



Communication skills training

Responding empathically to patients: Development, implementation, and evaluation of a communication skills training module for oncology nurses



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ABSTRACT

Objective: The purpose of this paper is to report on the development, implementation, and evaluation of a Communication Skills Training (CST) module for inpatient oncology nurses on how to respond empathically to patients.

Methods: 248 nurses from a USA cancer center participated in a CST module on responding empathically to patients. Nurses completed pre- and post-training Standardized Patient Assessments (SPAs), a survey on their confidence in and intent to utilize skills taught, and a six-month post-training survey of self-reported use of skills.

Results: Results indicate that nurses were satisfied with the module, reporting that agreement or strong agreement to 5 out of 6 items assessing satisfaction 96.7%–98.0% of the time. Nurses' self-efficacy in responding empathically significantly increased pre- to post-training. Additionally, nurses showed empathy skill improvement in the post-SPAs. Finally, 88.2% of nurses reported feeling confident in using the skills they learned post-training and reported an increase of 42–63% in the use of specific empathic skills.

Conclusions: A CST module for nurses in responding empathically to patients showed feasibility, acceptability, and improvement in self-efficacy as well as skill uptake.

Practice implications: This CST module provides an easily targeted intervention for improving nurse-patient communication and patient-centered care.

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1. Introduction

Patient-centered communication is critical to good patient care [1]. Patient-centered communication drives treatment planning through the transmission of information and provides a therapeutic and supportive environment for the patient [2–4]. Empathy is of particular importance in effective patient-centered communication [2,4–6]. A nurse's ability to recognize patients' empathic opportunities and respond to a patient empathically,

communicating a desire to understand, can help patients understand and cope effectively with their illnesses [5–7].

Patient-centered communication is especially vital in cancer care. Cancer patients report high needs for information and emotional support [8]. However, distressed patients do not always disclose their concerns directly to clinicians [9,10]. Rather, patients often display distress via a cue or a signal, defined as “a verbal or non-verbal emotional hint which suggests an underlying unpleasant emotion, but lacks clarity” [11]. This verbal and non-verbal communication requires that the clinician seek clarification to understand the concerns, which is part of the empathic process [11]. Patients are also more likely to disclose concerns or cues when these concerns are brought up by the clinician [12]. Thus, clinicians' ability to recognize

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patient distress cues and allow patients to disclose their emotional distress is an important aspect of empathic communication.

A review by Neumann and colleagues [13] delineated two pathways by which empathic communication may improve patient outcomes. First, empathic communication can lead to a patient disclosing more about their symptoms and concerns, which consequently leads to the clinician getting more information, making a more accurate diagnosis, and understanding and responding to patients' individual needs. This leads to improved outcomes. Second, empathic communication can also lead to the patient feeling listened to, valued as an individual, and understood and accepted. Through patients feeling valued, understood, and accepted, empathic communication can indirectly lead to improved patient outcomes. Further, a 2012 systematic review examined the link between empathy measures and patient outcomes in cancer care [14]. This review found that retrospective patient-reported measures of clinician empathy were linked to higher patient satisfaction and lower patient distress. Although studies with physicians and nurses were combined in this systematic review, some individual studies also showed positive links between nurse empathy and patient outcomes (e.g., [15]).

Despite the benefits of empathic communication for patients, there are few Communication Skills Training (CST) programs that train nurses to recognize and address patients' emotions [16–18]. In response to an institutional need, we developed a CST module, *Responding Empathically to Patients*, as part of a larger nurse-focused communication skills training curriculum. This module was designed to enhance nurses' ability to recognize empathic opportunities and respond empathically to patients. The development, implementation and evaluation of our module is novel because unlike other research on nurse or physician empathy, our work here focuses on the challenge of teaching empathic communication skills. Although empathic communication skills are taught frequently with health professions students, the focus on practicing nurses in a cancer center is innovative. In addition, as will be explained below, our approach to teaching empathic communication is unique because it is conceptualized based upon an established body of research on empathic communication, specifically on a methodological operationalization of empathic communication.

