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

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Surgery
ERAS
Communication analysis
Consultations
Person-centred care
Partnership
Teamwork

A B S T R A C T

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-centredness, 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 interactions.
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).

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**Table 1:**

<table>
<thead>
<tr>
<th>Consultation Type</th>
<th>Participants</th>
<th>E. Carlsson et al. / European Journal of Oncology Nursing 17 (2013) 820–826</th>
</tr>
</thead>
</table>

**Fig. 1:** Audio-recorded consultations during the care process from diagnosis to the pathology report and follow-up consultations with patients with colorectal cancer.
The number of words in the different phases was also calculated. The number of questions asked and main topics and sub-topics of conversation in the different consultations are presented with a mean value.

### Ethics

The project was approved by the Regional Ethical Review Board in Gothenburg (Reg. no. 545-10). Informed consent was obtained from the participants, both patients and staff, before participation.

### Results

Sixteen surgeons participated in 26 consultations. Patients met 3–4 surgeons during the four audio-recorded consultations. Six out of seven patients had 1 or 2 consultations after surgery with the operating surgeon (discharge, follow-up and pathology report consultation). None of the patients met the operating surgeon during the diagnosis consultation or the pre-operative consultation.

Twelve nurses were involved in the 13 audio-recorded consultations. None of the patients met the contact nurse during the

### Table 1

Demographics patients.

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age, sex</th>
<th>Diagnosis</th>
<th>Radiation</th>
<th>Type of operation</th>
<th>AC</th>
<th>Days in hospital</th>
<th>Significant other</th>
<th>Education</th>
<th>Work status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient A</td>
<td>70 M</td>
<td>Rectal cancer</td>
<td>5 × 5 gy</td>
<td>APR</td>
<td>No</td>
<td>10</td>
<td>Wife</td>
<td>Elementary school</td>
<td>Retired</td>
</tr>
<tr>
<td>Patient B</td>
<td>44 M</td>
<td>Sigmoid cancer</td>
<td>No</td>
<td>AR High</td>
<td>Yes</td>
<td>4</td>
<td>Wife</td>
<td>University</td>
<td>Businessman</td>
</tr>
<tr>
<td>Patient C</td>
<td>62 M</td>
<td>Colon cancer</td>
<td>No</td>
<td>Right hemicolecotmy</td>
<td>No</td>
<td>6</td>
<td>Wife</td>
<td>High school + vocational</td>
<td>IT technician</td>
</tr>
<tr>
<td>Patient D</td>
<td>84 F</td>
<td>Sigmoid cancer</td>
<td>No</td>
<td>Sigmoid resection</td>
<td>No</td>
<td>7</td>
<td>Widow</td>
<td>Elementary school</td>
<td>Retired</td>
</tr>
<tr>
<td>Patient E</td>
<td>88 F</td>
<td>Colon cancer</td>
<td>No</td>
<td>Right hemicolecotmy</td>
<td>No</td>
<td>6</td>
<td>Widow</td>
<td>Elementary school</td>
<td>Retired</td>
</tr>
<tr>
<td>Patient F</td>
<td>59 M</td>
<td>Colon cancer</td>
<td>No</td>
<td>Right hemicolecotmy</td>
<td>Yes</td>
<td>9</td>
<td>Wife</td>
<td>Elementary school</td>
<td>Office clerk</td>
</tr>
<tr>
<td>Patient G</td>
<td>66 F</td>
<td>Rectal cancer</td>
<td>5 × 5 gy</td>
<td>AR High laparoscopic</td>
<td>No</td>
<td>7</td>
<td>Husband</td>
<td>University</td>
<td>Teacher</td>
</tr>
</tbody>
</table>

**Demographics patients.**

(Silverman, 2010). The number of words in the different phases was also calculated. The number of questions asked and main topics and sub-topics of conversation in the different consultations are presented with a mean value.

### Table 2

Time and word space in the consultations.

