



## Structure and content in consultations with patients undergoing surgery for colorectal cancer



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### A B S T R A C T

#### Keywords:

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ERAS

Communication analysis

Consultations

Person-centred care

Partnership

Teamwork

**Purpose:** To explore the structure and content of pre-planned consultations as part of the care and treatment of patients undergoing surgery for colorectal cancer.

**Methods:** The study was based on 50 transcripts of audio-recorded pre-planned consultations between seven patients and 36 healthcare professionals from the time of diagnosis, pre-operative consultation, discharge consultation and pathology report in a colorectal unit.

**Results:** The spread of consultation time between professions was considerable. Total mean consultation time for patients during the care process (7 consultations/patient) was 111 min (range 83–191). The mean consultation time for surgeons was 18 min (7–40), anaesthesiologists 12 min (5–18) and nurses 14 min (5–49). Patients took up 40% of the word space, healthcare professionals used 59% and significant others 1%. Word space changed in such a way that the patient became more active towards the final consultation. Neither during the diagnosis consultation nor during the pre-operative consultation did the patients meet the operating surgeon.

Six major subjects emerged: general health, diagnosis, surgical procedure, pre-operative preparations, recovery and treatment and follow-up.

**Conclusions:** There is a need for clearer structure in the consultations. Most consultations lacked a clear introduction to the subject of the conversation. The study makes it possible to develop methods and structure for supporting conversations in which the patient is given space to help with the difficult issues present after undergoing surgery for colorectal cancer. The study also contributes to providing knowledge of how to organise surgical consultations in order to optimise person-centeredness, teamwork and clinical efficiency.

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### Introduction

Although one of the most common and important tasks in the daily work of physicians and nurses is to talk to and listen to patients, many lack training in communication skills (Fallowfield and Jenkins, 1999).

A particular challenge in colorectal cancer (CRC) care is to meet patient information needs throughout the care process, from diagnosis to CRC surgery, postoperative care and recovery (Allvin

et al., 2008; Norlyk and Harder, 2009). This has been emphasised during the last decade thanks to implementation of the enhanced recovery after surgery (ERAS) protocol (Kehlet, 1997), which has been evaluated positively in CRC care and has reduced morbidity, mortality and length of stay in hospital (Eskicioglu et al., 2009; Kehlet and Wilmore, 2002).

There is evidence that effective communication can make a difference to patient outcomes, such as understanding, emotional well-being and improved psychological adjustment (Fagerlind et al., 2012). While communication with patients in oncology and palliative care has been studied extensively (Fagerlind et al., 2012, 2008; Fallowfield and Jenkins, 1999; Ohlen et al., 2008), the surgical context of CRC has sparsely been studied (McCool and Morris, 1999). Biomedical issues often dominate in patient-physician

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communication, instead of focus on individual patient's needs, preferences and values. Medical issues are important but as a basis for a care and treatment plan they are complementary to the patients' narrated experiences of his/her condition. Little consideration is given to assessing and utilising patients' resources for handling illness, preferences and self-management (Brundage et al., 2010; Fagerlind et al., 2008). The outcome of consultations with healthcare professionals is also influenced by the structure and content of the consultations (Fallowfield and Jenkins, 1999) and both the quantity and content of what patients seek from their consultations change over time, even within the first visits (Vogel et al., 2008). Today, when patients need to navigate through a fragmented healthcare system, person-centred care is an emerging concept that highlights the importance of knowing the patient as a person and involving them an active partner in their care and treatment (Ekman et al., 2011; McCormack, 2004). In order to develop person-centred communication between healthcare professionals and patients in CRC care, knowledge about the structure and content of this communication is important. Such knowledge may serve as a baseline for future interventions aimed at the development of effective communication during consultations.

The aim of the study was to explore the structure and content of pre-planned consultations as part of the care and treatment of patients undergoing surgery for colorectal cancer.

