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Hargie, O., Brataas, H., & Thorsnes, S. (2009). Cancer patients' sensemaking of conversations with cancer nurses in outpatient clinics. *Australian Journal of Advanced Nursing*, 26(3), 70-78.
http://www.ajan.com.au/Vol26/26-3_Hargie.pdf

[Link to publication record in Ulster University Research Portal](#)

Published in:
Australian Journal of Advanced Nursing

Publication Status:
Published (in print/issue): 01/01/2009

Document Version
Publisher's PDF, also known as Version of record

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KEY WORDS

cancer care, communication, concordance,
nurse-patient interaction, patient perspectives,
sensemaking

ABSTRACT

Objective

Communication is of significant importance to cancer patients however little is known about how they experience and make sense of their interactions with cancer nurses. This study was designed to investigate how and in what ways patients interpret initial consultations with cancer nurses in terms of how they perceive the role of the nurse.

Design

This qualitative study involved 'sensemaking' interviews with patients following their first consultation with nurses.

Setting

The study was carried out in two outpatient cancer clinics in hospitals in Norway.

Subjects

The sample consisted of nine cancer outpatients experiencing a range of cancer situations.

Main outcome measures

The main outcomes measure was an understanding of the way in which cancer patients make sense of the role of nurses following initial consultation.

Results

Preconceptions of the role of the nurse were limited, with the nurse perceived as playing a mainly functional, task-centred, role. Patients' actual experience broadened their sense of the role of the cancer nurse to encompass a psychosocial supportive role.

Conclusions

The sensemaking approach used in this study offered a depth of insight into core factors that shaped the patients' understanding. It is argued this approach has benefits for nursing research. Possible advantages for nursing practice and further research are suggested.

INTRODUCTION

This paper examines how and in what ways cancer patients interpret and make sense of their initial interactions with nurses. It is known from research that communication is of significant importance to cancer patients (Botti et al 2006; Fincham et al 2005) however much less is known about how patients actually experience and make sense of their interactions with nurses. This study was designed to help redress this research gap by conducting 'sensemaking' interviews with cancer outpatients immediately following their first consultation with cancer care nurses. The study was based at cancer outpatient clinics in Norway. Patients referred to these clinics have initial consultations with oncology physicians about diagnosis and medical treatment. After these consultations, follow-up conversations take place with specialist oncology nurses. Here the patient and the specialist nurse are meeting one other for the first time. The purposes of these nurse conversations are fourfold: to establish a caring relationship; to clarify for patients any issues that may have emerged during the consultation with the physician; to discuss in more detail any individual caring needs identified; and to prepare patients for cancer treatment that is planned to take place at the clinics.

Sensemaking and meaning construction

The concept of 'sensemaking' literally means making sense of events and attempting to understand the situation so that decisions can be made about how to respond effectively (Klein et al 2006a, 2006b; Mills 2006). This concept has been studied since the early 1980s (Dervin 1983) with much of the research being carried out in the organisational context (Bean and Eisenberg 2006; Bean and Hamilton 2006; Weick 2007, 2001). Engaging in a sensemaking encounter allows people to express exactly how they feel, since: "Whether an explanation makes sense depends on the person who is doing the sensemaking. The property of 'being an explanation' is not a property of statements but an interaction of people, situations, and knowledge" (Klein et al 2006a p.72).

Sensemaking involves the sensemaker converting experiences into a form of intelligent reality. Klein

et al (2006b p.88) noted that: "When people try to make sense of events, they begin with some perspective, viewpoint, or framework". They term this initial perspective a 'frame'. While frames are used to decide what counts as data, they also help to shape the data. For example, a car smash will be perceived differently by the driver of each car, the passengers, the police, the insurance companies, and health professionals who have to treat the injured. In addition, frames are not static entities, but change as further information is gathered. In this way, interpretations of previous experiences change over time, in line with new information, differing emotional states, and prevailing circumstances. People do not deal with the world event by event, but rather frame events in larger meaning structures that provide them with an interpretive template within which they can make sense of relevant aspects of the events that they experience (Bruner 1990).

Interpretation is the explanation or meaning a person creates in his or her reflection to make sense of an event. This structural process is retrospective, in that people look back on events and construct their meaning (Mills 2009). Human beings experience what happens and then shape their interpretations in the context of their understanding of the ongoing order in life (Gwyn 2002). Communication is central because people must share their meanings to create a common sense of the informational environment (Seeger 2004). Sensemaking processes are therefore best understood within the context of communication patterns and relationships between the participants (Anderson et al 2005).

