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Information and Support for Patients Throughout the Radiation Therapy Treatment Pathway

Michelle Leech and Mary Coffey
Discipline of Radiation Therapy, School of Medicine, Trinity College, Dublin, Ireland

1. Introduction

Communication is integral to all human interaction. Effective communication is a skill required by all members of the radiotherapy team in order to provide the best care to patients. However, it is an area of practice frequently overlooked amidst all of the technological advances in radiotherapy. This chapter aims to give an overview of the theories and models which underpin communication and then focuses on interactions within the radiotherapy department and how these impact on patient care. There is a particular focus on communication with older patients, children and adolescents-patient groups who can easily be overlooked in the information giving process. The chapter ends with a series of typically presenting patients to the radiotherapy department and invites the reader to consider how they might provide information and support to such patients.

2. Theories of communication

Capella (1) suggests that there are five steps involved in effective communication:

- *Transmission:* Information passing from one individual and assumes that the information will be received by another.
- *Exchange:* During communication, there is an exchange of words, gestures and images, usually termed 'interaction'.
- *Generation of meaning:* Certain words and phrases, as well as other methods of communication have specific meaning in certain cultures or within particular groups of people.
- *Context:* Effective communication must be given within the context of the situation. The location or setting of the communication can impact on this significantly.
- *Discourse.* The message communicated will be within the scope of a recognised format, this is known as the discursive context.

3. Models of communication

A model of communication explains how the communication process actually works in practice; how does the intended message to be communicated actually reach its destination?

Some models of communication include the information theory model, the interactive model, the gatekeeper model and the transactive model. The information theory model of communication was proposed by Shannon (2) in 1948. This model sees a message being created by an information source, a transmitter then carries the message through a carrier or channel, and noise may obscure or confuse the message, which is received either visually or aurally. The message finally reaches its destination when it is processed by the receiver. The interactive model put forward by Weiner (3) in the same year is similar to the information theory model but also includes a feedback loop from the final destination of the initial communicated message to the first information source. The feedback itself then becomes a communicated message and the original information source now becomes the destination of the feedback.

The gatekeeper model was put forward by Katz (4) in 1957 and highlights the role of a 'gatekeeper' or intermediary in the communication process. The proposed message can become distorted or may not reach the intended audience at all. In the radiotherapy setting, the gatekeeper model may become apparent when a third party attends for a radiotherapy consultation with a family member.

The transaction model of communication was described by Hopper (5) in 1992. In this model, two communicators create and consume messages for one another, as during a telephone conversation.

4. Communication in cancer care

Communication is a complex process involving the transfer of information between people, whether intentional or non-intentional, regardless of the model of communication adhered to (6). We can appreciate therefore that effective communication is a core clinical skill in the practice of radiation oncology and health literacy has a central role in cancer patients' ability to discuss their disease and prognosis with their oncologist in a meaningful way. Effective communication has many positive effects on cancer patients' adjustment to their disease and its treatment, whereas poor communication has negative consequences for both health-care professionals and patients (7, 8). Research has demonstrated that effective communication during consultations positively influences patient recovery, pain control, adherence to treatment, satisfaction and psychological functioning (9, 10).

However, it has been reported that patients forget much of the information provided to them (11). Therefore, the timing of information, the amount and content of the information and the method used to provide this information influence how effective the radiation therapy team will be in their communication with patients.

Psychoeducational interventions that are tailored for each patient are more likely to be effective than are interventions that make assumptions about the patient's information needs. Hence content of information should be agreed between the patient, his/her family, as appropriate, and the radiotherapy team. Methods that have been used to deliver information to patients include direct verbal instructions, printed materials, video, group sessions and computer-mediated methods (12)

5. How do we transfer information to patients in the radiotherapy department?

5.1 Verbal information

This is the most frequently used method. The radiation oncologist, radiation therapists and radiotherapy nursing staff meet with the patient regularly during treatment and face to face consultations. For radiation therapists, this is every day over the course of treatment. However, a known problem with verbal information is that about half of the information given is quickly forgotten or perhaps not processed at all (13). A potential advantage however is that it has the potential to lead to an interactive discussion with the patient.