## Material and methods

### Study design and setting

The present study is part of a larger project aimed at investigating whether tailored information material and person-centred communication for persons diagnosed with CRC undergoing elective surgery can improve the patients' recovery following diagnosis and initial treatment. The design of this study is explorative and is based on analysis of transcripts of audio-recorded consultations between patients and healthcare professionals at a Swedish public university hospital where over 300 CRC operations are performed each year. According to the routine care plan, patients with CRC have five occasions with consultations with healthcare professionals pre- and postoperatively at the Colorectal Unit and four of these occasions were included in the study (Fig. 1). The study was conducted between December 2010 and August 2011.

### Study participants

Seven patients (three women and four men, median age 66, range 44–84), scheduled for CRC surgery with curative intent, participated in the consultation study (Table 1). The selection of patients was strategic in order to achieve variation sampling (Polit and Beck, 2012). Two patients with rectal cancer received pre-

operative radiotherapy, two were scheduled to receive post-operative adjuvant chemotherapy and one patient died after discharge from hospital.

The professionals involved in the consultations with the patients were 11 male and five female surgeons, one female and four male anaesthetists, one male and 11 female registered nurses, two female physiotherapists and one female enterostomal therapist (ET nurse). One surgeon and one anaesthetist did not wish to be recorded and were replaced. In total, 36 persons were involved in 50 consultations. A contact nurse was present during the diagnosis consultation. The contact nurse is the patient's primary nurse before admission to hospital for surgery and following discharge.

### Data collection

Seven patients' pre-planned consultations were audio-recorded at the time of diagnosis, on the pre-operative consultation day, during the discharge consultation and the follow-up and pathology report consultation (Fig. 1), in total 47 consultations. Two patient consultations (A and E) with the physiotherapist and one with the ET nurse (patient A) were also audio-recorded and analysed, not shown in Table 2. The audio-recordings of the consultations were performed with no researcher present.

### Data analysis

The recordings were transcribed verbatim. Firstly, the transcripts were read repeatedly in order to acquire an overall impression of the structure and content and were discussed by the research group. Secondly, the structure of the consultation communication was described in terms of the total time (minutes) of the consultation, the total number of words per consultation and the distribution of the discursive space in each consultation – word space as a percentage between the patient, professional and significant other. The mean number of words per turn per patient and professional were calculated. The total time for all consultations per patient during the trajectory was also calculated for the different types of consultation. Thirdly, data were coded inductively from the transcribed text to find topics that emerged from the text. A number of sub-topics were identified from each consultation. Similar sub-topics were categorized and abstracted further to reduce the number of sub-topics and create common sub-topics for all health care professionals. These sub-topics were then collapsed into main topics. The main topics were then further categorised into major subjects. For an example of the construction of a major subject (Fig. 2). As a fourth step, the structure of each consultation was described in terms of phases: the introduction (presentation, overview of the content, small talk before the agenda), the agenda (the focus of the consultation) and the end (the closing phase)

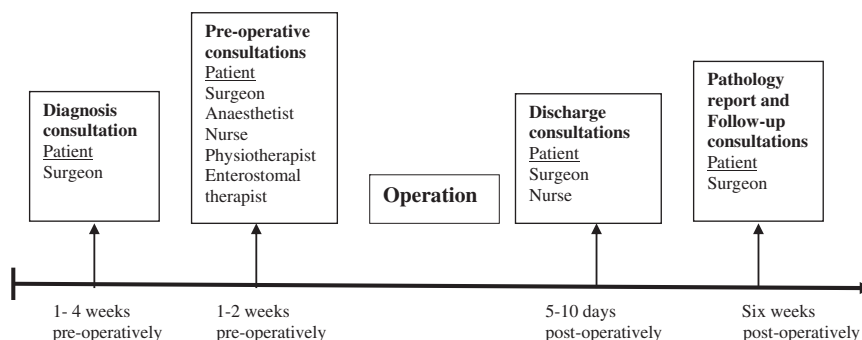


Fig. 1. Audio-recorded consultations during the care process from diagnosis to the pathology report and follow-up consultations with patients with colorectal cancer.

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