Sensemaking and communication in the cancer situation

When cancer patients participate in conversations with cancer care nurses, the health situation is new and patients may have feelings of uncertainty and fear of the cancer as a threat to everyday activities or to life itself. To compound the situation, cancer patients may be unfamiliar with conversations with doctors and nurses in the health encounter. So how do they make sense of this experience? To answer this question, a sensemaking approach to the patients'

experience of conversations can offer fruitful insights for nursing. Cancer patients are in highly vulnerable situation and it is important that meetings with health professionals take place in a reassuring way (Nåden and Sæteren 2006). When interacting with nurses, patients' communication goals can be difficult to actualise because the health situation is troublesome for them (Hargie and Dickson 2004). Also, patients and health care workers approach the health situation from different horizons and rank patients' needs differently (Hallström and Elander 2001).

Supported by a number of studies, Attree (2001) concluded that from the patient's perspective, the interpersonal dimension is a central component of quality care. However patient satisfaction is subjective in nature and relative due to factors such as individual perceptions and expectations (Bergenmar et al 2006). In interactions, expectations are of significance for interpreting and making sense of what happens. Patients may make sense of what they experience from the perspective of what they do or do not expect and what they do or do not value (McCabe 2004). Thus analyses of sensemaking should take into consideration what patients expect and value. Allard-Poesi (2005 p.176) noted that: "Researchers taking a sensemaking approach study the idiosyncratic and intersubjectively created meanings that people attach to their experiences". To date there is little research that employs a sensemaking perspective to investigate how cancer patients interpret their consultations with nurses. This research investigation was therefore designed to illuminate this area by answering two main research questions:

RQ1: How and from what existing framing perspectives do cancer patients interpret and make sense of the interactions they have with nurses?

RQ2: What do discussions with cancer care nurses mean to the patients?

METHOD

This study was qualitative in design, involving deep-probe semi-structured interviews with cancer patients. All patients were experiencing the

conversations with nurses at outpatient clinics for the first time. As such, a sensemaking approach was apposite, as it offered a lens through which the patients' views could be explored of what for them was an unfamiliar and potentially distressing situation. The sensemaking approach enabled the ways in which patients interpreted and made sense of their experiences to be illuminated in a way that took into consideration what they expected and how this varied from their perceptions of what actually occurred.

Sample

The sample comprised nine patients from two cancer care outpatient clinics at hospitals in Norway. A purposive, maximum variation, sample (Sandelowski 1997) of outpatients was employed in order to recruit patients experiencing a range of both primary cancer and cancer spread situations. All patients, apart from one, were going to have medical treatment, most often chemotherapy. A situation where cancer spread was found to be incorrect was not expected however when that situation actually occurred, it was added to give situational sampling variation. The cancer diseases were in breast, prostate, stomach, lung and endocrine organs, and the prognosis varied. Both male and female patients were included (4 female, 5 male); and the age of the patients ranged from 45 to 75, with an average of 59. This sample variation allowed us to compare and contrast sensemaking processes across a range of patients facing a variety of disease situations.

Procedures

Nurse leaders at clinics assisted with the sampling process and received instructions from the researchers about how this was to be conducted. The nurse leaders gave a letter to patients detailing information concerning the project, data gathering and storage, the fact that only the researchers would have access to interview recordings, that the recordings would be transcribed and analysed, when the tapes would be destroyed, anonymity procedures, the project period, and a statement about voluntary participation. The letter also included the names, email addresses and telephone numbers of the

researchers, and stated they would provide further information as required. The leaders repeated all the written information that was in the letter when they met the patients and also underlined the voluntary nature of any participation. This procedure ensured that patients could decline although no patient did decline. When the patient agreed to participate, written informed consent was obtained. Ethical approval for the study was obtained from the Regional Committee for Medical Research Ethics.

Interviews took place after the nurse-patient conversations. First, the information given initially about voluntary participation was repeated and patients were asked if they still wished to participate and whether they had any further questions before making the decision to participate. Recording procedures were explained and a small digital voice recorder with built-in microphone was then switched on. The semi-structured interviews covered patients' expectations prior to the conversations, what they actually experienced during conversations, and what all this meant to them. The patients were asked about their perceptions of the consultations and the role of the nurse, how they responded in the conversations, what they had learned from the encounter, how their perceptions might have changed, and whether there was anything they now considered they could have done differently in the consultation.

