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Nurses' Communication in Providing Care for Children with Cancer: Literature Review

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ABSTRACT

Cancer in children presents a major global health problem, impacting not only the physical condition of pediatric patients but also causing significant psychological and social challenges for both the children and their families. Effective communication between nurses, children, and families is essential to ensure quality care, support psychosocial adaptation, and foster active involvement in decision-making. The study design used literature review. This literature review was conducted using PubMed, Scopus, and CINAHL (EBSCO) databases, focusing on articles published from 2014 to 2025. The inclusion criteria were English-language articles discussing nurse communication with children aged 0-18 diagnosed with cancer, with nurses as the main communicators, and full-text availability. The findings indicate that nurses assume multifaceted roles not only as providers of medical information, but also as emotional supporters, advocates, and key facilitators in multidisciplinary healthcare teams. Communication approaches identified include tailoring information to the child's developmental stage and cultural context, validating emotions, and employing active listening, open-ended questioning, and reflection. However, nurses face considerable barriers such as limited time, insufficient communication training, unclear professional roles, emotional burden, and systemic challenges within healthcare settings. Therefore, there is a need to improve communication training, enhance institutional support, and develop policies that encourage multidisciplinary collaboration and a work environment that supports effective communication. These efforts are expected to strengthen the role of nurses in providing holistic, adaptive, and family-centered care in the pediatric oncology setting.

Keywords: cancer, children, communication, nurse, pediatric oncology

INTRODUCTION

Childhood cancer is one of the world's major health problems, with more than 400,000 new cases each year (Ye et al., 2025). Advances in therapy have increased survival rates to 85% in developed countries, but the diagnosis and treatment of childhood cancer still place a significant physical, psychological, and social burden on patients and their families (Son & Kim, 2024). Effective communication between nurses and paediatric patients is a fundamental aspect of providing quality paediatric nursing care. This communication not only has an impact on clinical outcomes, but also greatly influences the psychosocial adaptation of paediatric patients and the active involvement of families in the decision-making process during hospitalisation (Weng et al., 2024).

Nurse communication is not merely the transfer of medical information, but consists of providing emotional support, building trust, validating feelings, facilitating uncertainty management, and strengthening hope (Ye et al., 2025). However, several studies show that communication between nurses and children with cancer and their families often faces various obstacles, such as time constraints, lack of communication training for nurses, and cultural differences in preferences regarding information disclosure. Many paediatric patients feel invisible and powerless because they are not involved in communication and decision-making regarding their treatment (Lin et al., 2020).

Communication barriers in children with cancer occur at various levels, ranging from the individual, team, organisational, community, and policy levels. In addition, communication barriers exist in individual factors such as nurses' communication skills and comfort level and family preferences. Communication barriers in children with cancer occur at various levels, ranging from individuals, teams, organisations, communities, and policies (Sisk et al., 2022). Furthermore, the lack of therapeutic communication between nurses, children, and families leads to dissatisfaction, psychological stress, uncertainty, and family dysfunction (Son & Kim, 2024).

Ineffective communication increases the risk of psychological distress, post-traumatic stress symptoms, anxiety, reduced quality of life, and low child involvement in decision-making. Furthermore, a lack of therapeutic communication between nurses, children, and families can lead to dissatisfaction, psychological stress, uncertainty, and even family dysfunction (Son & Kim, 2024). This is particularly important during the diagnosis, intensive treatment, and terminal phases, as the presence of nurses as primary communicators greatly determines the experience of children and families in dealing with cancer. Ineffective communication leads to a decline in family trust in the healthcare system. A lack of transparency and empathy in communication increases the likelihood of families experiencing regret after making major decisions, particularly regarding treatment choices and end-of-life care (Dobrozsi et al., 2019)

Strategies to improve communication in paediatric cancer care by identifying factors that influence the quality of team communication that can be improved. Strategies to improve communication in paediatric cancer care focus on planned and controlled environments such as medical team meetings, adequate resources, communication skills training, development of multidisciplinary communication protocols, and the use of technology-based communication aids (Agulnik et al., 2025). Some studies still focus on doctor-patient communication, while communication among nurses remains relatively unexplored.

This literature review aims to identify the types of communication and barriers faced by nurses when communicating with children with cancer. By conducting literature review of various studies, it is hoped that best practices in nursing communication and relevant evidence-based intervention recommendations can be identified. The findings of this study are expected to serve as guidelines for the development of training, protocols, and policies that support the role of nurses as primary communicators in the care of children with cancer.