2. Methods

2.1. Participants

During 2012 and 2013, a convenience sample of 248 inpatient nurses (99% female, 1% male) from Memorial Sloan Kettering Cancer Center (MSKCC) were selected by their nurse leaders to participate in the training program. Oncology nurses from multiple practice settings including acute care (69%), critical care (9%), urgent care (6.5%), and pediatrics (15.5%) participated in the training. Participating nurses varied in age and years of clinical experience. The study was given exempt status by the Institutional Review Board at MSKCC.

2.2. Development of training module

Our research group, housed within the Communication Skills Training and Research Laboratory, has traditionally focused on developing communication training modules to support the physician in communicating with oncology patients and their families [19]. Following the development of the physician training program, our group was approached by nursing leadership at our institution requesting support in developing CST for the nurses. This request was a result of nurses' responses to a climate survey, in which nurses indicated a need and demand for training oncology nurses in communication skills. In response to this need, we developed a one-day CST program for nurses that offered three modules: (1) *Responding Empathically to Patients*; (2) *Discussing Death, Dying, and End-of-Life Goals of Care*; and (3) *Challenging Interactions with Families*. This paper presents the development, implementation, and evaluation of the CST module on *Responding Empathically to Patients*.

All of our CST modules in the Communication Skills Training and Research Laboratory, including the module discussed in the present study, go through a series of seven consecutive steps of development used in prior research [20]: (1) systematic literature review, (2) consensus review meetings, (3) modular blueprint development, (4) training materials development, (5) scenario development, (6) making revisions and adaptations iteratively, and (7) assessment. The present module was developed for this study but was based on approaches used in prior module development in the Communication Skills Training and Research Lab.

Table 1

Modular blueprint: *Responding empathically to patients*.

Goal: To recognize or elicit and respond to patients' empathic opportunities in order to communicate understanding, alleviate distress and provide support.		
Strategies	Skills	Process tasks
Recognize or elicit a patient's empathic opportunity	Acknowledge Encourage expression of feelings	Notice patients' nonverbal communication
Work toward a shared understanding of the patient's emotion/experience	Ask open questions Clarify Restate	Avoid leading questions Avoid giving premature reassurance
Empathically respond to the emotion/experience	Acknowledge Validate Normalize Praise patient efforts	Identify patient's strengths and sources of support
Facilitate coping and connect to social support	Ask open questions Endorse question asking Make partnership statements	Make referrals Express a willingness to help

2.3. Conceptual approach for teaching empathic communication

Although most educators and researchers agree that empathy is an important component to effective patient-centered communication, there is little agreement about empathy as a teachable concept. In considering how to teach empathic communication, we made two key decisions. First, we decided to focus not on affective empathy (something that is felt), but instead on cognitive empathy (understanding how the other person is feeling) and behavioral empathy (communication of that understanding). Communication experts Silverman, Kurtz and Draper [21] define empathy as, “a two-stage process: (1) the understanding and sensitive appreciation of another person’s predicament or feelings and (2) the communication of that understanding back to the patient in a supportive way” (p. 83). Applying this definition, Platt and Keller [22] suggested that clinical empathy involves, “a learned intellectual process that requires understanding of feelings” (p. 225). They noted that when learning empathic skills, learners only need to incorporate a cognitive definition rather than an affective definition of empathy, as merely understanding an individual’s feelings suffices. The focus on developing components of empathy is of primary interest to educators and researchers focused on clinician–patient communication. Because the goal of these educators and researchers is to improve clinician–patient communication, the concern is not simply whether clinicians have empathy for their patients, but if and how they communicate empathically to patients.

Second, because of our focus on the behavior of empathic communication, we adopted the empathic opportunity–response conceptual model of empathy. Suchman, Markakis, Beckman and Frankel [23] defined the term “empathic opportunity,” as describing “a direct and explicit description of an emotion by a patient” (p. 679) and a “praise opportunity” to be “a direct and explicit description of a praiseworthy behavior by a patient” (p. 681). Bylund and Makoul [24] further clarified the different types of empathic opportunities as including the following: emotion, challenge, and progress, and further operationalized and applied a coding system using this model. We reasoned that if the empathic opportunity–response model was reliably observable in empathic communication, it should also be useful as a teaching model.

