
Enhancing palliative patients' experience of radiotherapy.



BREAKING DOWN THE BARRIERS

BY KATE URQUHART

Patients who have advanced or metastatic cancer are often prescribed a short course of radiotherapy to control the spread or to alleviate symptoms such as bony pain. As well as the physical pain and side effects of having cancer and its treatment, these individuals must also cope with the emotional and psychological consequences of their diagnosis: Many are wondering how long they have to live, whilst others worry what may happen

if the pain gets worse, or if their mobility decreases. Therapeutic radiographers can be a first point of contact for patients at this difficult time. Consequently, the way that the radiographers communicate with these individuals and their families can have a big impact on how they cope with their situation, and can be an important source of support, guidance and information.

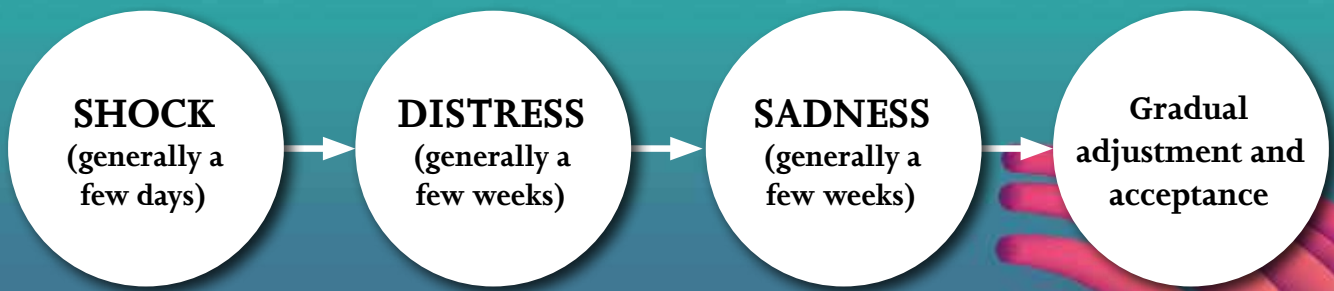


Figure 1. The emotions that a patient experiences at diagnosis generally pass through a series of stages¹¹.

- Medical prognosis
- Age, sex, social group
- Cause of disease, ie self inflicted or why me?
- Different symptoms experienced
- Direct effects on brain eg mets drugs
- Burden of treatment, eg mastectomy, colostomy
- Stigma
- Patient's relationship with staff
- Characteristics of the patient, eg past life experiences, personality, family relationships
- Current social circumstances, religious beliefs

Table 1: Psychological response to a diagnosis of cancer depends on a number of factors¹².

The aims of this article are:

- To identify the specific needs of patients receiving palliative radiotherapy.
- To identify and discuss the use of advanced communication skills by therapeutic radiographers when talking to this patient group and their families.
- To critically analyse the current evidence to demonstrate how the use of these skills can enhance patients' experiences of palliative radiotherapy.
- To discuss some of the common barriers that can prevent effective communication.

BACKGROUND

Approximately 50% of patients receiving radiotherapy in western countries are treated with palliative intent; to alleviate symptoms or reduce the spread of the disease¹. The average survival rate for these individuals is less than six months post-treatment². Consequently, they are considered to be receiving end of life care, as a cure is no longer possible³.

It is well-documented that people with incurable cancer may experience many emotional and psychological difficulties, including anxiety and depression^{3,2,4}. The National Institute for Health and Care Excellence (NICE) Quality Standards for End of life care in adults state that: 'The proper management of these issues requires effective and collaborative, multidisciplinary working within and between generalist and specialist teams, whether the person is at home, in hospital or elsewhere'³. Patients and their families appreciate face-to-face communication with healthcare professionals (HCPs) who can 'engage with patients

on an emotional level, to listen, to assess how much information a patient wants to know, and to convey information with clarity and sympathy'⁴.

