Delivery of telephone-based supportive care to people with cancer: An analysis of cancer helpline operator and cancer nurse communication

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ABSTRACT

Objectives: Telephone-based supportive care presents a potentially highly accessible means of addressing unmet supportive care needs for people with cancer. Identification of behaviours that facilitate communication is essential for development of training for telephone-based supportive care. The aim of this study was to describe communication behaviours within supportive care telephone calls in two contexts (1) a telephone outreach intervention and (2) cancer helpline calls, to identify potential areas for further training.
Methods: 50 recorded calls were analysed using two standardised coding systems: the RIAS and Verona-CoDES-C.
Results: Mean call length was 21 min (304 utterances) for nurse-outreach calls and 23 min (355 utterances) for helpline calls. Closed questioning, verbal attentiveness and giving information/counselling were the most common communication behaviours identified. Emotional cues were most commonly responded to through non-explicit back-channelling, exploration of content or provision of reassurance or advice.
Conclusions: This study confirmed the need to address the manner in which questions are framed to maximise patient disclosure. Responding to patent emotional cues was highlighted as an area for future training focus.
Practice implications: Communication skills training that addresses each of these tasks is likely to improve the effectiveness of telephone-based delivery of supportive care.

1. Introduction

Cancer has a significant impact on the lives of patients and their families. In addition to cancer symptoms and treatment side effects, the incidence of psychological distress is high [1,2] and patients and their caregivers have a range of informational, emotional and practical supportive care needs [3,4]. Telephone-based supportive care is one method of service delivery that can overcome barriers to accessing support. The telephone also provides a level of privacy and anonymity, reducing patients'

reluctance to discuss issues of concern [5]. Two systematic reviews of nurse-delivered telephone follow-up for cancer patients confirm this model of care is well accepted [6,7]. Additionally, for more than twenty years organisations such as the Australian Cancer Councils have delivered cancer-specific information and support via telephone helplines [8]. More recently, in a research context, telephone-based centralised nursing interventions that target oncology patients' supportive care needs are being used [9,10].

The successful delivery of telephone-based supportive care is contingent upon the communication competence of the health professional delivering the support. Studies have reported a perceived lack of acknowledgement of client needs by telephone counsellors [11,12]. This may reflect an added complexity associated with telephone-based communication not present in face-to-face interactions. Although little is known about the

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communication competency of nurses delivering supportive care, the literature more generally suggests that lack of training and fears about the consequences of delving into sensitive issues [13] can result in a reluctance by nurses to ask patients about their problems [14], use of blocking tactics to discourage patients from raising concerns [14] and a focus on clinical aspects of care [15,16]. Even in oncology, the communication skills of cancer care nurses are reported to be less than ideal [17].

Communication skills workshops in oncology settings [18,19] have demonstrated improvements in key communication such as such as increases in open and focused questions, more appropriate responses to patients' cues, and more empathic responses [15,20–22]. However these training methodologies do not address the challenges associated with telephone interactions such as the lack of visual cues [23,24], the need to convey empathy verbally and more regular checking of understanding [24]. Specialist programs for telephone counsellors focus on listening skills [25], but provide little instruction on assessing need for information and guidance and can actively discourage proactive problem-solving by counsellors [11]. There is a need for an oncology-specific communication skills training program to address the unique aspects of telephone-based supportive care interactions [26].

Assessing communication to identify current communication behaviour and potential training targets is an important step in developing training models and Interaction coding systems have made it possible to code and classify the structure and content of health professional-patient encounters [27,28]. This study explored communication within telephone-based interactions using a widely used system of analysis for patient–healthcare professional communication, the Roter Interaction Analysis System (RIAS) [27,29]. In addition, health professional responses to patient expressions of emotion were assessed using the Verona Coding of Emotional Sequences (VR-CoDES) [30].

Supportive care in Australia is currently delivered in both hospital and community based settings. Given the limited empirical evidence regarding communication behaviour in the delivery of supportive care needs interventions over the telephone, the aim of this study was therefore to describe current communication behaviours and identify strengths and gaps within supportive care calls in two contexts (1) a nurse-delivered telephone outreach intervention and (2) patient-initiated calls to an information and support helpline, to identify potential targets for training in health professional-patient telephone-based communication.

2. Methods

2.1. Sample

The study sample consisted of 50 existing telephone calls with patients diagnosed with cancer, recorded for training and quality assessment purposes. All patients consented to their calls being recorded. The sample included 25 randomly selected nurse-initiated calls from a randomised trial of telephone-based care coordination and supportive care intervention for colorectal cancer patients (the CONNECT intervention) [9,61] and 25 randomly selected patient-initiated calls to an Australian telephone information and support helpline operated by the Cancer Councils of Queensland and NSW. The CONNECT intervention involved five calls over 6 months to patients who have had surgery for colorectal cancer to provide information and support in the post operative. Cancer Council helpline is an Australian telephone information/support service operated from the state-based Cancer Councils (non-government charitable organisations) and callers to the helpline service were actively seeking information or support. Hence, the purpose of both CONNECT and helpline calls was to provide health-related information/resources, practical advice and emotional support to patients in the context of either a hospital or community based setting. Sex and cancer site for participants are detailed in Table 1. No other demographic information was provided during the calls. This study was approved by the Sydney Local Health District Ethics Review Committee (RPAH zone) and Griffith University HREC.

2.2. Measures

2.2.1. Roter Interaction Analysis System (RIAS)

The Roter Interaction Analysis System (RIAS) [27,29] was used to classify all utterances by the patient and the health professional into content categories and modes of exchange. The RIAS has been adapted for use in an oncology context [31] and has also been used to assess brief GP telephone consultations [32]. The RIAS codes the verbal utterances of both the patient and health professional into 40 mutually exclusive categories [29]. The unit of analysis is frequency of utterances in each coding category. An utterance is defined as the smallest meaningful speech segment related to one topic of discussion [31]. The system also distinguishes between instrumental (task-related) and affective utterances by dividing the coding categories into 8 instrumental and affective clusters [33,34]. Instrumental clusters can be broadly described as information-based behaviours such as giving information or counselling of patients and asking questions. Affective behaviours broadly include socio-emotional content of interactions such as expressions to convey interest, empathy, worry or concern. A full list of clusters is included in Table 2. The reliability of the system in oncology consultations is well documented [31,35], although psychometric properties of the RIAS in telephone-based cancer supportive care interactions has yet to be established.

2.2.2. The Verona coding definitions of emotional sequences – VR-CoDES CC

The Verona Coding of Emotional Sequences (VR-CoDES) [30] is a coding system specifically devised to assess health professional responses to patient emotional cues [36]. This instrument does not assess medical aspects of the consultation, but provides evidence of the behaviours health professionals engage in when faced with patient emotion. In this system, clear verbalisations of patient worries are coded as concerns and implicit expressions are coded as cues [37]. Healthcare professionals' responses are then classified into one of five categories based on whether the response facilitated (provided space) or discouraged (reduced space) further emotional expression by patients. Each response can be further

Table 1
Caller demographic and clinical information.

	CONNECT	Cancer council
Sex		
Males	10	8
Females	15	17
Cancer type		
Colon	25	2
Breast		7
Lung		3
Prostate		3
Renal		2
Lymphoma		2
Anal		1
Cervical		1
Bone		1
Brain		1
Thyroid		1
Throat		1