5.2 Print media

Printed materials have the advantage of ensuring uniformity in information given, compared to verbal methods. Solely using printed material can result in gaps in information and the patient-health professional interaction is lost. Literacy can be problematic (14, 15). Therefore, written information should be clear, concise and use simple, easily understood language.

5.3 Video

Reviews have shown that video can be an effective modality for increasing knowledge in particular instances such as knowledge of risks and benefits of treatment options (16). In a study of adult patients receiving radiotherapy (16), the intervention group viewed a video with educational and practical information and was also given a written booklet on radiotherapy. The control group received the booklet only. By the end of treatment the two groups had equal knowledge, although the intervention group did have superior knowledge at the outset of treatment.

5.4 Digital media

Computer-based information allows for high accessibility to information and use of additional tools, such as graphics. However, it should be used with caution, particularly in patient groups who may not be computer literate.

6. Other independent variables that influence information-giving in the radiotherapy department

6.1 Timing of information

Interviews with patients about their information needs have shown that information should be made available to the patient whenever the patient feels a need for it and not when the health professional feels that the patient needs it. It makes sense to provide the information at the time when the patient is actually seeking it and radiotherapy health professionals should be mindful that patients' information needs may change with time, as treatment progresses (17).

6.2 Sociodemographic factors

There is no evidence that education level of patients influences either satisfaction with or recall of information (14) but there is evidence that better-educated patients are more likely to seek information (18). The radiotherapy team should be aware of this and seek to provide relevant information to patients from all sociodemographic groups when it is needed.

7. Communication with the older person

Communication with older patients in the radiotherapy department is often perceived as a challenge. Indeed, older adults diagnosed with cancer are the population considered to be at the highest risk for poor communication with health professionals. Older patients are often less assertive in communicating with health professionals, less likely to ask questions and less inclined to take a controlling role in the decision making process (19).

In a green paper published by the EU in 2005 (6), the then 25 EU countries had a population of 18.2 million people aged 80 and over (4% of the population). This will rise to 24.1 million in 2014 (5.2% of the total population) and by 2020, 70% of all cancers will occur in patients aged 65 and over (20).

Ageing is an individualised process. While 65 is the recognised retirement age in most countries, physiological 'old age' does not begin until 75 years of age. Older people are not homogenous, the needs of those in their 60s varies considerably from those in their 80s. Even within these groups, there are considerable variations on psychological needs, social supports, medical problems and health perspectives (21).

Although treatment for cancer should be based on physiologic rather than chronologic age, there is evidence to suggest that older patients receive less aggressive or appropriate cancer treatment than younger patients (22,23). Often there are misconceptions about the likely survival of the older patient. For example, the life expectancy of a woman aged 50 is 35 years (to 85). Once patients survive to 70 years, their life expectancy is 16 years (to 86) and those aged 80 can expect to survive until 88 (24).

As with all patients, communication with the older patient should be based on that particular patient's needs and personal preference for information. Ascertaining their circumstances and their own personal preferences in relation to their care is critical in the development of a successful therapeutic relationship. In a study of the relationship between health workers and older patients, it was found that being recognised according to their needs and being treated with courtesy and respect was important to older patients (6).

The main changes associated with ageing which may impact on the radiation therapist's communication with the patient and the patient's recall of information include:

- Visual changes such as decrease in visual acuity and contrast sensitivity and increase in glare intolerance.
- Hearing changes, such as presbycusis (decreased hearing of higher frequencies)
- Dementia or neurological damage
- Intergenerational and cultural differences.

Evaluation of such factors is essential when meeting an older patient for the first time. These can be overlooked in general in oncology and frequently compromise the quality of communication (25).

Celik et al (26) report on the attitudes of nursing students towards ageing and older patients. The total sample consisted of 42 all female students. 83.3% of the sample (n=35) stated that they had problems with their older patients. Communication problems due to mental, visual and hearing impairments and chronic diseases were experienced by 38% (n=16) of the participants. A further 42.8% (n=18) had difficulties giving instructions to older patients.