Analyses

The transcriptions were initially read in order to obtain a general impression of the interview material. Analyses and interpretations of the transcribed interviews paid close attention to labels summarising a sense of past experience, cues of events during conversations, and ways in which these were connected. Two of the researchers were Norwegian and they completed the initial transcriptions. Following these transcriptions, the data was translated from Norwegian into English. Again, checks were made by the Norwegian researchers to ensure accuracy of translation. The English researcher checked the translated text and local Norwegian modes of expression were translated into more generic English. The transcriptions were

then analysed in detail and the data sorted into main elements. A particular focus was on what patients noticed and selected, in terms of frames or labels summarising a sense of experience and ways in which these were connected. During the data interpretation process alternative assumptions were considered. Analytical charts and memo writing to facilitate the navigation process (Denzin 1994). In order to ensure inter-observer reliability, researchers coded two main pieces of transcribed tape to check for agreement about frames, events and cues identified.

Table 1: Cancer patients and treatment situations

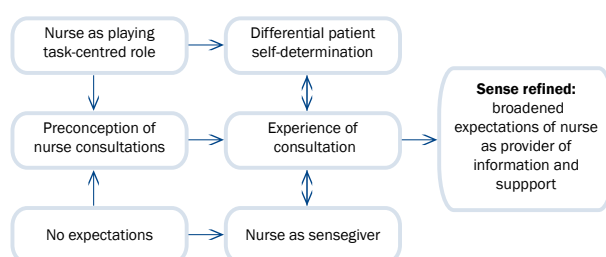
| Patients | Gender | Situation descriptions |
|------------|--------|--|
| Patient P1 | Male | Treatment after primary cancer coli surgery |
| Patient P2 | Male | Treatment because of newly diagnosed prostate cancer |
| Patient P3 | Female | Treatment after primary lung cancer surgery |
| Patient P4 | Female | Treatment after primary cancer coli surgery |
| Patient P5 | Male | Treatment because of spread of prostate cancer |
| Patient P6 | Male | Treatment because of recurrent cancer in endocrine organs |
| Patient P7 | Male | Treatment because of recurrent cancer coli |
| Patient P8 | Female | Treatment because of spread of breast cancer |
| Patient P9 | Female | No treatment because supposed lung cancer spread was found to be incorrect |

Findings

All patients, except one, were having treatment, mainly chemotherapy. The patients' cancer treatment situations are listed in table 1. Since the sense that individuals make of events is emergent (Bird 2007), a key goal of the sensemaking interviews was to explore how patients' expectations of the conversations were construed in terms both of their actual experiences with the nurse and in relation to their pre-sense of the nurses' role. The findings revealed that in relation to preconceptions, patients could be categorised in terms of two generic types, those who tended to hold no real pre-expectations, and those who were more likely to perceive the role of the nurse to be functional and task-centred. As

shown in figure 1, the 'no expectations' group were more likely to view the nurse as sensegiver. In the second group of patients, who viewed the nurse's role as mainly task-centred, there was variation in the extent to which they were self-determined with regard to their desire to shape the consultation. Both groups of patients changed and refined their sense of the nurses' role as a result of their experiences of the consultations.

Figure 1: The process of patient sensemaking in nurse consultations



'No expectations' group

These patients had few set preconceptions for the consultations. For example, in response to the question about prior expectations, two patients responded: '*I barely considered that*' (P1) and '*I had no expectations*' (P2). Another patient, with recurrent cancer, had previously attended for planned treatment. Thus for him, the hospital situation was not new. Yet he too, seemed to have no real anticipation of what to expect:

P7: I had no expectations for the conversation.

I7: You hadn't?

P7: No I had no idea... so when the nurse came here it was completely - ahm - new.

As shown in figure 1, this group having few firm expectations of the consultations, then attributed the role of sensegiver primarily to the nurse. They viewed the nurse as the person who would make decisions about the agenda for the conversations. As expressed by one patient:

P1: She talked about milestones we might have to pass but said we didn't need to talk about those until we met them... I thought that the information she gave me was OK.

The perception here was of the nurse as someone who knew more about cancer than patients, and so could give them a greater sense of their situation. They were therefore more likely to defer to the nurse's decision-making about choice of topics for discussion:

'Nurse as task-related' group

In those instances where patients had preconceptions of the nurse's role, these were viewed mainly through a task-centred lens. Here the nurse's central role was perceived to be functional and as a support person for the physician. For instance when P5 outlined his expectations, these were framed in terms of the treatment:

P5: We were talking in relation to the treatment tomorrow - preparation today for having it tomorrow...

I5: Yes

P5: ...and that was what I expected and was prepared for when I came here.

Another common assumption was that the nurse's role would be practical while physicians would provide the relevant health information.