2.4. Module content

Each component of the teaching module was operationally defined, as explained in the Comskil Conceptual Model [25]. Each interaction between the nurse and the patient is guided by an

overarching goal, which is achieved through the use of communication strategies, communication skills, and process tasks that are meant to be flexible in all interactions (see Table 1 for the Modular Blueprint). Nurses are able to apply these skills in a way that is translatable across all interactions with patients. The overall communication goal in the *Responding Empathically to Patient* module is to recognize or elicit and respond to patients’ empathic opportunities in order to communicate understanding, alleviate distress, and provide support. Within each strategy, there are skills and process tasks that help the nurse accomplish the strategy. Skills are defined as an utterance by which a nurse can further the clinical interaction to achieve a strategy. Strategies are *a priori* plans that direct communication behavior toward the desired communication goal. Process tasks are defined as sets of interactions or nonverbal behaviors that create an environment for effective communication (e.g., expressing a willingness to help). The strategies are not meant to be rigid, rather they provide a guideline for being able to elicit and respond to a patient’s emotion or experience.

In Strategy 1, the nurse recognizes or elicits a patient’s empathic opportunity. There are six possible empathic opportunities presented to the nurses: emotion, progress, challenge, nonverbal, indirect, and nurse-elicited (see Table 2). The nurse can achieve Strategy 1 by acknowledging an emotion that the patient expresses, or by encouraging expression of feelings to elicit an empathic opportunity. It is equally important to pay attention to the patients’ nonverbal communication behaviors. Strategy 2 involves working toward a shared understanding of the patient’s emotion or experience. By asking open questions, and using other questioning skills such as restate and clarify, the nurse strives to understand the patients’ emotions and/or experience. The process tasks of avoiding leading questions and giving premature reassurance are useful in creating a favorable communication environment so that the patient is able to share concerns. In Strategy 3, empathically responding to the patient’s emotion or experience is at the core of the module, and includes skills such as acknowledge, validate, normalize, praise patient efforts, and encourage expression of feelings. Finally, Strategy 4 focuses on facilitating coping and connection to social support. Once the nurse has a clearer understanding of what underlying emotions the patient has, he or she can try to work with the patient to address those emotions/experiences. Communication skills such as asking open questions, endorsing question asking, and making partnership statements allow the nurse to address the emotion, or (if appropriate), delve into a problem-solving mode. The process tasks involved in responding empathically to emotions may

Table 2
Empathic opportunities.

Empathic opportunity	Definition	Example
Emotion	A patient’s direct statement about an emotion he or she is feeling.	“I am really scared about how this cancer is going to change my life.”
Progress	A patient’s statement of some improvement in his or her condition or quality of life related to the cancer; or a positive event in his/her life that is unrelated to the cancer.	“I’ve been feeling well enough to start gardening again!” “My daughter just told me she is expecting!”
Challenge	A patient’s statement of a barrier or some challenging condition faced because of the cancer; or a negative event in his/her life that is unrelated to the cancer.	“The fatigue from this chemotherapy has made it hard for me to take care of my children.” “Yesterday, I attended my uncle’s funeral.”
Nonverbal Indirect	A patient’s facial expression or body language indicating the presence of a strong emotion. A patient’s cue or hint that something is wrong, without being direct. In these cases, the nurse may need to <i>clarify</i> and/or <i>restate</i> to better understand.	PT: “I’m not looking forward to starting chemotherapy.” RN: “What specifically concerns you?” PT: “I’m really scared of needles.”
Nurse-Elicited	Using the skill of <i>encourage expression of feelings</i> to elicit an empathic opportunity from the patient.	“Before we get started with your treatment today, I wanted to find out how you are coping with everything?”

include making appropriate referrals or expressing a willingness to help.