The majority of the participants in this study agreed that nurses caring for older patients need to be knowledgeable about the physical and psychological changes of ageing (26).

7.1 Ageism

Butler and Lewis (27) defined ageism as 'a systematic stereotyping and discrimination against people because they are old'. There has been a history of ageism in cancer treatment such as the under-representation of older patients in cancer trials, lack of attention of management of older patients at conferences and personal biases on the part of practitioners (28). The latter has often lead to a lack of opportunity for older patients to express their own opinions. Shorter interview time and less psychosocial discussion with older patients have been identified as ageist behaviour on the part of health professionals. Patients themselves have been found to be ageist, attributing pathological symptoms to the normal ageing process (21).

7.2 What information does an older patient require?

While one author (29) suggests that older patients may be less interested in knowing their diagnosis than younger patients, others have found that older patients still want information but do not want to be as actively involved in the decision-making process about treatment as younger patients (30).

Studies have shown variability in older patients' desires to actively participate in their cancer treatment (31, 32), while a systematic review revealed that few studies investigated the specific needs of older cancer patients surrounding treatment (33). The review revealed that while older patients prefer to receive information about the most important aspects of their illness and treatment, they are less inclined to look for extremely detailed information.

Posma et al (11) report that when providing information to the older person, it should be given in a structured manner with the most important and relevant information tailored to the patient's personal needs summarised and then repeated. Information should be given in a step like fashion, giving time for the patient to process the information. Language used should be simple and the use of jargon should be avoided. Information should be offered combining different methods (e.g.verbal and written) to improve information retention.

Despite these difficulties in the communication process, it should be noted that older adults may have better psychological resources than younger patients to adapt to their cancer diagnosis (34).

7.3 Role of a family member/friend in communication process

Posma et al (11) found that bringing another person to the consultation was favourable in outcome in helping the older patient remember the information and discuss concerns.

However, Greene et al (35) found that when a relative or friend accompanied the older patient to a consultation, the patient was less likely to ask questions, less assertive and expressive and less likely to be involved in the decision-making process.

Greene and Adelman (36) also concluded in a later paper that an accompanying person can change the dynamic of the communication process either positively or negatively. If the person is present at the patient's request and provides positive support and accurate information to the patient, then their presence is to be welcomed. Butow et al (37) found that over a third of patients preferred to be on their own with their physician when given their diagnosis.

Communication with older patients
• Introduce self and other members of team • Unsolicited use of the patient's first name should be avoided as a matter of respect • Provide verbal information in a structured, step-wise, logical fashion • Do not give an information 'overload'. Summarise the most relevant information for each individual patient • Use simple language and avoid jargon • Repeat the most pertinent points • Provide a summary of information in another format also (e.g. one page information sheet) • Ask the patient if he/she has any questions and answer appropriately

Table 1. Communication with older patients

8. Communication with paediatric patients

When a child is diagnosed with cancer, the initial reaction is to focus on prognosis. Accurate understanding of prognosis is important so that parents and adolescents can make more informed treatment decisions. Parents of children with cancer may be overly optimistic or pessimistic about the outcome of treatment. Parent misconceptions about the likelihood of cure are influenced by many factors including misunderstanding of the information provided to them by healthcare professionals and incorrect information provided to them from other sources, such as the internet (38). Therefore, it is incumbent on all health professionals involved in the cancer care of children to adopt a family-centred approach. Family-centred care encompasses the 'professional support of the child and family through a process of involvement, participation and partnership underpinned by empowerment and negotiation' (39).

For children and adolescents with cancer, hospitalisation causes loneliness, losing out on enjoyable aspects of their lives, and concern for their families (40).

A common theme in communication practices with children is in fact the lack of communication expressed by children of all ages. It has been reported that age is not at all a useful guide in determining children's preferences for information (41).

Like adults, not all children want to know everything (42). Some children find information overwhelming and some are content when communication is directed to their parent simply because they fear hearing bad things (43).

Younger children (<10 years) generally interact little during consultations (44). van Dulmen et al (45) found in a Dutch study that during consultations, 35% of children said nothing at all.