METHODS

Study design

The research method used in this study was a literature review to obtain a comprehensive overview of nurse communication in the care of children with cancer.

Search strategy

The literature search used the Pubmed, Scopus, and CINAHL (EBSCO) databases from 2014 to 2025. The keyword search strategy used MeSH terms. The text keywords were 'Communication' OR 'Health Communication' AND 'Nurse' OR 'Paediatric Nurse Practitioner' AND "Child" AND 'Neoplasm'. Phrase searches were adjusted to each database to ensure comprehensive coverage of relevant studies.

Study selection

The screening process was conducted in three stages. The first stage involved identifying relevant articles using PICO questions: How do nurses communicate when caring for children with cancer? The second stage involved screening by reviewing the titles and abstracts of the studies found to filter out relevant studies. The third stage is assessing eligibility by reading the articles to determine whether they meet the inclusion and exclusion criteria. The inclusion criteria used in the literature selection are studies that discuss nurse communication with children diagnosed with cancer, studies involving nurses as the main subjects in the communication process with children aged 0-18 years with cancer, studies in English, research results or original articles, and articles available in full text. The exclusion criteria were articles discussing doctor or health worker communication without a focus on nurses, studies on adult cancer patients, articles that were not accessible in full text, articles in languages other than English, and studies in the form of reviews, case reports, books, book reviews, comments, practice guidelines, conference abstracts, and theses.

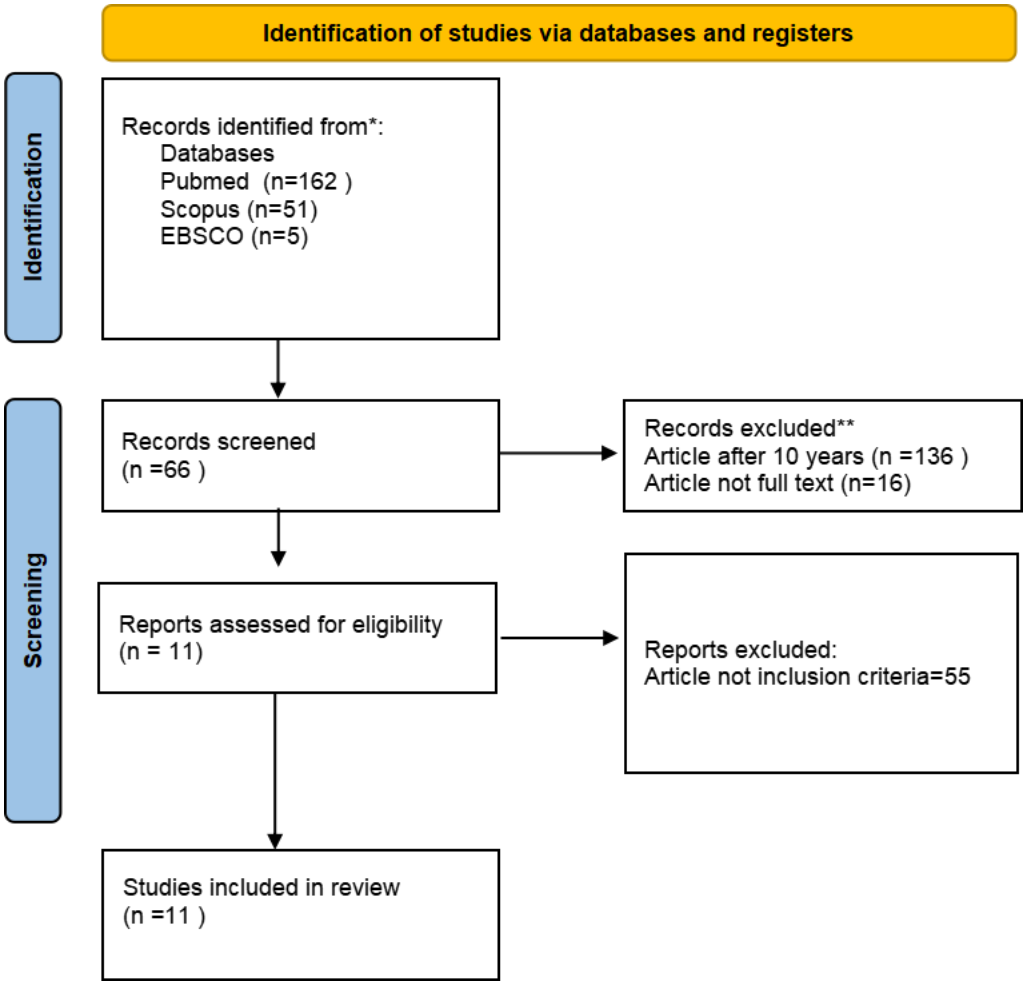

Figure 1. PRISMA flow diagram

RESULTS

Based on the literature review, 11 articles were found to meet the criteria. These articles were presented in Table 1.