2.5. Implementation of training

Our training of this module consists of didactic teachings and role plays, co-facilitated by experienced clinical nurses and behavioral science communication skills experts. Prior to training day, we send a booklet to participating nurses entitled, *Responding Empathically to Patients*, which includes relevant background literature on empathy and its importance in nursing practice, and detailed communication problems identified in research studies. The rationale for CST, our approach to empathic communication through the use of empathic opportunities, and the four core communication strategies are also explained in the booklet.

Modeled after our program's previously developed CST modules, the empathy module includes didactic teaching of strategies, presentation of exemplary videos modeling the key strategies, skills and process tasks, and a role play session to practice the skills. The 30-min didactic presentation reviews the evidence-based literature that supports the use of empathic opportunities and strategies and includes the presenter's own interaction examples. Each empathic opportunity or strategy slide presented in the didactic contains a short (approximately 20 sec–1 min) video clip, in which an expert clinical nurse demonstrates the skills associated with the particular strategy. All skills or process tasks are explicitly labeled in the video clip to facilitate integration of the names of skills and process tasks suggested for the completion of each strategy.

The small group role play sessions follow best practice principles in adult learning which is experiential and learner-centered, and involves individualized feedback [26]. In the small group sessions (90 min), consisting of approximately three learners per group, we utilize prepared scenarios that depict situations in which a nurse would recognize and respond to a patient's emotions and/or concerns. During the role play sessions, participants have the opportunity to practice the skills taught in the didactic presentation with standardized patients (SPs), followed by instantaneous feedback from peers, the facilitators, video feedback, as well as the SP.

The modules are taught and co-facilitated by trained, experienced oncology nurses and communication skills experts, in an effort to standardize facilitation across all small groups [27]. A co-facilitation model allows each facilitator to bring different areas of expertise to the group, which can improve learners' educational experience. The model also ensures that all important facilitation tasks were completed.

2.6. Evaluation of training

We were guided by the Kirkpatrick model, which is widely used in program evaluation, to test the effectiveness of training [28–30]. The Kirkpatrick model provides an evidenced-based method for

the evaluation of the CST module, and includes four levels that measure the reaction of the participants, their learning, their behavior, and the overall results. Level 1 involves eliciting a reaction from the trainees about their perceptions about the training; Level 2 requires that participants' learning be tested in an objective, quantifiable manner; Level 3 compares the participants' on-the-job performance, based on the objectives of the training program, before and after the program; and the fourth level tests the efficacy of the program to evaluate if the overarching desired result was accomplished. For this study, Levels 1–3 were measured.

2.6.1. Level 1: Evaluation of reaction to the training

Immediately following the module, participants were given an evaluation form that contained six statements using a 5-point Likert scale with anchors of (1) "strongly disagree" to (5) "strongly agree" (e.g., "The skills I learned in this module will allow me to provide better patient care"). These six items focused on post-training attitudes regarding the skills learned and how they could be applied in the nurses' clinical practice, including the effectiveness of the curricular activities (e.g., "The small group facilitator was effective").

2.6.2. Level 2: Evaluation of learning

Konopasek and colleagues [29] further divide Level 2, making a distinction between changes in attitudes (2A) and changes in knowledge and/or skills (2B). At Level 2A, the focus of the evaluation is on the learners' self-efficacy and the learners' changes in attitudes towards learning or using a specific skill. The learner's self-efficacy was measured by asking the learner to determine if the intervention had provided them knowledge or ability to perform a skill. In the present study, nurse participants' self-reported self-efficacy was assessed using a retrospective pre-post methodology in which participants were asked the following two questions post-training: (1) "Before this module, I felt confident responding empathically to patients," and (2) "Now that I have attended this module, I feel confident responding empathically to patients" (1 = "Strongly disagree" to 5 = "Strongly agree").

At Level 2B, learners' skill uptake was measured via Standardized Patient Assessments (SPAs). Observed encounters with SPs are considered a high fidelity method when measuring the skills related to communication [31]. SPAs involved an 8-min video recorded interaction between the nurse and the SP on a given clinical scenario. SPAs were completed both pre- and post-training. Two trained coders coded the SPA videos using the Comskil Coding System [32] and adapted to inpatient clinical scenarios. In addition, SPAs were rated by the SP immediately following the encounter using a checklist based on the Comskil Coding System.

