Exploring patient, family, and palliative care professional’s experiences of rapport in telehealth encounters.

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Abstract

Introduction: Telehealth has experienced unprecedented growth in response to the COVID-19 pandemic, as at that time healthcare moved away from in-person interactions to protect patients and staff. However, there has been concern from health professionals about the possible disruption to developing rapport when using telehealth with patients and families at home. This is particularly so in palliative care, where rapport is considered essential to patient and family care.

Aim: This study set out to explore the experiences of rapport between patients, families, and health professionals during telehealth encounters. The intention was to generate new knowledge and theoretical insights to improve the development of rapport during telehealth interactions in palliative care.

Methods: The study used an Interpretive Description approach with 3 phases: 1) patient and family interviews, 2) health professional focus groups and interviews, and 3) applying findings to the Theory of Human Relatedness.

Findings: This study provides several original findings. Firstly, a new conceptual definition of rapport was developed, grounded in the rapport experiences of patients and families during telehealth calls. Further, patients and families identified the “vibe” of the health professional as vital to the development of rapport during telehealth calls. The “vibe” was related to the presence and skill of the health professionals, not the technology used to communicate. Palliative care health professionals identified the complexities of telehealth calls and the soft skills required to develop rapport. Importantly, the adapted Rapport and Relatedness model identified interactions with a lack of rapport or pseudo-rapport which were unsatisfactory, and potentially harmful for patients and families, as well as health professionals.

Conclusion: This thesis adds important new knowledge about what constitutes rapport and how it is experienced during telehealth calls. Rapport is a vital soft skill that requires health professionals to be present and reflexive, with an associated need for training in rapport and telehealth. Interactions with rapport were the preferred state of relatedness during telehealth calls, and further research is recommended into interactions with pseudo-rapport or no rapport. Taken together, the findings of this thesis provide evidence that rapport, as defined in this study, can not only be achieved using telehealth, but rapport is fundamental to safe person-centred telehealth encounters.

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I am aware this study could not have happened without the generosity of a number of people.

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Publications and Presentations

Published papers

(In Chapter 3)

English, W., Gott, M., & Robinson, J. (2022a). The meaning of rapport for patients, families, and healthcare professionals: A scoping review. *Patient Education and Counseling*. https://doi.org/10.1016/j.pec.2021.06.003

(In Chapter 2)

English, W., Gott, M., & Robinson, J. (2022b). Being reflexive in research and clinical practice: A practical example. *Nurse Researcher*, *30*(2). https://doi.org/10.7748/nr.2022.e1833

(In Chapter 6)

English, W., Robinson, J., & Gott, M. (2023a). Rapport: A conceptual definition from the perspective of patients and families receiving palliative care. *Patient Education and Counseling*. https://doi.org/10.1016/j.pec.2022.10.012

(In Chapter 7, Part 2)

English, W., Robinson, J., & Gott, M. (2023b). Health professionals' experiences of rapport during telehealth encounters in community palliative care: An interpretive description study. *Palliative Medicine*, 026921632311722. https://doi.org/10.1177/02692163231172243

(In Chapter 7, Part 1)

English, W., Robinson., & Gott, M. (2023c). How are the vibes? Patient and family experiences of rapport during telehealth encounters in community palliative care. *Patient Experience*; 10(2):75-85. https://doi.org/10.35680/2372-0247.1786

(In Chapter 8)

English, W., Robinson., & Gott, M. (*Under review*). Applying experiences of rapport during telehealth calls to the Theory of Human Relatedness." *Communication in Healthcare Strategies, Media, and Engagement in Global Health*

Presentations

English, W. (2022, November). *The meaning of rapport: experiences of patients and families during telehealth calls in palliative care.*

Verbal presentation at the Hospice New Zealand Palliative Care Conference, Otautahi Christchurch, New Zealand.

English, W. (2023, September). *How are you? Experiences of rapport during telehealth calls*

Verbal presentation at the Oceania Palliative care Conference, Darling Harbour, Sydney, Australia.

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Glossary of Terms

English Glossary

The following terms are used frequently in this study. For the purpose of this study I have defined them as follows:

Encounter - a telehealth or in-person contact between a patient and a health professional (See also interaction).

Face-to-face - a meeting of people in the same room (See also in-person).

Family - includes relative, whānau, friend, carer, neighbour, and anyone else identified by the patient as comprising their family (See whānau).

Health care professional- a professional from any health discipline delivering palliative care. This includes but is not limited to nurses, doctors, dieticians, occupational therapists, physiotherapists, counsellors, social workers, and spiritual and cultural advisors.