Table 1. Literature review results

No	Author /Year	Study design/ sample	Types of nurse communication	Barriers in communication for nurses
1	Saidi &Heidari (2025)	Qualitative/6 nurses, 12 parents	Informational and psychological support, special skills (empathy, spiritual care), identification of family needs	Lack of training, lack of teamwork, time constraints, spiritual crisis, emotional burden
2	Gómez-Gamboa et al. (2022)	Qualitative/ 8 children and adolescents with cancer	Explaining procedures, providing honest information, friendly nurse attitude, involving children in decision-making, and providing emotional support	Technical focus, high work pressure, fatigue, time constraints, lack of communication training

3	Sisk et al. (2022)	Qualitative/ 59 professionals (nurses, doctors, psychosocial workers)	Providing support to parents, giving honest information, maintaining professional boundaries, validating decisions, sharing information	Role conflict, hierarchy, concerns creating anxiety, emotional burden, limited authority, and ethical dilemmas
4	Laronne et al. (2022)	Qualitative grounded theory/ 46 health workers (9 nurses, 21 doctors, 10 psychosocial teams)	Providing information gradually, honestly, age-appropriately, and involving parents	Emotional barriers, lack of training, legal constraints (parental authority), language, culture
5	Sisk et al. (2021)	Qualitative/59 clinicians (10 nurses)	Adaptive communication (culturally sensitive, personalised messages), building a shared mental model of the team	Lack of experience, time pressure, unclear roles, cultural barriers, differing expectations
6	Graetz et al. (2020)	Qualitative/ 83 providers (33 nurses)	Interprofessionalcommunication, empowering nurses through an early warning system (PEWS), team communication	Medical hierarchy, technology (lack of direct interaction), lack of recognition of the role of nurses
7	Newman et al. (2020)	Qualitative/18 nurses	Providing emotional support, advocacy, clarifying information after doctors have provided education	Not included in main discussions, minimal training, feeling uncomfortable, afraid of providing incorrect information
8	Landon et al. (2019)	Qualitative/12 nurses	Engaging in active communication by listening, asking open-ended questions, simulation, reflection, and role-playing with families	Time constraints, lack of administrative support, lack of privacy, challenges in maintaining intervention skills, workload
9	Newman et al. (2019)	Mix method/316 nurses and 18 nurses	Collaboration in communicating prognosis, providing emotional support, clarifying information, advocating for decisions	Not involved informal discussions, unclear roles, fear of contradicting doctors, lack of communication training
10	Newman et al. (2018)	Cross-sectional survey/316 nurses	Collaboration with doctors, clarification, decision-making support, provision of education	Unclear role, uncomfortable discussing prognosis, lack of training, lack of involvement in discussions
11	Montgomery et al. (2017)	Qualitative/24 nurses	Conducting discussions, advocacy, counselling, reflection on experiences	Stigma surrounding death, lack of experience, conflicts with doctors/families, personal emotions

Table 1 show that the form of communication used by nurses in the care of children with cancer and their families is highly diverse and adaptive to the needs of patients and families. Nurses not only provide informational and psychological support, but also demonstrate special skills

such as empathy, spiritual care, and collaborative communication with the medical team and families. Various studies, such as the importance of honest, friendly communication and the active involvement of children and families in decision-making. Additionally, interprofessional communication and nurse empowerment through the Early Warning System (EWS) have also been identified as key practices. The role of nurses as advocates, facilitators of information clarification, and emotional supporters. There are various obstacles faced by nurses in implementing effective communication. These obstacles include a lack of communication training, high work pressure, time constraints, emotional burden, and unclear roles within the medical team. Factors such as hierarchy, role conflicts, and discomfort in discussing prognosis or death are also challenges in themselves.