Lambert et al (46) found that children's participation in the communication process was based on the children's ability to articulate their desire to engage in the communication process, health professionals' attitudes towards communication with children and the hospital environment itself.

8.1 Preparing a young child for radiotherapy

Younger children are often distressed when faced with a course of radiotherapy. They are alone in unfamiliar surroundings in the dark during set-up, the noise of the linear accelerator can be frightening and they are asked not to move. Children who are being treated in a prone position, for example for craniospinal irradiation in medulloblastoma are increasingly likely to be distressed. The understandable distress of parents who observe their child in these surroundings can also add to the anxiety experienced by the child. Effective communication with the child and parents is critical in minimising trauma to both parents and child.

To prepare the child for the radiotherapy process, the radiation therapy team should have discussions with the child and parents about the steps involved in preparation and treatment. Use of age-appropriate props can assist the child in understanding the process, such as video or picture books. For younger children, an opportunity to bring their favourite soft toy into the treatment room and 'model' the treatment procedure with the soft toy, such as placing stickers with marks on the soft toy, raising the treatment couch, dimming the room lights and switching on the laser alignment system all aids in the child's comprehension of the process. Inclusion of siblings in this process may also assist the family in explaining the radiotherapy process to the entire family.

Allowing the child to play his/her favourite music in the treatment room and facilitating the child's parent to speak to him/her over the intercom system during the treatment are also useful methods to overcome the fear of the noisy treatment room. Similarly, looking at projected images onto the ceiling can distract children being treated in the supine position.

A 'reward' system is used in many radiotherapy departments for children, where the child is given a sticker to place in a booklet after every treatment fraction. Some radiotherapy departments have specialised play therapists who work with the radiotherapy team in treatment preparation. This is especially useful should the child require the construction of an immobilisation device.

A child and his/her parents develop a unique relationship with the radiation therapists over the radiotherapy course as parents are entrusting their child to the radiation therapists every day. It is preferable for the same team of radiation therapists to treat the child every day to allow such a bond to develop and increase the likelihood of effective communication between the team and the family.

Communication with a younger child
• Use age-appropriate props to assist the child in understanding the radiotherapy process • Encourage the child to visit the treatment room prior to treatment and engage in modeling of the treatment using a soft toy • Involve play therapists for communication of difficult procedures such as the construction of a thermoplastic mask for paediatric brain tumours. • Involve other siblings and parents in the communication process • Use music in the treatment room, the intercom system and projected images on the ceiling to relax the child during radiotherapy • Use of a 'reward' system, such as sticker booklets communicates to the child that they have completed their treatment for the day

Table 2. Communication with a younger child.

8.2 Adolescent patients

Effective communication with the adolescent patient can pose a challenge for radiation therapy professionals. Adolescents with cancer require the radiotherapy team to understand intuitively when and how much interaction they want and seek at any given moment in time. Cantrell (40) suggests that knowing when to engage adolescents and when to provide them with time and space is an effective component of care.

In a study of 51 patients with cancer aged between 12-24 years, Dunsmore and Quine (47) found that adolescents with cancer wished to be more informed and involved in treatment decisions. They also found that the ability to listen, having genuine concern, clinical expertise and honesty facilitated healthcare professionals' communication with this population. Negatives reported included that communication was hindered by an impersonal manner, use of technical jargon, haste and the generation gap among healthcare providers. Hedstrom et al (48) interviewed 23 adolescents who described good care as being provided by healthcare professionals who were nice, friendly, supportive and competent. The same author postulates that receiving information assists adolescents with cancer in being active participants in their care and promotes a sense of security and control. Hinds et al (49) identified that humour used by nurses positively affects adolescents' behaviour.

Being authentic in caring is important to adolescent patients and is commented upon by them, well into survivorship. Cantrell (40) reports that survivors knew that nurses cared 'about them' in addition to 'caring for them' when they discussed other topics apart from their illness.

