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Patients' perceptions of how healthcare providers communicate with them and their families following a diagnosis of colorectal cancer and undergoing chemotherapy treatment



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A B S T R A C T

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Purpose: Chemotherapy can result in many unpredictable and often debilitating side-effects hence patients undergoing chemotherapy treatment may have to rely on their loved ones to support them through this most challenging period. In view of this possibility then good communication skills between patients, healthcare providers and family members is of paramount importance for effective patient outcomes. The aim of this study therefore, was to explore patients' perceptions of how healthcare providers communicate with them and their family members whilst undergoing chemotherapy treatment for cancer.

Methods: Using a qualitative methodology and a descriptive design, data were collected using unstructured interviews with patients undergoing chemotherapy ($n = 14$) and analysed by content analysis. **Results:** Participants expressed that both they and their family members were treated with compassion, kindness, empathy and understanding. They appreciated the time given to them and their family members to listen and answer their questions before, during and/or after treatment. In addition they commented positively on the warm and cheerful environment and the selective use of appropriate humour by oncology healthcare providers in the chemotherapy units.

Conclusion: The data highlights in particular the positive communication encounters between patients with cancer and their healthcare providers and family members. Oncology nurses were identified as being particularly supportive to both patients and their family members. Despite chemotherapy units being a difficult place to be a part of, this study highlights that healthcare providers can help make this a less daunting place for patients and their family members through their appropriate use of professional communication.

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Introduction

Colorectal cancer (CRC) presents an extensive health problem globally and in Ireland where it is the second most common cause of death (Department of Health & Children (DoH&C), 2012). When discovered early it is highly treatable and surgery alone can cure approximately 90% of CRCs (National Cancer Institute, (NCI), 2014). If it has spread into nearby lymph nodes, surgical treatment followed by chemotherapy is also highly successful (NCI, 2014). Unfortunately chemotherapy can result in many undesirable side-effects. Whilst many of these side-effects are temporary and reversible (e.g. nausea, vomiting, diarrhoea), others such as fatigue,

neuropathy, cardiac and pulmonary toxicity, chronic pain and sexual dysfunction can have more permanent or long lasting effects on individuals (Battley and O'Reilly, 2011).

Chemotherapy is increasingly being delivered on an outpatient basis hence, there is an assumption that family members (FMs) will take some of the responsibility for the clinical care of these patients. In addition, with so many unpredictable and often debilitating side-effects of chemotherapy, patients may have to rely more on their loved ones to support them through this most challenging period. In light of these possibilities then it seems fitting that good communication between all three parties (the patient, healthcare provider (HCP) and FM) is of paramount importance for effective patient outcomes.

A review of the literature conducted to explore patients' experiences of how HCPs communicate with them and their families whilst undergoing chemotherapy treatment for cancer highlighted

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a paucity of research in this area thus warranting a need for investigation.

Background

Good communication between patients, HCPs and FMs following a cancer diagnosis is critical for patients and their families' knowledge and understanding of the illness, treatment and care. In relation to cancer illness in particular good communication is acknowledged as being instrumental to patients experiences and psychosocial outcomes (Butow, 2005; Baile and Aaron, 2005; Fallowfield, 2008; Kuroki et al., 2013).

Patients' view of good communication skills by HCPs is when they are patient-centred, are sensitive and empathic, answer questions honestly, give information in simple language and when they provide opportunities for patients to ask questions and express emotions (Geiser et al., 2006; Fujimori et al., 2007; Thorne et al., 2010; Figg et al., 2010; Kuroki et al., 2013). In contrast, patients describe poor communication skills as when HCPs give poor or no explanation about diagnosis, do not discuss treatment options, respond to questions in an irritated manner, give information in a vague manner, use technical words and do not give time or privacy to discuss the diagnosis and/or treatments (Geiser et al., 2006; Fujimori et al., 2007; Figg et al., 2010).