DISCUSSION

Based on a literature review, nurses' communication in child and family care shows a consistent pattern. Nurses not only play a role in providing medical information, but also serve as a source of emotional and psychological support, as well as advocates for patients and families. The forms of communication carried out by nurses include providing informational support, collaborating with the team, communicating in a manner that respects cultural values and is age-appropriate, and using communication techniques to ensure effective communication (Gómez-Gamboa et al., 2022; Saidi & Heidari, 2025).

Nurses provide informational support such as procedures, prognosis, and psychological and spiritual support to families (Gómez-Gamboa et al., 2022; Saidi & Heidari, 2025). This study is in line with Hashimoto et al. (2023) that the main factors in nursing practice to meet the information needs of families are the provision of information that supports the child's future and the family's daily life, information related to the child's care during the therapy process, and information about the child's illness and treatment. This shows the importance of two-way communication and sensitivity in conveying information as well as understanding the psychosocial

Nurses play a role in validating family decisions, maintaining professional boundaries, and providing counselling (Sisk et al., 2022; Aydın et al., 2024). This is in line with Olling et al. (2021) who identified four main roles of nurses in interprofessional team decision-making: decision-making, patient advocacy, and maintaining continuity between the family and the medical team. Nurses act as facilitators by educating, assessing decision-making needs, and ensuring that patients and families are represented in team discussions.

Nurses communicate between professions and collaborate with doctors and psychosocial teams to ensure continuity of information and support joint decision-making. Collaboration includes clarifying information, advocacy, and building a uniform team mental model (Newman et al., 2019, Graetz et al., 2020, Sisk et al., 2021). This is in line with the research by Soukup et al. (2020) that the quality of communication and interaction within multidisciplinary teams is greatly influenced by case complexity, time pressure, and internal team dynamics. The more complex the case, the greater the need for targeted communication and task-based interaction. Effective collaboration increases the chances of achieving optimal clinical decisions and reduces the potential for conflict and misinformation among team members.

Nurses communicate with consideration for culture and adapt to age. Nurses convey information according to the age, cultural background, and individual needs of patients and their families (Laronne et al., 2022). This is in line with Tuohy (2019) and Rayani et al, (2024) who state that effective communication in nursing practice cannot be uniform but must be adapted to the demographic and socio-cultural characteristics of patients and their families. This is particularly important in a multicultural context and with a diverse age population. This is in line with Bissonette et al. (2024) state that an effective communication model prioritises initial orientation, such as explaining the care process and clarifying communication preferences, as well as the working phase, such as active listening, empathetic responses, providing simple explanations, clarification, and the use of appropriate non-verbal language, thereby validating the family's understanding. Knight et al. (2024) state that effective communication requires not only technical skills, such as asking questions, listening, and clarifying, but also the ability to understand and adapt to the patient's socio-cultural context.

Nurses communicate by actively listening, using open-ended questions, simulations, and reflections, as well as role-playing with families to maintain the effectiveness of communication interventions with patients (Landon et al., 2019). This is consistent with Knight et al. (2024) and Bissonette et al. (2024) who found that the use of communication strategies such as active listening, open-ended questions, and reflection has been proven to increase patient and family involvement in decision-making. It also enhances collaboration between nurses, patients, and families. Study by Kerr et al. (2020) shows that communication training significantly improves nurses' communication skills in various clinical contexts.

Barriers to communication faced by nurses include lack of training, time constraints and workload, role ambiguity, emotional and cultural barriers. Lack of communication training and minimal experience are the main barriers affecting the quality of nurses' communication

(Newman et al., 2019, Gómez-Gamboa et al., 2022, Saidi & Heidari, 2025). This is in line with Gerchow et al. (2020), who found that most nurses stated that they had never received formal training in effective communication, particularly in dealing with patients and families from different cultural and linguistic backgrounds. In addition, lack of experience causes nurses to lack confidence, be unskilled at reading the communication needs of patients and families, and easily avoid important conversations, especially when they have to convey sensitive information or bad news.

Nurses' time and high workload are major obstacles to optimal communication (Gómez-Gamboa et al., 2022). This is consistent with Soukup et al. (2020), who found that time pressure and workload are negatively correlated with the frequency of task-oriented communication and positive social-emotional interactions within healthcare teams. This is supported by Gheshlagh et al. (2024) who found that excessive workload, long working hours, and lack of support facilities lead to decreased motivation and engagement among nurses, thereby worsening communication quality.

