reflects that he was in crisis and says: "I'm not sure whether I have the skills to care for patients with a newly diagnosed malignant melanoma." […]. The other nurse replies [addressing her answer to me as well]: "Of course we're equipped – a crisis is a crisis. We're professionals, but the question is whether we have the proper conditions to handle the crisis."* (Observation, conversation between two nurses in their office, day 9).

The nurse who shared her experience interpreted the situation as her own lack of professional skills, whereas the other nurse interpreted that the physical conditions in the clinic reduced the possibility of adequately supporting patients. This understanding of the spatial limitations for conversation and support was especially observed in the large treatment room, where nurses sometimes used their bodies to create a confidential space between themselves and the patients, e.g. moving closer to the patient, lowering their voices, and widening their backs as a shield. The nurses thus used their bodies as a medium to compensate for the lack of privacy by creating space for a more private dialogue.

In summary, the analysis found that communication in the outpatient clinic focused on issues related to treatment, which is the main objective of the outpatient clinic visit. Most communication was about the practical or instrumental aspects of chemotherapy, which was delivered efficiently while nurses simultaneously provided information about side effects. Furthermore, communication was characterized by its briefness, reflecting that patients were socialized into the specific communicative practices in the clinical context. Nurses experienced that the lack of privacy, lack of communication skills and restricted time to communicate made it difficult to communicate about sensitive existential, psychosocial and sexual issues.

The themes identified should be understood dynamically as they can influence and mutually reinforce one another, i.e. the setting in which the communication took place with time limitations created a form of communication characterised by efficiency that required prioritization of the content of conversation, resulting in treatment-centered communication. At the same time, the spatial conditions in the clinic made it difficult to have conversations about psychosocial issues, which was further challenged by the brief communication form.

5. Discussion

The study showed that communication was characterised in terms of its content (focusing on topics related to treatment and side effects), its efficient form (brief, implied and multitasked) and that the setting of the outpatient clinic affected both the content, form and quality of communication between the nurses and patients. In the following, we discuss the communication practice observed and the implications it may have for the support patients are offered during chemotherapeutic treatment.

The study revealed that the nurse-patient communication in the clinic predominantly focused on information and aspects of treatment and its side effects. This focus was also expressed in nonverbal communication as the observed actions centered around the technical aspects of treatment. These findings are in line with McIlfatrick et al. who found that the primary focus on treatment in an oncological outpatient clinic was criticized by nurses who expressed that they spent most of their time administering chemotherapy at the expense of their caring role, which they described as "nursing the clinic" as opposed to "nursing the patient" (McIlfatrick et al., 2006). The study argued, that the dominant focus on treatment-related issues in the communication reduced the attention given to other needs that patients have during cancer treatment (McIlfatrick et al., 2006). Our study found that treatment-centered communication provides patients with the opportunity to learn about and discuss the medical and physiological aspects of their treatment. This type of support is highly valued by patients according to a systematic review synthesizing knowledge on patient-HCP relationship and communication in oncology outpatient settings (Prip et al., 2018). The review found that patients request information about treatment and side effects to help them manage the disease and