<table>
<thead>
<tr>
<th>Patient</th>
<th>Patient/ professional/ SO Nurse</th>
<th>Diagnosis consultation surgeon</th>
<th>Pre-operative consultation surgeon</th>
<th>Pre-operative consultation anaesthetist</th>
<th>Pre-operative consultation nurse</th>
<th>Discharge consultation surgeon</th>
<th>Discharge consultation nurse</th>
<th>Pathology report and follow-up consultation surgeon</th>
<th>Total consultation time, minutes mean (range) median</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td></td>
<td>40</td>
<td>20</td>
<td>18</td>
<td>49</td>
<td>14</td>
<td>30</td>
<td>20</td>
<td>191</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total words</td>
<td>5934</td>
<td>2866</td>
<td>2003</td>
<td>7426</td>
<td>1755</td>
<td>5580</td>
<td>3456</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Word space %</td>
<td>(40/44/6/10)</td>
<td>(13/83/4)</td>
<td>(32/66/2)</td>
<td>(8/17/4)</td>
<td>(10/20/9)</td>
<td>(39/47/14)</td>
<td>(31/63/6)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total words</td>
<td>2102</td>
<td>2853</td>
<td>1143</td>
<td>911</td>
<td>30</td>
<td>1643</td>
<td>3489</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Word space %</td>
<td>(31/68/1)</td>
<td>(24/76)</td>
<td>(32/68)</td>
<td>(39/61)</td>
<td>(26/74)</td>
<td>(6/19)</td>
<td>(13/13)</td>
</tr>
<tr>
<td>B</td>
<td></td>
<td>22</td>
<td>8</td>
<td>10</td>
<td>21</td>
<td>10</td>
<td>9</td>
<td>7</td>
<td>12.4 (7–22)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total words</td>
<td>3450</td>
<td>1261</td>
<td>1787</td>
<td>3071</td>
<td>1475</td>
<td>1582</td>
<td>1328</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Word space %</td>
<td>(33/63/4)</td>
<td>(39/61)</td>
<td>(35/65)</td>
<td>(24/74)</td>
<td>(70/30)</td>
<td>(44/56)</td>
<td>(60/40)</td>
</tr>
<tr>
<td>D</td>
<td></td>
<td>18</td>
<td>15</td>
<td>5</td>
<td>34</td>
<td>16</td>
<td>17</td>
<td>21</td>
<td>126</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total words</td>
<td>2090</td>
<td>2461</td>
<td>833</td>
<td>5867</td>
<td>2865</td>
<td>2843</td>
<td>3858</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Word space %</td>
<td>(58/33/9)</td>
<td>(56/44)</td>
<td>(33/67)</td>
<td>(55/45)</td>
<td>(35/65)</td>
<td>(46/52/2)</td>
<td>(64/36)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Word/turn-mean</td>
<td>(9/57/5)</td>
<td>(9/12)</td>
<td>(5/10)</td>
<td>(12/10)</td>
<td>(9/17)</td>
<td>(10/11)</td>
<td>(13/7)</td>
</tr>
<tr>
<td>E</td>
<td></td>
<td>14</td>
<td>14</td>
<td>18</td>
<td>14</td>
<td>20</td>
<td>7</td>
<td>Died</td>
<td>87</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total words</td>
<td>2043</td>
<td>1780</td>
<td>2102</td>
<td>2093</td>
<td>3340</td>
<td>1101</td>
<td>15 (7–20)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Word space %</td>
<td>(39/57/4)</td>
<td>(47/48/5)</td>
<td>(34/66/1)</td>
<td>(45/52/2)</td>
<td>(41/59)</td>
<td>(35/65)</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Word/turn-mean</td>
<td>(8/11/9)</td>
<td>(7/7/1)</td>
<td>(11/8/5)</td>
<td>(7/7/3)</td>
<td>(9/12)</td>
<td>(17/13)</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td></td>
<td>12</td>
<td>10</td>
<td>7</td>
<td>9</td>
<td>8</td>
<td>5</td>
<td>32</td>
<td>83</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total words</td>
<td>1750</td>
<td>1945</td>
<td>1181</td>
<td>1135</td>
<td>801</td>
<td>985</td>
<td>4680</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Word space %</td>
<td>(35/60)</td>
<td>(36/64)</td>
<td>(29/71)</td>
<td>(22/77)</td>
<td>(24/76)</td>
<td>(58/42)</td>
<td>(41/59)</td>
</tr>
<tr>
<td>G</td>
<td></td>
<td>21</td>
<td>16</td>
<td>16</td>
<td>13</td>
<td>20</td>
<td>8</td>
<td>11</td>
<td>105</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total words</td>
<td>2937</td>
<td>1993</td>
<td>1949</td>
<td>1926</td>
<td>2089</td>
<td>1413</td>
<td>1592</td>
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<tr>
<td></td>
<td></td>
<td>Word space %</td>
<td>(33/66/1)</td>
<td>(48/51/1)</td>
<td>(51/49)</td>
<td>(42/58)</td>
<td>(24/76)</td>
<td>(30/70)</td>
<td>(38/62)</td>
</tr>
<tr>
<td>All consultations</td>
<td>Total time</td>
<td>147</td>
<td>105</td>
<td>85</td>
<td>147</td>
<td>88</td>
<td>86</td>
<td>120</td>
<td>778 min</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mean (range)</td>
<td>21(12–40)</td>
<td>15(8–22)</td>
<td>12(5–18)</td>
<td>21(7–39)</td>
<td>15(18–20)</td>
<td>12(5–30)</td>
<td>21(7–32)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Median</td>
<td>20</td>
<td>15</td>
<td>11</td>
<td>14</td>
<td>15</td>
<td>10</td>
<td>20</td>
</tr>
</tbody>
</table>