As shown in figure 1, patients in this group differed in the extent to which they displayed a self-determined orientation. Some expressed a wish for the nurse to drive the consultation, whereas others were more determined to help direct the conversation. For example, P1 seemed to have an 'other-determined' orientation when entering the conversation where the nurse was regarded as the sensegiver who ascribed goals for the discussion. Retrospectively, he said he found it very important that the nurse seemingly understood his wish not to have any discussion of cancer risk factors. He inferred the nurse to be: '*capable of reading more from me than I managed to tell*'. He emphasised a determination to sustain his hope for a cure and believed that the conversation underpinned his: '*remain optimistic*' strategy. Self-reinforcement of this framing viewpoint was clearly expressed: '*I have learned that to believe, to be optimistic, is half of the treatment*'.

On the other hand, P4 was determined to discuss matters that worried her. She had proposed to talk about such matters and as a result felt that: *'a lot was cleared up'* and she *'got answers'* from the nurse. Likewise, another patient, who had been living with cancer for several years, presented a sense of a self-determined orientation. He interpreted the nurse conversation as an opportunity to finally find out more about the illness:

P6: Up until now I haven't been given much information about what the disease means...but it has always been in my mind...

I6: Was this conversation one you had been expecting, or...?

P6: Yes. In fact I had been waiting some time for such a conversation.

Sense refined

When they reconstructed what had occurred during the conversation in terms of the nurse's role, there was considerable consistency across all patients. The refined sense of the nurse was that she played the important twin roles of information giver and supportive carer (figure 1). The new sense of the role of the nurse as information giver was welcomed by respondents. Patients felt not only had the nurse provided more knowledge about their treatment situation, but they now tended to view her as a valuable resource in future consultations and indicated it was very likely they would seek more information from her. P2 stated:

I couldn't concentrate on everything that was said today... so later... there may be something I want to ask about... and it's very good to have her as the same person to talk with in the future.

Thus, this patient's refined sense of the nurse gave him a new framing premise for future conversations, which also provided a feeling of security. P9, like the others, was given the nurse's business card and was invited to contact her as required. Reflecting on this procedure this patient, who was going to have no treatment because her supposed spread was invalidated, greatly appreciated this supportive back-up and perceived the role-system as including a form of early-warning check:

P 9: With such a disease you never know whether it will flare up again or not - it is good to have someone to contact if you suspect spread.

The nurse's card was warmly welcomed by this patient and provided a form of comfort which gave her a strong feeling of security. As she iterated: *'I'll take good care of that card'*. P1 also recognised the importance of the continuity role of the nurse as information provider:

P1: We didn't talk much about side effects, we'll do that later.

I1: I see.

P1: That's OK, there's a lot to take in.

I1: Yes.

P1: Yes and it has been OK to take it bit by bit... we don't need to talk about things before they are relevant.

The twin roles of information giver and psychosocial carer were seen to dovetail. A recurring perception was that nurses were calm, used a language that was understandable, and gave a clear impression of having time. This theme of the nurse having time and encouraging the patient to talk was raised several times. Thus P8 pointed out: *'Even though she maybe had other things to do, she didn't make me feel that she had anything else to do...so I felt free to talk about it'*. Likewise P7 stated: *'I have no idea of whether she was in a rush or not but she gave me the impression that she had lots of time for me...and that's what meant a lot to me.'*

In similar vein, P8 noted that she was able to discuss not just health matters (lower back pain), but also existential matters, as when she asked the nurse: *'Am I close to death?'* The nurse recognised and encouraged discussion of her emotional reactions and the patient interpreted her to be professional, insightful, receptive and caring:

P8: She was able to express what I had been thinking - and I got feedback on that... She was as close as I wanted to let her be, and was suitably human. I felt that was very good.

She also felt that the responses of the nurse were: '*better than expected*' and interpreted this as an unexpected '*gift*'. There was humour in some conversations, and the patients' sense of this was that it was a way for the nurse to display empathic rapport. For some patients discussing everyday life was of particular importance.

P7: We began with the basis for this treatment session... and moved on to talk about family and social network... family, friends and work.

I7: Yes

P7: All of that is part of the situation... and we were talking about... the family's reaction to my illness and... we were discussing many things... more a total picture.