It is evident however, that patients receiving palliative care do not always receive the best multi-disciplinary care possible, nor the best communication from HCPs^{4,5}. Unfortunately, often due to pressures of time or workload, HCPs may not fully address the concerns of patients and this can lead to less effective treatment and poorer outcomes^{5,6}. Furthermore, there is evidence that certain cancer diagnoses, such as brain tumours and blood cancers, suffer inequality in treatment such as lower access to specialist palliative care⁷.

An example from clinical practice includes the author's own experiences as a therapeutic radiographer, where patients sometimes ask if it is definitely cancer they have that is being treated: This kind of potentially distressing and significant information should be provided by specially trained professionals, and by the time the patient has arrived for their first day of radiotherapy they should know their diagnosis and prognosis (if they want to know it)⁴. However, psychological distress at diagnosis can mean that patients are not able to take in all the information they are given, leading to confusion and questions such as this at a later point⁸.

Therapeutic radiographers should have a level of communication that is at least at Level 1 of psychological care, ie the ability to recognise psychological needs and give effective information, communicate with compassion and provide general psychological support⁴. Furthermore, if therapeutic radiographers are to offer person-centred care, then offering people support to recognise and develop their own strengths and abilities is fundamental, and is based

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(both their own death as well as the patient's) in order to facilitate a patient's own acceptance of their impending death. Zimmermann writes that a person's acceptance of their own death is the basis of much of the palliative care philosophy, but she considers whether this is truly necessary in order to have a 'good' death as perceived by the medicalised environment, including hospices. Therapeutic radiographers may only have a short time to talk to patients, but by allowing patients the freedom to explore feelings (which they may not get in other areas of their lives), they may be helped to come to terms with their situation a little more easily¹⁴. One study¹⁵ found that terminally ill patients on a cancer ward seemed to be living with a hidden suffering which was not acknowledged by the nurses nor by the patients themselves, but in contrast to other research, they found that patients wanted to speak aloud of this unspoken suffering.

It is perhaps unsurprising then, that clinical depression is present in up to 40% of people receiving palliative care, yet detection of depression by HCPs is low, and many patients do not receive appropriate treatment, with a consequent reduction in quality of life^{5,6}. Hallford and colleagues⁵ describe some of the problems that HCPs have with recognising clinical depression in the palliative care setting. These include mistaking symptoms as being due to medical condition or pharmacological side effects. They conclude that further training is required for HCPs in order that they can recognise and obtain treatment for patients suffering from depression. A key part of this training is related to discussing emotional issues with patients with more confidence, as well as improved empathetic responding.

USE OF ADVANCED COMMUNICATION SKILLS

There is limited research into the role of advanced communication skills in therapeutic radiographers specifically in a palliative context. However, several studies have explored the role of radiographers' communication within specific disease sites and these can give insight into their communication skills more generally.

For example, Halkett and colleagues¹⁶ carried out a qualitative study exploring the communication of therapeutic radiographers with breast cancer patients during their planning appointment. Survey data found that therapeutic radiographers had a varying level of confidence depending on what issues they needed to talk about with patients. One area of lower confidence was that of psychosocial issues. The authors suggest that this insight could assist in planning education for radiographers.

around effective and supportive communication⁹.

This article will explore how, given the complex needs of palliative patients, the use of advanced communication skills, such as reflective listening, paraphrasing and genuineness, can enhance the experience of this patient group¹⁰.

THE NEEDS OF PALLIATIVE PATIENTS

Some patients receiving palliative radiotherapy will have been informed of their incurable diagnosis many weeks or months prior to having radiotherapy, but others will have only found out days, or sometimes hours, beforehand (author's personal experience). Consequently, patients may be going through various stages of psychological response to their diagnosis (See Figure 1), and an individual's response can depend on a large number of factors such their age, sex, and past experiences (see Table 1 for a more comprehensive list).