SO — significant other.

a Significant others.

b Nurse participating in the consultation.
pre-operative and discharge consultations. She was only present at the diagnosis consultation with the surgeon. None of the nurses who participated in the consultations was a qualified specialist nurse.

Ten of the sixteen surgeons involved in the consultations were specialists in CRC surgery and participated in 21 of the consultations. The significant other was present during 18 (38%) of the consultations, of which one participated in the pathology report and follow-up consultation.

Structure

The consultations were divided into three phases: introduction, agenda and end. Fifteen (31%) of the consultations lacked an introduction and jump-started with the agenda. When included, the introductions were usually very short (range 4–378 words). All pre-operative consultations with the surgeon had an introduction. Some consultations had a longer introduction but this only included small talk without a presentation and content. The end of the consultation was shorter in the diagnosis and pre-operative consultations (range 0–391 words), and increased during the discharge consultation and the pathology report consultation (range 24–843 words). None of the professions had a consistently clear introduction and a clear end.

Time

The spread of consultation time between professions was considerable. The nurses’ mean consultation time was greater than for the other professions (Table 2 and Fig. 3). The total mean consultation time for the patients ranged between 83 and 191 min. No patient was consistently given most time in all the consultations. Patients B and F had the longest time regarding the follow-up and the pathology report consultation and an analysis of the consultations revealed that both patients had cancer that had spread to the lymph nodes. There was no relationship between time and the individual professional conducting the consultation. Consultation time was shortest for the anaesthesiologists. The consultation time for the ET nurse was 49 min and for the physiotherapist 10 min (patient A) and 11 min (patient E). The male patients had a slightly longer consultation time in all consultations than the female patients although the greatest difference is six minutes (diagnosis and pathology report consultations).

Word space and word per turn

Patients accounted for 40% of all the words spoken in all consultations while the healthcare professionals for 59% and the significant others 1%. This distribution was about the same for all consultations with the exception of the pathology report consultations, where the patients accounted for slightly more words (48% for patients and 52% for professionals). Men spoke less in the different consultations (35% of the total number of words compared to 42% for the women).

The numbers of turns was almost equal between professionals and patients, indicating that there is a dialogue even if the patients mostly agreed with a hum or a yes. The professionals in general had longer turns (number of word per turn) than patients (Table 2).

For patient A, the mean number of words per turn in the consultation with the physiotherapist was nine and for the physiotherapist 36. For patient E, the numbers were 11 for the patient and 16 for the physiotherapist. In the only consultation with the ET nurse, the number of words per turn was 10 for the patient and 22 for the ET nurse.

Content

The main topics were categorised into six major subjects: general health, diagnosis, surgical procedure, pre-operative preparations, recovery and treatment and follow-up (Table 3).
The anaesthetist used the same sub-topics in all consultations, e.g. preparations before anaesthesia, epidural anaesthesia, sedatives, risks and perceptions of earlier anaesthesia. The anaesthetists' clinical assessments were consistently the same: oral status and function of the neck and jaw. Smoking as a risk factor was brought up in two of the conversations.