treatment by, e.g. reducing anxiety and helping them gain control in their everyday lives (Prip et al., 2018). Although we observed that the nurse-patient communication was mainly about treatment and side effects, other studies demonstrate that patients have unmet informational needs regarding side effects (Bonacchi et al., 2016; McKenzie et al., 2011; Prip et al., 2018) which underscores the value of and a continual need to promote communication about treatment. Despite its importance, the treatment-centred content of communication cannot stand alone in nurse-patient communication in an oncological treatment setting. Existential, psychosocial and sexual issues are important to address in cancer care (Bonacchi et al., 2016; Fitch et al., 2013; Maguire et al., 2013) and studies show that patients with cancer have unmet needs regarding such psycho-emotional issues (Bonacchi et al., 2016; Prip et al., 2018). In our observations, these issues were rarely part of the content of the communication. The absence of these issues can be explained in different ways. Limited time is a common explanation expressed both by the nurses in our study and by HCP in the literature (Banerjee et al., 2016; Chan et al., 2013). We observed that nurses had limited time to communicate with the patients in the outpatient clinic, which may explain why nurses prioritized talking about treatment and side effects rather than psychosocial aspects of the disease. Also patients express that limited time may have a negative impact on communication (Chan et al., 2018; Coolbrandt et al., 2016; Finset et al., 2013) and influence which topics patients choose to communicate (Chan et al., 2018). Poorly-designed outpatient settings may also fail to provide an adequate environment for good communication and supportive care (McIlfatrick et al., 2006; von Plessen and Aslaksen, 2005) and may hinder confidential conversations about sensitive issues as some of the nurses in our study expressed. Another explanation may be that patients do not experience a need to discuss psychosocial issues. This was found by Dilworth et al. in a study of patients' support needs in an oncology clinic (Dilworth et al., 2014). The study however also found that patients were not aware of the psychosocial support services available to them (Dilworth et al., 2014), which is a possible reason why patients do not request support regarding these issues. Patients' supportive needs and desire to communicate about their needs are person-specific, and vary depending on the individual cancer trajectory (Botti et al., 2006; Coolbrandt et al., 2016; Thorne et al., 2013). Therefore, communication during treatment needs to be adapted to the individual's specific and changing needs. Although there may be patients who do not experience a need to address the psychosocial issues of cancer and treatment, our study suggests a need to improve the conditions for communicating about and addressing psychosocial needs. If the conditions are not improved, patients must find other ways of dealing with such needs outside the context of the hospital (McKenzie et al., 2011). Moreover, this is an important opportunity for HCP to apply their highly specialized knowledge to help and support patients with psychosocial needs.

The verbal and nonverbal communication in the clinic was also characterised by its efficient form in which the nurses tried to optimize the time available with the patient. This efficiency and level of activity made the clinic appear busy, but nevertheless, patients appeared unfazed as they quickly learned the clinics' routines. However, Chan et al. found patients' experiences of nurses' busyness and multitasked communication to be counterproductive to good communication (Chan et al., 2018). In fact, some patients have even described receiving outpatient chemotherapy as de-humanizing, and even compared it to visiting a fast-food restaurant (McIlfatrick et al., 2007). Although our study did not inquire into patients' experience of the communication practice, these findings indicate the potential drawbacks of efficiency of the outpatient clinic. The observed communication was also characterized by its briefness and implied meaning. This may have consequences for the patients' ability to cope as it can lead to misunderstandings and hamper the flow of information that patients need. Although communication was predominantly brief, we also observed variations where nurses took time for longer conversations, as during the patients 'first chemotherapy session or when patients showed signs of distress. In these situations, the nurse responded to patients' reactions and attempted to overcome some of the barriers created by the spatially bound challenges in the outpatient clinic. This indicates that nurses adjusted their communication to the individual patient and situation, which is important to meet the needs of patients and to ensure effective care (Coolbrandt et al., 2016). The brief and implied communication may indicate that the nurses delivered effective care by utilising time efficiently and communicating complex information in a brief manner to convey as much meaning as possible in the constrained setting.

This study found that the outpatient setting influenced the content and form of the communication. Lack of privacy can hamper conversations about existential, psychosocial and sexual issues, an issue that has been found in other oncology outpatient clinics (Coolbrandt et al., 2016). Furthermore, another study found that patients hospitalized in a single room asked more questions compared to patients in four-bedded rooms, arguing that smaller rooms create a positive impact on HCP-patient communication (van de Glind et al., 2008).