Home- where the patient lives, which may be their own or a whānau/family member's home. It may also be an aged residential care facility.

Hospice- is both a philosophy of care and a place of care. The goal of hospice care is to help people with life limiting and life-threatening conditions to make the most of their lives by providing specialist palliative care.

In-person- a meeting or consultation where people are in the same physical space. According to The NZ Telehealth Leadership Group "in-person a very clear, unambiguous description of the interaction between patient and provider." (NZ Telehealth, 2023)

Interaction- the activity of being with and talking to other people, and the way that people react to each other either in-person or via telehealth.

Life limiting illness – a condition for which there is no reasonable chance of cure and from which the person is expected to die.

Palliative care – an approach that improves the quality of life of patients (adults and children) and their families who are facing problems associated with life-threatening illness. It prevents and relieves suffering through the early identification, correct assessment and treatment of pain and other problems, whether physical, psychosocial, or spiritual." (WHO, 2023).

Patient- someone with a life limiting illness who is receiving specialist palliative care. The term patient is used in this context to access the "patient perspective" acknowledging that being a patient is only a label used in the healthcare context.

Primary palliative care –is provided by all individuals and organisations who deliver palliative care as a component of their service, and who are not part of a specialist palliative care team. Primary palliative care is provided for those affected by a life-limiting or life-threatening condition as an integral part of standard clinical practice by any healthcare professional (Ministry of Health, 2015).

Specialist palliative care – is palliative care provided by those who have undergone specific training and/or accreditation in palliative care/medicine, working in the context of an expert interdisciplinary team of palliative care health professionals. Specialist palliative care may be provided by hospice or hospital based palliative care services where patients have access to at least medical and nursing palliative care specialists (Ministry of Health, 2015).

Telehealth – is health care delivered using digital technology where participants may be separated by time and/or distance (NZ Telehealth, 2023). Telehealth in this study covers equivalent terms such as telemedicine/telehealth/ telepallcare and is contextualised more specifically as "personalised health care delivered via digital technology (i.e. telephone and video calls) to patients and their families at home."

Te Reo Māori Glossary

I have used the following te reo Māori (Māori language) words throughout the thesis. The definitions are from Te Aka Māori Dictionary (2023).

Aotearoa - Māori name for New Zealand, usually translated as "Land of the long white cloud."

Kaihautū Māori - a Māori leader.

Kaupapa - a plan, a set of principles and ideas that inform behaviour and customs. For example, *Kaupapa* Māori research methods.

Karakia - a prayer or incantation used to invoke spiritual guidance and protection.

Kaumātua - a Māori elder.

Kai - food, an important part of manaakitanga.

Kaiāwhina- a helper, assistant, or advocate. In the hospice context kaiāwhina assist, liaise, and advocate for Māori patients and whānau and this term can be loosely translated as Māori liaison.

Kanohi ki te kanohi - face-to-face, in-person meeting.

Koha - a gift or offering of hospitality.

Korero - conversation, talking, meeting.

Hauora - a holistic view of health and wellbeing.

Hinengaro - of the mental and emotional realm.

Iwi – tribe.

Manaakitanga - care of others, cultural and social responsibility.

Mana - justice and equity reflected through power and authority; also refers to status and spiritual power.

Mana tangata - individual autonomy.

Manu whenua - authority in the land or territory.

Māori -indigenous people of Aotearoa, NZ.

Mate – death.

Mauri - life force.

Mauri Mate – the name given to the Māori Palliative Care Framework for Hospices. The work was commissioned by two hospices in 2019.

Pākehā – non-Māori New Zealanders.

Taonga – a treasure, an object or natural resource which highly prized.

Te Aka Whai Ora - (Māori Health Authority) is a statutory entity, formed in 2022, responsible for ensuring that the New Zealand health system meets the needs of Māori.

Te Aō Māori - Māori worldview.

Te Ara Tika - To follow the right path. The name given to a set of Māori ethical principles that draw on a foundation of tikanga Māori.

Te Ara Whakapiri -the unifying path. Te Ara Whakapiri (2017) provides principles and guidance for caring for people in the last days of their lives.

Te Ārai – the other side of the veil. This is the name given to the Te Arai Palliative Care and End of Life research group.

Te reo Māori - is the language of the indigenous Māori and is an official language of New Zealand along with English and Sign language.