2.6.3. Level 3: Evaluation of behavior

For a subset of the nurses who participated in the training, a self-reported online survey was completed to assess communication skill usage six months post-training. This was a pilot effort, conducted with trained nurses from February 2013 to February

Table 3
Participant ratings of *Responding Empathically to Patients* module.

Item from course evaluation	Agree or strongly agree
I feel confident that I will use the skills I learned today. (n = 247)	96.8%
The skills I learned today will allow me to provide better patient care. (n = 247)	96.7%
The workshop prompted me to critically evaluate my own communication skills. (n = 247)	98%
The experience of video feedback was helpful to the development of my skills. (n = 245)	82.1%
The skills I learned were reinforced through the feedback I received in the small group. (n = 247)	97.1%
The small group facilitator was effective. (n = 247)	97.6%

Table 4
Standardized patient ratings of empathic skills.

Empathic Skills	Pre-Test <i>M (SD)</i>	Post-Test <i>M (SD)</i>	<i>df</i>	<i>t</i> test value
The nurse acknowledged my emotions. (<i>n</i> = 244)	3.71 (1.01)	3.83 (0.89)	243	−1.496
The nurse made me feel that my emotions were valid. (<i>n</i> = 242)	3.51 (1.01)	3.81 (0.82)	241	−3.997**
The nurse made me feel that my emotions were normal. (<i>n</i> = 242)	3.47 (0.92)	3.78 (0.81)	241	−4.072**
The nurse encouraged me to express my feelings. (<i>n</i> = 244)	3.11 (1.04)	3.25 (1.01)	243	−1.493
The nurse praised me for my efforts in coping or dealing with the disease. (<i>n</i> = 244)	2.84 (1.06)	3.08 (1.01)	243	−2.669*

* $p < .01$.

** $p < .001$.

2014. Of the 248 trained nurses approached to complete this survey, *N* = 199 (48%) completed this post-training survey.

2.7. Data analysis

Frequencies of individual skills were used as the unit of measure in all analyses. Paired *t*-tests were used to assess changes in outcomes pre–post training. To code the empathic skills measured in the Level 2B assessment (i.e., SPA), we utilized the Comskil Coding System (CCS) developed in previous CSTs [32]. The CCS codes skills when present, but does not code nonverbal behaviors. First, similar to past research, 10% of the video recordings were coded independently by two separate coders (a primary coder and a secondary coder) as an initial reliability test. For these 10% coded, the inter-coder reliability assessment demonstrated an average of 75.5% agreement between the two coders, and all disagreements were reconciled by a team member. After establishing acceptable reliability, the primary coder coded 40% of the video recordings. At the mid-coding stage (after 50% video recordings were coded), a second inter-reliability assessment (75% agreement) was conducted, followed by the primary coder independently coding the remaining 40% of the video recordings.

3. Results

3.1. Level 1: Evaluation of reaction to the training

A rating of “agree” or “strongly agree” was considered to be an indicator of satisfaction with the module and its effectiveness in teaching communication skills regarding responding empathically to patients. Nurse participants responded that they were satisfied (“agree” or “strongly agree”) with five measures of the CST’s effectiveness 96.7%–98.0% of the time and 82.0% of the time for the effectiveness of the video playback (see Table 3).

3.2. Level 2: Evaluation of learning

3.2.1. Level 2A

A paired sample *t*-test indicated that the nurses’ self-efficacy in responding empathically to patients significantly increased when compared before ($M = 3.59$, $SD = .67$) and after ($M = 4.26$, $SD = .55$) they attended the module, $t(246) = -17.094$, $p < 0.001$.