Outpatient clinics are a cost-effective way of organizing treatment, often enabling patients to maintain a normal everyday life. However, our study showed that outpatient treatment poses certain communicative challenges that may hinder the support of patients' care needs, especially needs regarding the psychosocial, existential and sexual dimensions of cancer and treatment. Furthermore, our study emphasised the relevance of attending to HCPs nonverbal communication and the symbolic meaning communicated to patients. This communication may support or discourage patients' willingness to share certain concerns and thus influence the support they have access to in the clinic. It is central that improvements of communication in oncological outpatient clinical settings not only include verbal and written information, but also attend to the nonverbal communication.

5.1. Methodological considerations

As this study focused on the communication between nurses and patients during chemotherapy, we do not know whether the patients had discussed psychosocial needs with the HCPs in other encounters or if patients in fact, have unmet needs based on observations alone. Yet, our observations provided insight into nurse-patient communication and the supportive practices in the outpatient setting in general regardless of, e.g. gender, tumour site, treatment and duration of treatment. Our findings correspond with other studies focusing on oncology outpatient clinics, but also developed new insight into what characterises the communication practice within this context. The SI perspective emphasised the importance of being aware of how HCPs communicate through their non-verbal actions as this influences which subjects the patients bring up in their conversation with the nurses and thus influence the support the patients are offered in the clinic.

Researcher triangulation at several stages (data generation, analysis and writing process) amplified the validity of the study. However, transferability would have been strengthened if we had conducted the study at multiple outpatient sites and included adhoc interviews with patients during the observations.

6. Conclusion

The findings in this study show that communication in an outpatient oncology clinic is characterized by its treatment-centred content and effective form. Other important aspects of cancer care, such as the patients' existential, psychosocial and sexual concerns are rarely explored and expressed in the communication between patients and nurses in this setting. Our study demonstrated both the general communicative challenges in the outpatient clinic and how nurses work creatively within the constraints of the setting to address patients' individual needs. Nevertheless, there is still a need to make

environmental adjustments that can facilitate the opportunity for patients to express their needs and for nurses to respond to them. Moreover, there is a need to find methods to identify the patients' supportive care needs in an outpatient setting so that these needs can be met either in the clinic or in alternative settings, such as community services, general practitioner, or cancer rehabilitation centers. This will ensure that a broader range of supportive care needs are addressed and managed when patients are treated in oncology outpatient clinics.

References

Banerjee, S.C., Manna, R., Coyle, N., Shen, M.J., Pehrson, C., Zaider, T., Hammonds, S., Krueger, C.A., Parker, P.A., Bylund, C.L., 2016. Oncology nurses' communication challenges with patients and families: a qualitative study. Nurse Educ. Pract. 16, 193–201. https://doi.org/10.1016/j.nepr.2015.07.007.

Blumer, H., 1969. Symbolic Interactionism : Perspective and Method. University of California Press, Berkeley, Calif.

Bonacchi, A., Miccinesi, G., Galli, S., Primi, C., Chiesi, F., Lippi, D., Muraca, M., Toccafondi, A., 2016. Use of the needs evaluation questionnaire with cancer outpatients. Support. Care Canc. 24, 3507–3515. https://doi.org/10.1007/s00520-016-3176-4.

Botti, M., Endacott, R., Watts, R., Cairns, J., Lewis, K., Kenny, A., 2006. Barriers in providing psychosocial support for patients with cancer. Cancer Nurs. 29, 309–316.

Braun, V., Clarke, V., 2006. Using Thematic Analysis in Psychology. Qual. Res. Psychol., vol. 3 (2), 77–101. https://doi.org/10.1191/1478088706qp063oa.

Brédart, A., Kop, J.L., Efficace, F., Beaudeau, A., Brito, T., Dolbeault, S., Aaronson, N., 2015. Quality of care in the oncology outpatient setting from patients' perspective: a systematic review of questionnaires' content and psychometric performance. Psycho Oncol. https://doi.org/10.1002/pon.3661.

Chan, E.A., Jones, A., Wong, K., 2013. The relationships between communication, care and time are intertwined: a narrative inquiry exploring the impact of time on registered nurses' work. J. Adv. Nurs. 69, 2020–2029. https://doi.org/10.1111/jan.12064.