Adolescents have a strong desire for information relating to their illness, but their views on the relative importance of different types of information are not always the same as those of health professionals. Pfefferbaum and Levenson (50) found some significant differences between the groups indicating that health care professionals placed more importance on information about broader, psychological and social issues whereas adolescents placed more emphasis on basic factual information about aetiology, prognosis and late effects. However, there was some evidence of a common core of perceived information needs in the areas of illness severity and long-term effects of treatment.

9. Conflict

Conflict has been defined as a process that occurs within a group, which can take several forms. Some of these include hostility, decreased communication, mistrust, sabotage, verbal abuse and use of coercion (51).

Some level of conflict is inevitable when working in a pressurised, demanding environment such as a radiotherapy department. However, conflict does not have to be viewed as a negative entity; it can challenge our thinking and improve our practice. It can also be an energising experience. However, prolonged conflict in the radiotherapy department can result in a breakdown of communication either between healthcare professionals and patients or within the healthcare team itself. This is understandable when feelings are hurt, morale can become low and tempers flare. This ultimately leads to a negative experience for patients; hence early resolution of conflict through communication is advisable.

9.1 Conflict within the radiotherapy department: Staff

Conflict between healthcare professionals in the radiotherapy department manifests for a number of reasons. Role conflict can occur when the 'traditional' roles of some healthcare workers change due to increased education and hence role development and expansion. An example of this within the radiotherapy department is where radiation therapists have expanded their role from the traditional treatment and psychosocial support of the patient to include some tasks previously undertaken by the radiation oncologist or physicist, such as delineation of organs at risk and target volumes and treatment planning. Such role development for radiation therapists may lead to conflict between disciplines, if the rationale for the development is not clearly explained and the benefits acknowledged. Conversely, such development can motivate other radiotherapy professions to evaluate their own roles and seek to expand and develop them also for the benefit of patient care.

Status and education differences can also be a source of conflict between healthcare professionals. Where one professional believes themselves to be of a higher status than another within a team, conflict is inevitable. Education differences may be problematic where some professionals do not place value on the benefit of further education within the profession. This is due to fear of change as well as the perception that further education is a threat to the current status of the profession. In such circumstances, open communication between departmental managers and healthcare professionals can alleviate any such fears.

Poor communication skills can be detrimental to any working environment. Lack of communication between radiation therapists can ultimately impact negatively on the quality

of patient care as teamwork is essential for the successful preparation, implementation and delivery of a course of radiotherapy. Communication of the physical and psychosocial needs and supports of the patient is required to provide optimal care of the patient in the radiotherapy department. A fundamental role of the radiation therapist is critical analysis of the treatment technique and treatment plan and this can lead to conflict when decisions made by others are challenged. Querying decisions of others should be done calmly and politely, without attributing blame. Similarly, queries should be received and answered in the spirit in which they are put forward.

9.2 Managing conflict

There are many styles which healthcare professionals adopt to manage conflict as outlined by Eason and Brown (52).

These include:

Competing: This individual is aggressive and non-compromising and pursues their own goals, disregarding others. In essence, this individual is 'always right'.

Compromising: This individual is equally assertive of their own opinion and accommodating of others.

Avoiding: This individual does not address the conflict situation at all.

Accommodating: This individual is cooperative but is not assertive regarding their own position.

Collaborating: This individual is both assertive and cooperative and strives to find a mutually satisfying endpoint to the decision in question.

Managing conflict in the radiotherapy department is difficult when so many different styles of conflict management are present and inevitably, personalities clash. Departments who always adhere to evidence-based practice can alleviate conflict situations surrounding practice, as seen in case scenario 1. Conflict resolution in other instances relies on professionalism, open communication and a collaborative approach by all involved.