All the nurses’ pre-operative consultations included the main topic of health status. Half of the nurses were specific regarding the importance of mobilisation according to the ERAS concept, while some did not mention it at all. In six of the consultations, the nurses performed clinical assessments either in the middle or at the end of the conversation, e.g. pulse, blood pressure and oxygen saturation.

Erectile dysfunction was a main topic only in the consultation with the ET nurse and respiratory care only in the consultation with the physiotherapist.

In most consultations, it was the patient who initiated the talk about symptoms, the discovery of the tumour, diagnosis, prognosis, spread of the cancer, bowel function, recovery and the new life after surgery. There was a more obvious dialogue between the professional and the patient in the surgeons’ consultations over time compared to the nurses’ consultations over time.

In the diagnosis consultation, the surgeons asked most questions and in most cases, the initial question was “What do you already know?” and a common question at the pre-operative consultation with the surgeon was “Do you know why you are here?” In all pre-operative consultations with the surgeon, the patient asked “Are you the surgeon who will perform the operation?”

In most pre-operative consultations with the nurses, the nurses asked more questions compared to the patient and during the discharge consultation, both patients and nurses asked a similar number of questions. A common question in the nurses’ consultation was “What has the doctor told you?” In all pre-operative consultations with the nurses, there was a clear agenda with standardised questions. In all pathology and follow-up consultations with the surgeons, the initial question was “How do you do?” “How has it been at home?” All the professionals provided an opportunity for the patient to ask questions in all the consultations. The nurses and the anaesthetists were the professionals who asked most questions. During the discharge consultation with the surgeons, the patients asked more questions than the surgeon whereas during the discharge consultation with the nurses the number of questions was equal. In the pathology consultation, patients and surgeons also asked an equal number of questions. When the significant others were present they asked 1–2 questions.

The number of main topics was similar for the different professionals during the diagnosis and pre-operative consultation. In all consultations, the sub-topics were twice as many as the main topics except for consultations with the nurses, who had three times as many sub-topics, (Table 4).

## Discussion

The results reveal that patients met many different surgeons and nurses during care process and there was a considerable spread of consultation time. Most consultations lacked a clear introduction about the content of the agenda. The word space during consultations changed over time to become more similar between patients and professionals. Nurses had more sub-topics and questions than the surgeons. Biomedical main subjects dominated the consultations.

One of the benefits of this study was that it followed both surgeons’ and nurses’ consultations with patients who had undergone CRC surgery. To our knowledge, this is an area that has not been studied before. Knowledge of the structure and content of the consultations will presumably serve as a basis for interdisciplinary and team-oriented inquiries. It also makes the boundaries with the other team members’ professional areas clearer with the result that the consultations reflect different aspects of care. A notable finding in the present study was that patients with CRC met several different surgeons and nurses during the pre-planned consultations, which was probably due to the surgical care organisation. This could be seen as a reflection of the current fragmented healthcare system, which implies that if patients are to have continuity over time in the conversations that take place as part of the consultation process, the agenda needs to be made explicit among the professionals. In addition, to ensure continuity in the consultations in terms of content and structure, there seems to be a need for an overlap of certain conversational content. The different consultations need to be documented appropriately to guarantee transparency in the knowledge transferred throughout the care process. However, the way consultations were organised goes against the concept of person-centred care and jeopardises the enablement of partnership between the professional and the patient that encourages patients to take an active part in solving their problems (Ekman et al., 2011). All patients in the present study wanted to know who the operating surgeon was and in the study by Lithner et al. (Lithner and Zilling, 2000) patients wanted to be informed about the operation by the operating surgeon. One way to create partnership in a CRC context would be to designate the contact nurse as a navigator for the patient throughout the care process. A notable result was that in the follow-up consultation after the pathology report has been received the significant other was only present at one of the consultations. This