Many studies however, continue to highlight that poor communication between HCPs and patients is still prevalent in the oncology context (Geiser et al., 2006; Azu et al., 2007; Thorne et al., 2008; Figg et al., 2010; Kuroki et al., 2013). Poor communication is problematic for patients and their families for a number of reasons. For example, it can impact on their trust on HCPs, adherence to treatment regimens and subsequently on patient outcomes (Thorne et al., 2005; Epstein and Street, 2007; Figg et al., 2010).

Disclosure of patient information to FMs has long been a contentious issue in medical care. Major changes however, are evident in the physician–patient relationship over the last few decades, from a paternalistic model of care to one based increasingly on autonomy and patient self-determination (Angelos and Kapadia, 2008). Patients have become more vocal in that they want their FMs to be more involved in their care and with their consent to be given information about their illness. With the increasing need for patients to derive help and support from FMs during the chemotherapy treatment period, then it would seem realistic for FMs (with the patient's consent), to have some information about the cancer illness and treatments in order to provide immediate, efficient and appropriate healthcare.

Aim

The aim of this study therefore, was to explore patients' perceptions of how HCPs communicate with them and their FMs whilst undergoing chemotherapy treatment for colorectal cancer.

Method

A qualitative descriptive design was selected for this study. This design allows for a naturalistic approach to inquiry and is especially useful for researchers wanting to know the who, what, and where of events (Sandelowski, 2000). The aim is to produce a meaningful summary of the data in everyday language (Sandelowski, 2000) and in this case to provide a description of patients' accounts of what style of communication with HCPs and between HCPs and their FMs helps or hinders them to achieve their potential during the chemotherapy treatment period.

Participants and setting

Fourteen patients participated in this study (Table 1). Patients undergoing their first course of chemotherapy following surgery for colorectal cancer were invited to participate. To be included participants had to be age 18 or over, English speaking, male or female and attending a chemotherapy unit for treatment. Patients undergoing chemotherapy treatment for palliative care were excluded as more formal structures are in place for communication with patients, HCPs and FMs. Patients were recruited with the support of Colorectal Cancer Nurse Specialists (CCNS) employed in two chemotherapy units in the Munster region of Ireland.

Data collection and analysis

Data were collected using face-to-face unstructured interviews. This was to allow the participants to respond in their own words as to what they thought was important (LoBiondi-Wood and Haber, 2013). The parallel process of data collection and analysis took place during the interviews as well as during the transcribing process. Data were analysed using content analysis, a form of analysis of verbal data that is oriented toward summarizing the informational contents of that data (Morgan, 1993) in a way that best fits the data (Sandelowski, 2000).

In the first phase, transcripts were read and reread several times in order to get an overall sense of the data (Graneheim and Lundman, 2004). In the second phase, transcripts were read word by word to derive codes (Morse and Field, 1995), by first highlighting the exact words from the text that appear to capture key thoughts or concepts and then making notes of these ideas. In the third phase, similar codes were grouped together and given a label. Finally, codes were sorted into categories depending on their link and relationship with the category. These emergent categories were used to organise and group codes into meaningful clusters (Patton, 2002), and subsequently into themes. In-keeping with a qualitative descriptive design, participant wording was maintained where possible throughout the analysis (Sandelowski, 2000).

Ethical considerations

Ethical approval to conduct the study was obtained from the local Clinical Research Ethics Committee. Permission to access the participants was first sought from patients' Oncology Consultants, then from the Directors of Nursing in two hospitals and finally the Clinical Nurse Managers in the two chemotherapy units. All participants were informed both verbally and in writing about the aim/purpose of the study, structure of the interview, details about confidentiality of data and anonymity of participants and chemotherapy units. Each participant was asked to sign a consent form before proceeding to a digitally recorded interview. Participants were also informed that they could stop the interview at any time

Table 1

Demographics of participants ($n = 14$).

Gender: M: 8, F: 6
Age ranged from 39–73
Nationality: Irish
Area of Residence: Urban: 6, Rural: 8
Marital status: Married × 4, Partners × 3, Widowed × 4, Single × 2, Separated × 1.
Living alone: 2
Children: 9
Occupation: Retired × 4, Full time employment × 4, Part-time employment × 1, Self-employed × 2, Homemaker × 3.
Education: Level one × 3, Level two × 7, Level three × 4

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