Case Scenario 1
Location: Radiotherapy Department **Staff Involved: Manager of the radiotherapy department, radiation oncologist (Dr. Smyth), radiation therapist (Kate) and physicist (Mark)** **Discussion: The implementation of a new breast technique** **Manager:** Thank you all for attending this meeting. We are here to discuss the suggestion of changing the three field breast technique to a monoisocentric technique. This was brought to me by Kate, a radiation therapist on unit 1. **Kate:** Thank you. I have been concerned for quite some time now about the dosimetric implications of a match-line on skin in our current 3-field breast technique. Off-line verification has indicated that in some patients, the match-line is not stable from one day

Case Scenario 1
to the next. I think we can do better. In the centre where I worked previously, a monoisocentric technique was used to overcome this problem. **Manager:** Mark, what is your opinion? Are Kate's concerns valid in your opinion? **Mark:** Absolutely not. I have been working for 20 years in planning and this has never been an issue until now. Yes, the match-line can tend to be a bit hot but if the radiation therapists got themselves sorted out to use on-line imaging, this would not be a problem. Changing a technique like this has huge implications for planning and we are not prepared to do it just because Kate prefers the technique she used elsewhere before. **Kate:** Mark, this has nothing to do with what I prefer. I am trying to introduce some progress in this department. (**Raises voice)** Just because you clearly are not interested in patient care, don't pretend there isn't a problem with the current technique, I can plan monoisocentric techniques myself if you can't. **Manager:** Let's all take a minute please. Kate and Mark, you clearly have contrasting views on the validity of changing the technique. Dr. Smyth, as the specialist breast radiation oncologist, is there any clinical evidence to suggest that changing the technique is something worth consideration? **Dr. Smyth:** Actually yes. There are articles which illustrate that a monoisocentric technique provides better dose homogeneity and also leads to fewer errors on-set. However, there are drawbacks also associated with this technique, such as the restriction in field length. I am happy to email these references to all here so that we can inform ourselves of the evidence. I understand that Mark has reservations about the workload and it needs to be considered, given the number of patients that are planned in this department each week. I can also see Kate's point of you; the technique as it currently stands is not optimal and it is time that we incorporated best practice in breast radiotherapy. **Manager:** Perhaps, Dr. Smyth you can email those references this afternoon and we can re-convene here again at the same time next Wednesday when we are better informed to have this discussion. Is that reasonable to all? **Mark:** Yes, fine with me. **Kate:** Me too. **Manager:** Thank you all for your input.

9.3 Conflict within the radiotherapy department: Staff and patients

Conflict between patients and healthcare professionals in the radiotherapy department can occur for many reasons. The radiotherapy department can be a difficult environment for patients and exacerbate the stress they are already under. Patients may be feeling unwell, tired from treatment and may be struggling to cope with their diagnosis and its management. Coupled with this, patients may be under financial and personal stress also. They may be faced with lengthy waiting times every day and on occasion, have to cope with the impact of linear accelerator breakdowns on their treatment. Therefore, it is not surprising that patients and healthcare professionals may sometimes come into conflict in the radiotherapy department. A typical instance is given in case scenario 2. The majority of such situations can be diffused through polite and calm dialogue away from the main waiting area.

Case Scenario 2
Location: Radiotherapy Department **Staff and patients' involved: Jill, Radiation Therapist and Head of unit 1; Mr. Murphy, a 45 year old patient receiving post-operative radiotherapy for colorectal cancer and John, a newly-qualified radiation therapist on unit 1 who is working on the unit for the first time today.** **Scenario: Jill returns from her lunch break to find Mr. Murphy outside the console area in a heated discussion with John.** **Jill:** Mr. Murphy, may I help you? **Mr. Murphy:** Jill, thank goodness you're back. This young man has left me here waiting for over an hour. **John:** Jill, Mr. Murphy had gone to see Dr. Smyth and his appointment card was not in the queue, so I didn't realise he was there **Mr. Murphy:** Didn't realise!! **(Raises voice)** You are walking in and out of that room constantly and you didn't realise I was in the waiting area. I am sitting where I always sit, where I have sat every day for the last 3 weeks! **Jill:** Let's take this discussion into the patient information room please. John, would you like to explain to me please what has happened here? **John:** Mr. Murphy, I have not treated you before, therefore I was not aware that you always sit in the corner of the waiting area. You know that we always identify patients with their name and date of birth in this department prior to treatment. I did not know that you were at Dr. Smyth's clinic or that you had returned. **Mr. Murphy:** Jill, this is unacceptable. I am late now for my business meeting and you know I don't want to tell anyone that I have cancer. **Jill:** Mr. Murphy, I can only apologise that you have been inconvenienced to this extent. As you are aware, we are extremely short-staffed in the department today and while this is not an excuse for the oversight, we are not operating as efficiently as we would like. You will be next for treatment and again I can only apologise. **Mr. Murphy:** I know you are always run off your feet. Its the thought of facing that business meeting when I am just exhausted.... **Jill:** Perhaps it's time you considered taking a few days off. You are into the 4th week of treatment at this stage and I can see that the fatigue is starting to take it's toll. I know that work is very important to you and I'm not suggesting you give it up entirely, but perhaps a day off at the beginning and end of the week is something you could consider? **Mr. Murphy:** I'll think about it Jill and John I'm sorry for getting so annoyed. **John:** I'm so sorry that you were waiting so long; I can assure you that it will not happen again.