Hierarchy within healthcare teams, unclear nursing roles, and the lack of nurse involvement in key discussions are prominent issues (Newman et al., 2019, Graetz et al., 2020). This is in line with de León Oliva et al. (2025) who found that nurses are not fully involved in key discussions, especially when making important decisions related to patients. Rigid hierarchies cause nurses to hesitate to ask questions or seek clarification from doctors, resulting in incomplete information being received and conveyed. Discussions in highly hierarchical teams tend to be one-sided, with nurses more often acting as executors of instructions rather than discussion partners, thereby increasing the risk of miscommunication.

Emotional barriers, such as the emotional burden of nurses, spiritual crises, and nurses' fears create anxiety in families (Sisk et al., 2022) . Psychological conditions such as stress, burnout, or physical exhaustion due to workload cause nurses to tend to avoid deep communication, choose interactions with minimal emotional risk, and often fail to identify the communication needs of families (Gheshlagh et al., 2024, de León Oliva et al., 2025). This is supported by Atinga et al. (2024) who found that interpersonal conflicts and weak psychosocial support often result in suboptimal communication between shifts, leading to miscommunication with clinical implications. In addition, cultural and language challenges within families complicate the communication process for nurses (Laronne et al., 2022). This is in line with the research by Gerchow et al. (2021) that nurses feel they are not sufficiently equipped with cross-cultural competencies, both in understanding communication preferences, spiritual beliefs, and family

values of patients. This is supported by Knight et al. (2024) stating that the ability of nurses to communicate with patients from various cultural backgrounds is very important in realising inclusive and patient-centred health services. The implementation of culturally-based interventions, the use of professional interpreters, and the development of culturally sensitive health education materials are crucial to reducing the risk of miscommunication.

Previous studies have shown that there is a relationship between doctors and patients in decision-making, but communication by nurses as primary communicators has received less attention. This study shows that the role of nurses in advocacy and family decision facilitation is very important (Weng et al., 2024). Study by Gerchow et al. (2021) shows that nurses feel they lack effective cross-cultural communication training, so that the needs of patients and families are often not optimally met. Research by Newman et al. (2019) and Graetz et al. (2020) shows that hierarchical structures within healthcare teams often prevent nurses from actively participating in decision-making discussions. This contradicts multidisciplinary collaboration that places nurses as partners. This gap is supported by the findings of de León Oliva et al. (2025) that nurses tend to be passive and follow instructions, thereby increasing the risk of miscommunication and decision-making.

The implications of this study for nursing practice are that nurses should be actively involved in decision-making, not only as executors of doctors' instructions, but as discussion partners and family advocates. Effective communication practices that take into account age and culture, as well as communication through active listening, open-ended questions, and reflection, have been shown to increase patient and family involvement in decision-making. Furthermore, the implications for nursing education are that effective communication should be integrated into the nursing education curriculum. The lack of formal training indicates the need for comprehensive and ongoing communication training programmes, including communication simulations with families from diverse educational and cultural backgrounds. The policy implications of this research are that it enhances the development of multidisciplinary communication protocols and the formulation of institutional policies that require communication training for nurses, as well as the provision of structural support to address workload and emotional stress.

CONCLUSION

Based on a literature review, the form of communication used by nurses does not only focus on conveying medical information related to procedures, prognosis, and treatment, but also

provides emotional, psychological, and spiritual support, as well as facilitating decision-making for patients and their families. Nurses communicate by taking into account age, cultural background, and individual needs, and build collaborative interactions with multidisciplinary teams through effective communication techniques such as active listening, open-ended questions, and reflection. However, the implementation of nursing communication still faces various obstacles, including a lack of formal training, time constraints due to high workloads, unclear roles within the team, hierarchies in the work environment, and emotional barriers and cultural and language differences. Therefore, healthcare services facilitate communication training for nurses, the development of communication protocols, and the enhancement of multidisciplinary collaboration to support the role of nurses as primary communicators so that the care of children with cancer is more optimal. Considering the high workload and risk of burnout, it is crucial to provide psychosocial support, clinical supervision, and peer support to maintain nurses' mental health and communication quality. Future research should focus on the development, implementation, and evaluation of formal communication training programmes for nurses, particularly those based on simulation and real-life cases.

LIMITATION

There are still few intervention studies that examine the effectiveness of training or communication programmes for nurses in the context of paediatric cancer. The majority of articles reviewed used a qualitative approach with a limited sample size, so the generalization of findings was limited.

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