DISCUSSION

The results of this study revealed that patient preconceptions of the role of the nurse fell into two main groups. One set of patients tended to have no real expectations, while the other perceived the nurse as playing a primarily functional, task-centred, role (figure 1). The sensemaking interviews revealed that patients refined their perceptions of the nurse's role as a result of their actual experience. It is known from previous research that where no firm preconceptions exist, perceptions are influenced by ongoing information (Mills 2006). This was the case in this study, where patients' sense of the nurse's role evolved. This sense of constructing meaning out of action is a common occurrence. Schön (1996) described the strategy of taking action to see what would happen as an 'exploratory experiment', and this seems to have been the approach adopted by these patients. Battles et al (2006) pointed out that a key purpose of sensemaking is to reduce ambiguity. This was also evident in this study, in that patients' perceptions and interpretations of the conversations broadened their sense of the role of the cancer nurse to encompass both a supportive, caring approach and an information giver.

More informed expectations of the role of nurses could help empower patients and encourage

them to play a more active and purposeful role in conversations. This could be facilitated in various ways. For example, patients could be informed beforehand in written communications, such as letters or information booklets, about the exact nature and remit of the nurse's role. These prior instructions could also encourage the patient to formulate questions they wished to ask the nurse or areas they would like to talk about in more depth. There are definite benefits to be achieved from such an approach. For instance, Brown et al (2001) found that the provision to cancer patients of a question prompt sheet prior to the initial consultation, and the systematic review of this by an oncologist, resulted in a number of benefits. Patients asked more questions about prognosis than a control group and received more information from oncologists. Consultation times and anxiety levels were reduced and recall of information significantly increased.

Patients could also be prepared more fully during the consultations with physicians with regard to the ensuing role of the nurse. At the outset of their conversations, nurses could then devote time to achieving effective set induction (Hargie and Dickson 2004). Set induction is the skill used by professionals to ensure that clients are fully prepared for the interaction to follow. It is part of the overall process of goal-setting (Dickson et al 1997). Among the main objectives of this skill are to ascertain the expectations of patients, relate these to the actual nurse's role, and agree a working rationale and agenda for the encounter.

The fact that some patients saw the nurse as sensegiver indicates a need to encourage greater concordance in consultations. In recent years there has been a move away from a nurse-centred model of health care toward one that emphasises the benefits of shared responsibility (Latter et al 2007; Lim et al 2007). Bissell et al (2004 p.851) highlighted the benefits of adopting such a concordance approach where interactions with patients are 'seen as a space where the expertise of patients and health professionals can be pooled to arrive at mutually agreed goals.' This would encourage the patient,

insofar as is possible, to take the role of joint decision-maker in consultations. Such a partnership approach where the consultation is perceived to be more of a process of negotiation would give patients greater 'ownership' of their cancer journey. Research has shown that the majority of health professionals underestimate the extent to which they lead the consultation and overestimate the degree to which they elicit and take cognisance of the patient's views. Equally, the majority of patients express a desire to be more involved in decisions regarding their treatment. Thus in a review of studies in this field, Harrington et al (2004) found that efforts to increase patient participation produced a range of positive benefits for patients, including: greater recall of information and adherence to recommendations; preference for a more active health role; perceived heightened control over health; higher attendance rates; and improved clinical outcomes. It is therefore important for cancer nurses to devise methods whereby patients can take a more proactive role in consultations.

Differences in patients' level of self-determination also seemed to influence their experience of consultations (figure 1). Those who displayed more of an 'other-determined' orientation, tended to perceive the nurse as responsible for setting the agenda. Such an attitude raises the potential for the needs of patients to remain unexplored. This is particularly the case with those cancer patients who are 'blunters' and tend to avoid information-seeking, as opposed to 'monitors' who actively seek such information (Mayer et al 2007). The problem is not only that 'blunters' may receive no detailed information about the technical aspects of their cancer, but they may also have a reduced opportunity for discussion of the psychological aspects of their illness (Sægrov and Halding 2004).

Study limitations

Qualitative sensemaking studies are usually carried out with small sample sizes so as to achieve a depth understanding of how patients make sense of their situation. This study therefore involved a small sample of patients in one country and so further research is required in this area.

CONCLUSION

The sensemaking approach employed in this study illustrated how preconceptions and conversational attitudes were frame-of-reference factors that influenced the process whereby patients refined their sense of nurse conversations. This approach has benefits for nursing research. The patient's attitudes, beliefs and values are activated in the process of making sense of communication. This provides a depth of insight into core personal and environmental factors that shape their understanding.

Planned cancer nurse conversations with outpatients are significant health events, though not always straightforward ones. The results of this study highlight important issues for nurses, particularly in relation to patients' 'nurse role' preconceptions and the constructions of nurses as sensegivers. These pose challenges for nursing practice in terms of taking action to fully inform patients about the nature of the nurse's role and to communicate skilfully and collaboratively to achieve concordance in this health care context.

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