10. Masculinity, femininity, body image and sexuality

Men and women have different experiences of cancer, not only because of differing biologies but also from differing expectations about appropriate gendered behaviour (53).

Body changes, such as coping with a stoma in colorectal cancer , gynaecomastia and erectile dysfunction in prostate cancer, breast conservation surgery or mastectomy in breast cancer and facial disfigurement resulting from surgery in head and neck cancers are extremely difficult for patients to cope with. Sensitivity on the part of the radiotherapy team is required when discussing body change and sexuality with patients.

However, masculinity and femininity do not refer solely to sexuality. They are complex phenomena, with sexuality only as one component. Cecil et al (54) reported that financial and employment issues, changed role within the family and community as well as body changes and body image all contribute to an altered sense of masculinity for male cancer patients, over a range of cancer sites. They found that men, in general, did not share their experience of cancer and some had even cut themselves off entirely from their social network. Saini et al (55) studying a group of prostate cancer patients found that depression strongly correlated with poor quality of life, anxiety and sleep disorders. This group also reported that while medics are aware of the metabolic and physical toxicity of androgen deprivation therapy in prostate cancer, little attention is given to its detrimental psychological side effects.

In colorectal cancer, Sharpe et al (56) report that the psychosocial consequences of stoma formation include sexual problems, reduced social functioning, increased level of depression and disturbances to body image. This group found that the stoma itself and its impact on function was not the direct cause of psychosocial problems, but was in fact the extent to which the stoma impacts on body image.

Gilbert et al (57) report that women with gynaecological cancer experience a range of negative feelings relating to their identity including weight gain, loss of femininity, anxiety about sexual attractiveness, concern about their partner's reaction to their illness and changed body and loss of confidence. These can impact negatively on a couple's relationship and can be compounded by a lack of information and support from health professionals about sexuality and sexual well-being (58). Weijmar Schultz et al (59) have argued that if healthcare professionals put an emphasis on the importance of information on sexual function at the time of general information-giving, this brings a sense of 'normality' to the couple's subsequent sexual discussions.

Women with breast cancer experience a range of negative emotions relating to body image and sexual identity. These can include: fear of loss of fertility, feelings of sexual unattractiveness, loss of femininity, depression and anxiety, concern about weight gain or loss, partner's reaction to their changed body appearance (60). Radiotherapy professionals can play a significant role in alleviating concerns surrounding sexuality post treatment, offering information on how to adjust to these changes, the use of sexual enhancement products or differing sexual positions. However, research indicates that further education of healthcare professionals in relation to this is required to address the needs of patients which are currently unmet in this regard (61).

11. Communication in a multicultural society

Effective communication between healthcare professionals and patients in the radiotherapy department can be challenged due to differences between individuals in our now global multicultural society.

11.1 Language barriers

Language barriers are not easily surmounted; it is difficult to establish an easy relationship when the language used by the healthcare professional for the discussion is not the first language of the patient. Interpreters may be used, but confidentiality issues become problematic. Coupled with this, it is not the role of a translator to deliver difficult or sensitive information to a patient. Family members who can speak other languages are useful, but again the health care professional is not quite sure that the patient has understood the information provided, when a third party is included.