3.2.2. Level 2B

Two kinds of evaluations were completed for Level 2B–SP ratings and SPA skills coding. A paired sample *t*-test of the SP ratings of the nurses’ use of empathic skills during the SPAs significantly increased pre-to-post training in the following three out of five skills: validating, normalizing, and praising patients’ efforts (see Table 4). A paired sample *t*-test of the SP skills coding of the nurses’ use of empathic skills during the SPAs significantly increased pre-to-post training in the following three out of five skills: encouraging expression of feelings, normalizing, and praising patients’ efforts (see Table 5).

3.3. Level 3: Evaluation of Behavior

When nurses were asked about their confidence six months post-training, 88.2% of nurses reported feeling confident in using the skills they had learned in the *Responding Empathically to Patients* module (as indicated by an endorsement of “agree” or “strongly agree”). In particular, when we asked nurses about their frequency of empathic skills use in the six month time period following the training, as compared with their use of empathic skills prior to training, nurses reported an increase in their use of skills. Specifically, the frequency of nurses reporting an increase in empathic skill use were: 63% in acknowledging, 61% in validating, 60.5% in encouraging expression of feelings, 56% in praising patient efforts, and 42% in normalizing.

4. Discussion and conclusion

4.1. Discussion

Empathic communication in the clinical encounter is a laudable goal, providing benefits for patients and families alike. Empathy should also be the fundamental cornerstone of all communication with patients with advanced disease. Despite this, there has been little published work on how to teach empathy to practicing nurses. We combined the well-accepted method of experiential CST with the evidence-based empathic opportunity–response concept to develop and implement a module on empathic communication for oncology nurses. Our evaluation data shows that nurses found satisfaction with the course as well as improved their use of empathy skills in SPAs, and self-reported a higher use of skills in clinical encounters.

Table 5
Standardized patient assessment skills coding of empathic skills.

Empathic skills (<i>n</i> = 242)	Pre-Test <i>M (SD)</i>	Post-Test <i>M (SD)</i>	<i>df</i>	<i>t</i> test value
Acknowledge	.52 (.88)	.62 (.84)	241	−1.360
Validate	1.22 (1.51)	1.13 (1.24)	241	.810
Normalize	.07 (.27)	.17 (.42)	241	−3.102**
Encourage expression of feelings	.35 (.70)	.46 (.68)	241	−2.045*
Praise efforts	.12 (.35)	.19 (.46)	241	−2.200*

* $p < .05$.

** $p < .01$.

The question of whether clinical empathy can be taught has been raised in the literature. While some believe that clinical empathy is innate, others believe that it can be taught by instructing individuals in how to understand and appreciate another person's predicaments or feelings and communicate that understanding in a supportive way [21,33]. As Platt and Keller state [22], clinical empathy represents a, "learned intellectual process that requires understanding of the feelings" (p. 225). Our focus was on empathic communication as a skill with the assertion that whether or not a nurse feels empathy for a patient, she/he can still communicate in a way that demonstrates she is trying to understand the patient's perspective (i.e., cognitive empathy) [22]. Silverman, Kurtz and Draper (1998) have defined empathy as "a two-stage process: 1) the understanding and sensitive appreciation of another person's predicament or feelings; 2) the communication of that understanding back to the patient in a supportive way" (p. 83). Platt and Keller (1994) suggested that clinical empathy involves "a learned intellectual process that requires understanding of feelings" (p. 225).

Results from the present study indicate the effectiveness of this brief, empathy module for oncology inpatient nurses in increasing empathic communication skills. Namely, nurses' indicated satisfaction with the module, with the majority of nurses indicating agreement with the effectiveness of the module. The only measure of CST effectiveness that received less endorsement was the helpfulness of the video playback improving communication skills. Future research should examine how to improve the effectiveness of the video playback. Additionally, nurses' self-reported self-efficacy showed significant improvement before and after the module, indicating an improvement in confidence using these communication skills. In follow-up surveys 6 months post-module, nurses continued to endorse having confidence in using these empathic communication skills as well as self-reported still using them in clinic. Nurses' actual skill uptake also improved pre- to post-training in the areas of validating, normalizing, and praising patients' efforts. Acknowledgement of emotions did not increase significantly, but this may have been due to the high average of times nurses' acknowledged emotions in the pre-module SPA. Expression of feelings also did not increase significantly, and results indicate that this was the least common communication skill used pre- and post-module. As such, this may be a communication skill that needs to be targeted more specifically.