Chan, E.A., Wong, F., Cheung, M.Y., Lam, W., 2018. Patients' perceptions of their experiences with nurse-patient communication in oncology settings: a focused ethnographic study. PLoS One 13. https://doi.org/10.1371/journal.pone.0199183.

Coolbrandt, A., Dierckx de Casterlé, B., Wildiers, H., Aertgeerts, B., Van der Elst, E., van Achterberg, T., Milisen, K., 2016. Dealing with chemotherapy-related symptoms at home: a qualitative study in adult patients with cancer. Eur. J. Cancer Care 25, 79–92. https://doi.org/10.1111/ecc.12303.

Dilworth, S., Higgins, I., Parker, V., Kelly, B., Turner, J., 2014. Patient and health professional's perceived barriers to the delivery of psychosocial care to adults with cancer: a systematic review. Psycho Oncol. https://doi.org/10.1002/pon.3474.

Edhlund, B.M., McDougall, A.G., 2012. NVivo 10 essentials : your guide to the world's most powerful data analysis software. Form & Kunskap AB.

Ekwall, E., Ternestedt, B.-M., Sorbe, B., Graneheim, U., 2011. Patients' perceptions of communication with the health care team during chemotherapy for the first recurrence of ovarian cancer. Eur. J. Oncol. Nurs. 15, 53–58. https://doi.org/10.1016/j.ejon.2010.06.001.

Epstein, R.M., Street Jr., R.L., 2007. Patient-centered communication in cancer care: promoting healing and reducing suffering. Communication 222. https://doi.org/NIH Publication No. 07-6225.

Finset, A., Heyn, L., Ruland, C., 2013. Patterns in clinicians' responses to patient emotion in cancer care. Patient Educ. Counsel. 93, 80–85. https://doi.org/10.1016/j.pec.2013.04.023.

Fitch, M.I., Beaudoin, G., Johnson, B., 2013. Challenges having conversations about sexuality in ambulatory settings: part II— health care provider perspectives. Can. Oncol. Nurs. J. 23, 182–188. https://doi.org/10.5737/1181912x233182188.

Hammersley, M., Atkinson, P., 2007. Ethnography : Principles in Practice. Routledge.

Handberg, C., 2016. Male Cancer Patients and Healthcare Professionals at Hospitals: an Interpretive Description of Men's Barriers to Participation in Municipal Cancer Rehabilitation, vol. 1 Health Aarhus University.

Hendershot, E., Murphy, C., Doyle, S., Van-Clieaf, J., Lowry, J., Honeyford, L., 2005. Outpatient chemotherapy administration: decreasing wait times for patients and families. J. Pediatr. Oncol. Nurs. 22, 31–37. https://doi.org/10.1177/1043454204272539.

Hjorleifsdottir, E., Hallberg, I.R., Gunnarsdottir, E.D., Bolmsjo, I.A., 2008. Living with cancer and perception of care: Icelandic oncology outpatients, a qualitative study. Support. Care Cancer 16, 515–524. https://doi.org/10.1007/s00520-007-0333-9.

Hunt, M.R., 2009. Strengths and challenges in the use of interpretive description: reflections arising from a study of the moral experience of health professionals in humanitarian work. Qual. Health Res. 19, 1284–1292. https://doi.org/10.1177/1049732309344612.

Maguire, R., Papadopoulou, C., Kotronoulas, G., Simpson, M.F., McPhelim, J., Irvine, L., 2013. A systematic review of supportive care needs of people living with lung cancer. Eur. J. Oncol. Nurs. 17, 449–464. https://doi.org/10.1016/j.ejon.2012.10.013.

Malterud, K., 2001. Qualitative research: standards, challenges, and guidelines. Lancet. https://doi.org/10.1016/S0140-6736(01)05627-6.