When a patient arrives at a radiotherapy department they can be at any stage of this emotional journey and it is important that therapeutic radiographers are aware of this in order to tailor their communication to the individual, and provide optimal care and support. Barraclough¹² discusses the importance of allowing patients the opportunity to express feelings of sadness and/or anger and that conversely, encouraging a 'think positive' attitude is not always a good thing. Time is needed to absorb, adapt and come to an acceptance of their diagnosis.

However, it is debated in the literature whether all patients reach the final stage of adjustment and acceptance (Figure 1). In Zimmermann's¹³ detailed discourse analysis on the acceptance of dying, she discusses the importance of the HCP's role in assisting in the acceptance of death

The more confident a HCP feels at handling distress and emotional concerns, ie the more training they have had, the more likely they are to communicate well.

In a small study of head and neck cancer patients receiving radical radiotherapy, qualitative interviews were used in order to establish the needs of these patients and what constituted good care for them from therapeutic radiographers. Successful and supportive encounters as reported by the patients, included referring to the patient by their first name, using friendly and open body language, informing the patient thoroughly, and asking open questions¹⁷. These findings can easily be applied to the palliative patient, as they will experience many of the same feelings and uncertainties as patients having radical radiotherapy.

Martin and Hodgson¹⁰ discuss the role of counselling and communication skills during radiotherapy patients' 'first day chat'. They argue convincingly that the use of advanced communication skills such as active/reflective listening and clarification, alongside counselling skills demonstrating empathy, genuineness and respect, can lead to a reduction in patient anxiety and lead to a better radiographer-patient relationship throughout radiotherapy treatment, which in turn leads to better patient outcomes^{5,6}. Again, although this is not specifically in the palliative context, the idea that patients who are listened to, and empathised with, will be less anxious and happier with their treatment, is a powerful one.

There is more research evidence in palliative and end of life care more generally and it is possible to apply many of the findings of these studies to therapeutic radiographers and palliative radiotherapy. For example, numerous studies in palliative care nursing show that nurses are generally more confident when discussing physical pain and suffering with patients than when it comes to discussing psychological, spiritual and existential concerns^{15,18,19}. This is similar to the findings of Halkett and colleagues¹⁶ as discussed earlier and is also the author's own experience.

In a small qualitative study of palliative care nurses' experiences of addressing existential and spiritual concerns with palliative patients, it was found that the more experienced the nurse was, the more confident they were in discussing concerns around death and dying²⁰. Advanced communication skills such as therapeutic touch, active listening, self-awareness and being present were all found to be beneficial. The paper lists a number of helpful questions which the nurse participants use to create openings for further discussion with patients and the researchers hope to use these to assist in training of nurses (and other HCPs) to be more confident in discussing existential concerns. For example: "What's the thing that troubles you the most?" and if a patient says "I just wish it was all over" the nurse will say "Why is that? What causes you to say that?"²⁰.

Continuity of care was also recognised as an important aspect for creating an environment where patients felt able to talk to them²⁰. This can be difficult to achieve in radiotherapy as well as in nursing, as shift patterns and part-time workers mean that often a patient will see a large number of different HCPs during their treatment⁶. Furthermore, the number of doctors seen by patients can also be huge – one study found that a group of palliative patients with an illness of less than one year had seen an average of 28 doctors, with one patient having seen 73 different doctors in approximately two years¹⁴. This is clearly not good for continuity of care and something which needs to be addressed.

Many papers suggest that communication skills training (CST) will help HCPs to improve their communication with patients^{4,6,14,18,20}. A recent Cochrane review analysed the results of 15 randomised controlled trials investigating the use of CST with a variety of

HCPs, mainly doctors and nurses²¹. They did find that there was a statistically significant improvement in the use of open questions and of showing empathy post-CST. Unfortunately, there was limited evidence that CST showed any long-time improvement in HCPs' communication skills. However, it could be argued that any improvement, even if only short-term, is better than none at all.