Future work may examine how to disseminate this module outside of our institution. More recently, we have worked with the Nursing Education Department at Hamad Medical Corporation in Doha, Qatar to implement this module with cancer nurses. Additionally, future work could examine the effectiveness of this module in other clinical settings. Although we developed this course specifically for nurses, the content of the course and the approach to teaching the course should be applicable to multiple types of clinical training. Future research could also examine nurses' individual differences in improving their empathic communication skills, particularly around the interaction between the trait of empathy and empathic communication. For instance, perhaps nurses who have high levels of trait empathy will more easily modify their communication skills than nurses with lower levels of trait empathy.

A limitation of the present study is that it does not examine the uptake of skills in clinic or at the bedside. Future research could examine how this empathy training module influences oncology nurses' uptake of skills with patients. Another limitation of our training program is that it is time and personnel intensive. As such, adaptations of the module may need to be developed in order to disseminate this training to less resource-rich settings.

4.2. Conclusion

The present study provides a solid framework for the development of an empathic CST module for oncology nurses. Results indicated that this newly developed module was associated with an increase in comfort and confidence in responding empathically to patients, and nurses reported that the module and learning approach was helpful in improving their skills. Additionally, the SPAs demonstrated an increase in perceived empathic communication pre- and post-training, indicating that nurse skill uptake improved.

4.3. Practice implications

The module developed in the current study is one of the first empathic CST modules developed specifically for a nursing audience. Given that practicing nurses receive little training in communication, this module could be applied to different types of nursing settings. As such, it is critical to examine how to modify this empathic module to be utilized in less resource-rich institutions. Data from the present study indicate that nurses found the training beneficial, were more comfortable responding empathically after participating in this CST, and that SPs reported increases in empathic communication from trained nurses. Future research could test how this training translates to skill uptake in the clinical setting.

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References

- [1] C. McCabe, Nurse-patient communication: an exploration of patients' experiences, *J. Clin. Nurs.* 13 (1) (2004) 41–49.
- [2] M. Attree, Patients' and relatives' experiences and perspectives of 'Good' and 'Not so Good' quality care, *J. Adv. Nurs.* 33 (4) (2001) 456–466.
- [3] E. Jangland, L. Gunningberg, M. Carlsson, Patients' and relatives' complaints about encounters and communication in health care: evidence for quality improvement, *Patient Educ. Couns.* 75 (2) (2009) 199–204.
- [4] L.S. Thorsteinsson, The quality of nursing care as perceived by individuals with chronic illnesses: the magical touch of nursing, *J. Clin. Nurs.* 11 (1) (2002) 32–40.
- [5] K.J. Kelley, M.F. Kelley, Teaching empathy and other compassion-based communication skills, *J. Nurs. Prof. Dev.* 29 (6) (2013) 321–324.
- [6] W.J. Reynolds, B. Scott, Do nurses and other professional helpers normally display much empathy? *J. Adv. Nurs.* 31 (1) (2000) 226–234.
- [7] J.M. Morse, et al., Beyond empathy: expanding expressions of caring. 1991, *J. Adv. Nurs* 53 (1) (2006) 75–87 discussion 87–90.
- [8] T.F. Hack, L.F. Degner, P.A. Parker, The communication goals and needs of cancer patients: a review, *Psychooncology* 14 (10) (2005) 831–845 discussion 846–7.
- [9] V. Duric, et al., Reducing psychological distress in a genetic counseling consultation for breast cancer, *J. Genet. Couns.* 12 (3) (2003) 243–264.
- [10] M. Oguchi, et al., Measuring the impact of nurse cue-response behaviour on cancer patients' emotional cues, *Patient Educ. Couns.* 82 (2) (2011) 163–168.
- [11] C. Zimmermann, et al., Coding patient emotional cues and concerns in medical consultations: the Verona coding definitions of emotional sequences (VR-CoDES), *Patient Educ. Couns.* 82 (2) (2011) 141–148.
- [12] A. Finset, L. Heyn, C. Ruland, Patterns in clinicians' responses to patient emotion in cancer care, *Patient Educ. Couns.* 93 (1) (2013) 80–85.
- [13] M. Neumann, et al., Analyzing the nature and specific effectiveness of clinical empathy: a theoretical overview and contribution towards a theory-based research agenda, *Patient Educ. Couns.* 74 (2009) 339–346.
- [14] S. Lelorain, et al., A systematic review of the associations between empathy measures and patient outcomes in cancer care, *Psychooncology* 21 (12) (2012) 1255–1264.