McIlfatrick, S., Sullivan, K., McKenna, H., 2006. Nursing the clinic vs. nursing the patient: nurses' experience of a day hospital chemotherapy service. J. Clin. Nurs. 15, 1170–1178. https://doi.org/10.1111/j.1365-2702.2006.01495.x.

McIlfatrick, S., Sullivan, K., McKenna, H., Parahoo, K., 2007. Patients' experiences of having chemotherapy in a day hospital setting. J. Adv. Nurs. 59, 264–273. https://doi.org/10.1111/j.1365-2648.2007.04324.x.

McKenzie, H., Hayes, L., White, K., Cox, K., Fethney, J., Boughton, M., Dunn, J., 2011. Chemotherapy outpatients' unplanned presentations to hospital: a retrospective study. Support. Care Canc. 19, 963–969. https://doi.org/10.1007/s00520-010-0913-y.

Oliver, C., 2012. The relationship between symbolic interactionism and interpretive description. Qual. Health Res. 22, 409–415. https://doi.org/10.1177/1049732311421177.

Prip, A., Møller, K.A., Nielsen, D.L., Jarden, M., Olsen, M.-H., Danielsen, A.K., 2018. The patient–healthcare professional relationship and communication in the oncology outpatient setting. Canc. Nurs. 41, E11–E22. https://doi.org/10.1097/NCC.0000000000000533.

Roberts, C., Benjamin, H., Chen, L., Gavigan, M., Gesme, D.H., McCarthy, P., Samuels, R.J., Baile, W.F., 2005. Assessing communication between oncology professionals and their patients. J. Canc. Educ. 20, 113–118. https://doi.org/10.1207/s15430154jce2002_13.

Skea, Z.C., MacLennan, S.J., Entwistle, V.A., N'Dow, J., 2014. Communicating good care: a qualitative study of what people with urological cancer value in interactions with health care providers. Eur. J. Oncol. Nurs. 18, 35–40. https://doi.org/10.1016/j.ejon.2013.09.009.

Street, R.L., Makoul, G., Arora, N.K., Epstein, R.M., 2009. How does communication heal? Pathways linking clinician–patient communication to health outcomes. Patient Educ. Counsel. 74, 295–301. https://doi.org/10.1016/j.pec.2008.11.015.

Thorne, S., 2016. Interpretive Description. Qualitative Research for Applied Practice, second ed. Routledge.

Thorne, S., Oliffe, J.L., Stajduhar, K.I., Oglov, V., Kim-Sing, C., Hislop, T.G., 2013. Poor communication in cancer care. Canc. Nurs. 36, 445–453. https://doi.org/10.1097/NCC.0b013e31827eeda4.

Thorne, S., Stephens, J., Truant, T., 2016. Building qualitative study design using nursing's disciplinary epistemology. J. Adv. Nurs. 72, 451–460. https://doi.org/10.1111/jan.12822.

Thorne, S.E., Hislop, T.G., Armstrong, E.-A., Oglov, V., 2008. Cancer care communication: the power to harm and the power to heal? Patient Educ. Counsel. 71, 34–40. https://doi.org/10.1016/j.pec.2007.11.010.

van de Glind, I., van Dulmen, S., Goossensen, A., 2008. Physician-patient communication in single-bedded versus four-bedded hospital rooms. Patient Educ. Counsel. 73, 215–219. https://doi.org/10.1016/j.pec.2008.07.004.

von Plessen, C., Aslaksen, A., 2005. Ambulatory Patients with Lung Cancer Improving the Quality of Palliative Care for Topic Collections Improving the Quality of Palliative Care for Ambulatory Patients with Lung Cancer. https://doi.org/10.1136/bmj.330.7503.1309.

WHO, 2017. Cancer. WHO. https://www.who.int/cancer/resources/keyfacts/en/.

WMA, 1974. Declaration of Helsinki. Lance. https://doi.org/10.2471/BLT.08.057737.