BARRIERS TO EFFECTIVE COMMUNICATION

As previously discussed, studies show that psychological concerns are not always elicited effectively by HCPs, and that HCPs tend to be more confident discussing physical aspects of disease than the psychological aspects. This has been shown to be particularly evident in patients who have progressing disease, suggesting that HCPs are more uncomfortable when assessing these patients²². Further evidence to support this includes a study by Bushinki and Cummings²³ who found that nurses actively avoided patients with terminal diagnoses. Distancing and blocking tactics are common among HCPs¹⁴. These strategies are employed in order to prevent the unleashing of strong emotions which HCPs are afraid may cause too much distress to themselves and to the patient.

As Dettmore and Gabriele¹⁸ point out: 'The nursing challenge is to remain physically, emotionally, and spiritually present for [the] family, despite the inclination to avoid the situation'.

This challenge also applies to therapeutic radiographers as well as many other HCPs working in palliative care. Therapeutic radiographers may not be in quite as close contact with patients as palliative care nurses but there is still a psychological cost to them and it can be emotionally draining^{6,14,22}. A number of factors can affect the likelihood of a HCP's 'survival' including personal awareness, preparation, working hours and support²². The more confident a HCP feels at handling distress and emotional concerns, ie the more training they have had, the more likely they are to communicate well¹⁴. Botti and colleagues⁶ found that when nurses set personal barriers this helped them to 'survive', and Faulkner and Maguire²² discuss the need for HCPs to accept that 'care can be of good quality and effective without necessarily leading to a cure.'

A further barrier to effective communication which is frequently cited in the literature is the lack of time and high workload^{6,14}. This is certainly a problem in radiotherapy where a patient may have an appointment time as short as nine minutes. Knowing about further sources of support available to patients is one way to, at least partially, alleviate this problem¹⁴, and multi-disciplinary team working is another⁴. Referral to specialist palliative care services (SPC) such as counsellors and local hospice staff should be available and accessible to all who need them and it is important that therapeutic radiographers are aware of what support is available in their area⁴. Earlier referral to SPC is also needed. A recent audit found that referrals to SPC from Scottish GP practices were made on average five weeks before death even though average time between diagnosis and death was 27 weeks⁷.

In summary, it would seem that key skills for therapeutic radiographers to have when planning, treating and supporting patients receiving palliative radiotherapy include:

- Skills to identify concerns and pick up on cues, such as use of open questions and active listening.
- Patient assessment skills, particularly looking for signs of clinical depression and anxiety.
- Skills to build relationships, including friendly, open

body language and empathetic responses.

- Knowledge of local specialist palliative care services, along with the ability to refer patients appropriately and in a timely manner.
- Skills of explanation and information provision at an appropriate level for the patient at that time.

CONCLUSIONS AND RECOMMENDATIONS

Patients receiving palliative radiotherapy may be highly distressed and/or clinically depressed and it is important that therapeutic radiographers have the skills to recognise and deal appropriately with these psychological issues. The use of advanced communication skills can significantly enhance the experience of patients undergoing palliative radiotherapy. By eliciting patients' main concerns and questions, radiographers can direct patients to the most appropriate sources of support and advice, or ensure that support is already in place. Furthermore, the patient will feel 'heard' and this alone has been shown to greatly reduce anxiety levels. The current evidence base investigating radiographers' communication with palliative radiotherapy patients is limited, but what evidence there is strongly suggests that the better the communication skills of the HCP, the better the patient experience. Consequently, training in advanced communication skills should be considered a high priority for therapeutic radiographers at all stages of their career.

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REFERENCES

<http://www.sor.org//learning/library-publications/itp>

This article has been prepared following local guidance relating to the use of patient data and medical images.

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HOW TO USE THIS ARTICLE FOR CPD

- Consider your own experience of communication with palliative patients and their families and carers. Do you feel confident discussing psychosocial issues and how good are you at active listening and empathetic responding?
- Can you identify with any of the barriers described in the article?
- Review your own communication skills and assess whether you feel you would benefit from further training. If so, discuss with your manager how you could get this training.

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