### Table 3

<table>
<thead>
<tr>
<th>Major subjects</th>
<th>General health</th>
<th>Diagnosis</th>
<th>Surgical procedure</th>
<th>Preoperative preparations</th>
<th>Recovery</th>
<th>Treatment and follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main Topics</td>
<td>Health status</td>
<td>Discovery</td>
<td>Operation</td>
<td>Preparations before anaesthesia</td>
<td>Recovery after anaesthesia</td>
<td>Radiation</td>
</tr>
<tr>
<td></td>
<td>Medication</td>
<td>Tumour</td>
<td>Stoma</td>
<td>Preparations before operation</td>
<td>Recovery after surgery</td>
<td>Follow-up</td>
</tr>
<tr>
<td></td>
<td>Thromboprophaxis</td>
<td>Prognosis</td>
<td></td>
<td>Anaesthesia</td>
<td>Bowel function</td>
<td>Spread of cancer</td>
</tr>
<tr>
<td></td>
<td>Symptoms</td>
<td></td>
<td></td>
<td></td>
<td>Daily activity</td>
<td>Chemotherapy</td>
</tr>
</tbody>
</table>

### Table 4

<table>
<thead>
<tr>
<th>Main Topics</th>
<th>Diagnosis consultation surgeon</th>
<th>Pre-operative consultation surgeon</th>
<th>Pre-operative consultation anaesthetist</th>
<th>Pre-operative consultation nurse</th>
<th>Discharge consultation surgeon</th>
<th>Discharge consultation nurse</th>
<th>Pathology report and follow-up consultation surgeon</th>
</tr>
</thead>
<tbody>
<tr>
<td>Questions (patient/professional)</td>
<td>8</td>
<td>19</td>
<td>13 (5/8)</td>
<td>18 (8/10)</td>
<td>21 (6/15)</td>
<td>28 (8/20)</td>
<td>14 (7/7)</td>
</tr>
</tbody>
</table>

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could be because patients had not received information or had not understood that in the follow-up consultation the surgeons would discuss the pathology report and prognosis.

The agenda for the consultation was not made clear to the patients since most consultations lacked a clear introduction to what the consultation was about and jump-started with the agenda. (Goldman et al., 2009) reported that none of the physicians asked the patients what they were hoping to gain from the consultation. The content of the agenda was clear to the professionals but not the patient, which leads to an imbalance from the very start of the consultation and reduces the possibility of creating a partnership.

The introduction of the agenda could be a way of offering the patient more discursive space (Risa et al., 2011). Risa et al. (2011) showed that small talk in the introductory phase opened the way for the patient’s narrative, which is an indication of a person-centred approach.

There was a considerable spread of consultation time for both surgeons and nurses although there was no relationship between time and the individual professionals performing the consultation. However, a study aimed at investigating consultations in primary care in six countries in Europe showed that the characteristics of patients had as much effect on consultation length as the characteristics of the countries and doctors combined (Deveugele et al., 2002). During the care process, the mean time for the seven consultations with the surgeons and nurses was approximately two hours. It is important to know the time involved in the different aspects of care in order to be able to organise and plan healthcare activities.

The mean consultation time with the surgeon in our study was 21 min, which was almost equal to consultations between patient and physician in an oncology department, where the mean time was 19 min (Fagerlind et al., 2008). However, patients whose cancer had spread to the lymph nodes had a longer follow-up consultation, which may indicate greater potential for dialogue during which the parties could raise topics of concern. In the nurses’ pre-operative and discharge consultations, the mean time was lower, 17 min compared to 25 min in high-risk midwifery consultations (Risa et al., 2011).

The mean word space in all consultations was larger for the professionals than for the patients, which has also been reported in other studies (McCool and Morris, 1999; Ohlen et al., 2008; Risa et al., 2011). In the present study, however, the patients were followed from diagnosis to follow-up and the word space and words per turn changed over time to become more similar between patients and professionals. This may be an indication that the patient assumed a more active role and that a partnership developed over time.

The men had a somewhat longer consultation time but used fewer words compared to the women, which is also reported in a meta-analysis by Hall et al. (Hall and Roter, 2002). However, the number of patients in the present study was too small to draw any conclusion about gender differences.

The major subjects in the consultations that took place as part of the care process were general health, diagnosis, surgical procedure, pre-operative preparations, recovery, treatment and follow-up, which suggests that the biomedical perspective dominated the consultations, which has also been reported in an earlier study (Fagerlind et al., 2008). In this study, an analysis of the major subjects and main topics was reported for all 50 consultations (Table 3). The content from the transcripts are based on more than 60% from the physicians’ conversation, which means that the specific professions topics did not emerge clearly in the result of this analysis. Further analysis of the data would provide more detailed information regarding content in the sub-topics for the different health care professionals specifically more in detail patients’ consultation with the nurse.