- [15] R. Uitterhoeve, et al., Nurse–patient communication in cancer care: does responding to patient's cues predict patient satisfaction with communication, *Psychooncology* 18 (10) (2009) 1060–1068.
- [16] S. Chant, et al., Communication skills: some problems in nursing education and practice, *J. Clin. Nurs.* 11 (1) (2002) 12–21.
- [17] L. Cunico, et al., Developing empathy in nursing students: a cohort longitudinal study, *J. Clin. Nurs.* 21 (13–14) (2012) 2016–2025.
- [18] I.P. Kruijver, et al., Nurse–patient communication in cancer care. A review of the literature, *Cancer Nurs.* 23 (1) (2000) 20–31.
- [19] C.L. Bylund, et al., Developing and implementing an advanced communication training program in oncology at a comprehensive cancer center, *J. Cancer Educ.* 26 (2011) 604–611.
- [20] R.F. Brown, et al., Patient centered communication skills training for oncologists: describing the content and efficacy of training, *Commun. Educ.* 59 (2010) 236–249.
- [21] S. Kurtz, J. Silverman, J. Draper, *Teaching and Learning Communication Skills in Medicine*, Radcliffe Medical Press Ltd, Abingdon, 1998.
- [22] F.W. Platt, V.F. Keller, Empathic communication: a teachable and learnable skill, *J. Gen. Intern. Med.* 9 (1994) 222–226.
- [23] A.L. Suchman, et al., A model of empathic communication in the medical interview, *J. Am. Med. Assoc.* 277 (1997) 678–682.
- [24] C.L. Bylund, G. Makoul, Examining empathy in medical encounters: an observational study using the Empathic Communication Coding System, *Health Commun.* 18 (2) (2005) 123–140.
- [25] R.F. Brown, C.L. Bylund, Communication skills training: describing a new conceptual model, *Acad. Med.* 83 (1) (2008) 37–44.
- [26] M.S. Knowles, *The Adult Learner: a neglected species*, Houston, Texas: Gulf, 1978.
- [27] C.L. Bylund, et al., Training faculty to facilitate communication skills training: development and evaluation of a workshop, *Patient Educ. Couns.* 70 (2008) 430–436.
- [28] L. Hutchinson, Evaluating and researching the effectiveness of educational interventions, *BMJ* 318 (1999) 1267–1269.
- [29] L. Konopasek, et al., Evaluating communication skills training courses, in: D.W. Kissane (Ed.), et al., *Handbook of communication in oncology and palliative care*, Oxford University Press, Oxford, 2010, pp. 683–693.
- [30] Kirkpatrick, *Evaluation of Training*, in: R. Craig, I. Bittlel (Eds.), *Training and Development Handbook*, McGraw Hill, New York, 1967.
- [31] F.D. Duffy, Assessing competence in communication and interpersonal skills: the Kalamazoo II report, *Acad. Med.* 79 (2004) 508–510.
- [32] C.L. Bylund, et al., The implementation and assessment of a comprehensive communication skills training curriculum for oncologists, *Psychooncology* 19 (6) (2010) 583–593.
- [33] M. Neumann, et al., Analyzing the nature and specific effectiveness of clinical empathy: a theoretical overview and contribution towards a theory-based research agenda, *Patient Educ. Couns.* 74 (3) (2009) 339–346.