11.2 Cultural differences

Differing cultures take differing approaches to healthcare. Generally, in Western society, it is common for patients to have active interactions with healthcare professionals regarding their treatment and illness. Other cultures may take a more passive role and healthcare professionals need to be aware of this and respond appropriately. Approaches to masculinity and femininity may vary from one culture to another and this must be respected by the healthcare professional. An example might be where it is not considered appropriate for a male radiation therapist to treat a female patient. Such cultural differences must be treated with sensitivity and understanding.

11.3 Value differences

Values may differ on how illness is perceived from one culture to another. For many years in Western society, a diagnosis of cancer was perceived as shameful and its treatment hidden from others. However, the role of 'conventional' medicine in Western society is well recognised and accepted; the healthcare professional must be cognisant that there are cultures where this is not necessarily so. Acceptance of death and dying also varies between cultures and when treating palliative patients, the radiotherapy team must be aware of this.

11.4 Religious beliefs

Healthcare professionals must be aware of and respect the religious diversity of all patients. Difficulties can arise when religious beliefs clash with what is believed to be the best treatment choice by the healthcare professional. The importance of informed consent in such an instance cannot be overstated.

12. Task sheet

Consider how you might adapt your communication style to provide information the following patients:

Patient A
Margaret is a 48 year old lady presenting to the radiotherapy department for treatment of an optic nerve glioma. She has lost vision in one eye as a result of her disease.

Patient B
Eric is a 57 year old male presenting with a glioblastoma multiforme to the radiotherapy department. He has significant personality changes and expressive aphasia.
Patient C
John is a 68 year old male who is attending the radiotherapy department for treatment to the prostate. John has been deaf since birth. John has specific communication needs.
Patient D
Adam is a 55 year old male with a T4 N2 tumour of the subglottis. He is attending for post-operative radiotherapy and has a tracheotomy in situ.
Patient E
Michael is a 20 year old male presenting for para-aortic radiotherapy for a testicular tumour. Michael has significant learning difficulties and lives with his parents.

13. Summary

Communication is key to the successful delivery of a course of radiotherapy. Radiotherapy professionals must be mindful of the differing needs of all patients and provide information in a timely, sensitive and supportive fashion, using whatever method is easiest for the patient to understand. Professional communication within the radiotherapy and multi-disciplinary teams is essential in providing the best care for the patient.

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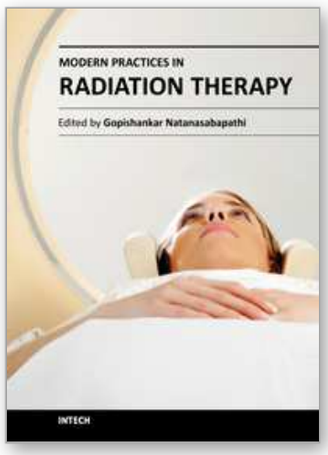
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Cancer is the leading cause of death in economically developed countries and the second leading cause of death in developing countries. It is an enormous global health encumbrance, growing at an alarming pace. Global statistics show that in 2030 alone, about 21.4 million new cancer cases and 13.2 million cancer deaths are expected to occur, simply due to the growth, aging of the population, adoption of new lifestyles and behaviors. Amongst the several modes of treatment for cancer available, Radiation treatment has a major impact due to technological advancement in recent times. This book discusses the pros and cons of this treatment modality. This book "Modern Practices in Radiation Therapy" has collaged topics contributed by top notch professionals and researchers all around the world.

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InTech Europe
University Campus STeP Ri
Slavka Krautzeka 83/A
51000 Rijeka, Croatia
Phone: +385 (51) 770 447
Fax: +385 (51) 686 166
www.intechopen.com

InTech China
Unit 405, Office Block, Hotel Equatorial Shanghai
No.65, Yan An Road (West), Shanghai, 200040, China
中国上海市延安西路65号上海国际贵都大饭店办公楼405单元
Phone: +86-21-62489820
Fax: +86-21-62489821

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