The patients in the present study were operated on for CRC and a significant finding was that psychological and existential issues were not a major subject in the consultations. This is in contrast to the study by Fagerlind et al. (2008), where three of the six main conversation categories with oncology patients were psychological well-being, coping with disease and expression of concerns and feelings.

The structure of the anaesthetists’ consultations was most evident since the same sub-topics were seen in all consultations. This could probably be explained by the fact that they used the ASA physical classification system (Owens et al., 1978).

The abdominoperineal resection effect on erectile dysfunction was only brought up in the consultation with the ET nurse and the lack of information about sexual dysfunction has been reported previously (Dowswell et al., 2011). Whilst the issue of erectile dysfunction is a sensitive subject, it is very important for the patient to discuss and most of the men in the study by Dowswell et al. (2011) were uninformed about erectile dysfunction and were unprepared for it.

In all pre-operative consultations, the nurses performed clinical assessments either in the middle or at the end of the conversations, e.g. pulse, blood pressure and oxygen saturation. It can be assumed that performing clinical assessments during sensitive conversations could affect the conversation negatively. Half of the consultations with the nurses did not stress the importance of mobilisation, which is one of the key aspects of the ERAS concept.

Questions about symptoms and the spread of the cancer were raised mainly by the patients and the professionals did not respond in any depth. Similar results were reported in other studies (Fagerlind et al., 2012; Fallowfield and Jenkins, 1999; McCool and Morris, 1999), where patients raised the more complex issues, e.g. the chances of a cure, possible side effects of treatment and emotional concerns. The reason why professionals did not discuss symptoms and feelings in depth could be that surgery is expected to relieve patients of their symptoms. However, the spread of cancer is a sensitive issue to discuss (Fagerlind et al., 2008).

In most consultations, it was the patients who started the conversation regarding symptoms, discovery, diagnosis, prognosis, spread of cancer, bowel function, recovery and a new life after surgery. Lithner and Zilling (2000) also showed that patients wanted more prognostic information about the future. The level of dialogue that took place between the surgeon and the patient in all the consultations conducted during the care process was higher than the level of dialogue in the nurses’ consultations. The surgeons also asked more open questions in the conversations with the patients, which open up for patient’s own story telling (Charon, 2001). The reason for more frequent reflections and more open questions in the surgeons’ conversations could be that they had more professional experience than nurses and none of the nurses had a specialist nursing qualification. It is possible that professionals with more experience also feel more confident about their skills and are aware of the limits of their own area and of other professional areas.

The nurses asked a lot of closed questions in their conversations, which did not open up a dialogue with the patients. It would seem that the main aim for the nurses was to obtain answers to their questions. Each main topic consisted of a number of sub-topics, many of which are included in the nursing documentation system in the hospital data records (Ehrenberg et al., 1996). It is important that the nurse involves the patients in the consultation and a starting point is to allow the person to tell their own story and how they understand their illness (Charon, 2001; McCormack, 2004). A structure of the consultation that gives the patient the opportunity to present him/herself as a person in the form of an illness narrative could be the starting point for building a collaborative, egalitarian, provider-patient partnership that encourages and empowers patients to take an active part in finding solutions to their problems (Charon, 2001).
One limitation of the study is that only the pre-planned consultations have been studied and not the informal conversations that take place throughout the care process. This study only reflects the culture of persons who can speak and understand Swedish and results could not be directly transferred to other cultures and settings where hospital care might be organised differently. The recordings may also affect the structure and content of the consultations. Communication involves the use of both verbal and non-verbal means. In this study, however, we have only analysed the text from the spoken communication and not observed what happened in the interaction between the patient and the professional. Another concern is related to interpretation of the results. Although we have presented the significant parts of the consultations, to understand the consultations more fully, studies are needed that focus on the contribution to the communication process made by the different parties. The results from this study can only be applied to patients with a cancer diagnosis and cannot be generalised to patients with a benign diagnosis.

Conclusion

There is a need for a 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 a 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 result also contributes to providing knowledge of how to organise surgical consultations in order to optimise person-centeredness, teamwork and clinical efficiency. This knowledge could serve as a baseline for future interventions aimed at developing the communication skills of healthcare professionals.

Conflict of interest

The authors report none declared.

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