Te Tiriti o Waitangi - (known in English as the Treaty of Waitangi) is an agreement made between representatives of the British Crown and (ultimately) more than 500 Māori. It was signed in Waitangi, Northland in 1840. There were two versions of the treaty, one in English and one in te reo Māori which held different meanings. Most Māori signed the te reo Tiriti. Māori and Pākehā have had different expectations of the treaty’s terms ever since (Orange, 2023).

Te Whatu Ora – (Health New Zealand) is the overarching organisation responsible for New Zealand’s national health service and works closely with its partner, Te Aka Whai Ora – the Māori Health Authority. Both were formed July 2022. One conceptual meaning of Te Whatu Ora is the “weaving of wellness.”

Tika - to be correct. For example. tika research design.

Tikanga - correct cultural practice.

Tinana - physical realm.

Wairua – spirit or of the spiritual realm.

Waiata – to sing or a song.

Whānau - a term for ‘family’, that includes relatives, friends, carers, and neighbours. Whānau is also social and relational in a wider context. In this study, I have used the inclusive term family/whānau dominantly throughout.

Whanaungatanga - forming and maintaining relationships and strengthening ties between kin and communities.

Whakapapa – genealogy, a line of descent from ancestors down to the present day. This concept also includes relationships and relatedness.

Abbreviations

WE- Wendy English

MG- Merryn Gott

JR- Jackie Robinson

TMM- Tess Moeke Maxwell

GP- general practitioner

NZ- Aotearoa, New Zealand

Structure of thesis

The publications included in Chapters 2,3,6,7 and 8 are presented as published (or as submitted for review) and follow the University of Auckland’s 2020 PhD Statute. In view of the word limitations associated with publications, further discussion is included where relevant, in order to add depth and provide a cohesive body of work. References have been standardised throughout to American Psychological Association (APA) style 7th edition, collated, and included at the end of the thesis. All pages, tables, and figures have been numbered consecutively throughout the thesis for continuity. Appendices provide supporting documents that have been included in the publications and, in addition, include documents such as ethical approvals, examples of participant information and consent forms, and examples of interview schedules.

Chapter 1 Introduction

Recapturing rapport

"Rapport building, at its heart, requires curiosity, a desire to understand others, and, most of all, the ability to listen.

These are becoming lost skills that we need to recapture in how we speak to others".

Excerpt from a published interview, Emily Alison, 2020.

Any conversation about giving context to the world in the early 2020's is likely to consider the impact of the COVID-19 Pandemic and global climate change. There has also been a war raging for a year on the other side of the world; a horrifying invasion of a sovereign nation Ukraine, by its neighbour Russia. The effects of all of these things are global, polarising, and long lasting. In the last few years while I have been studying, I have sometimes lain awake thinking of how little impact this work will have on any of these matters of global human politics.

On one hand this is true. However, I do see at the core of so many social, political, and indeed health problems that we face, is the need to communicate with each other in a more caring and connected way. I support the above comments from Emily Alison, psychologist, and a leading researcher of rapport. I too, believe that we need to recapture and enhance our abilities to develop rapport to maintain our humanity with each other. This is particularly important for those of us who are health professionals.

The topic of rapport has been a constant companion for me over the years. One of the key moments which set me off to research rapport further was a meeting I had with a blind man and his daughter for the first time in hospice.

> *He was blind and sitting in the dark room on the edge of his bed. His daughter came to greet me, and we sat on either side of him. He offered me his hand which I took into mine. Before I even had time to speak his daughter said, "This is your nurse dad, she seems lovely." He replied, "I know, I can tell by the way she is holding my hand." He opened his unseeing eyes and turned to me, my eyes welled up as I could indeed feel his warmth and connection as well as his vulnerability. His daughter said, "So you understand who he is?" I replied, "I do." We sat like this wordless for a few more moments.*

This encounter formed the basis for a wonderful relationship with what felt like strong rapport. It made me wonder what the experience must have been like for him. How did rapport happen just like that with no visual cues for him and no words from me? Did he feel rapport with me as I did with him? The encounter also made me question what his daughter was experiencing when she questioned my understanding of her father? Did she experience rapport? This encounter is a treasure that is still mysterious and yet some parts are very clear. It seems he assessed me by holding my hand and appeared not to need to hear my voice or know how much clinical knowledge I might have. This encounter seemed to be more about being present with the other. I have thought about this encounter often, as I explored the topic of rapport further in this research.

Chapter introduction

This study was conducted during the height of the COVID-19 pandemic between 2020 and 2023. The original topic and methodology for the research proposal was an ethnographic study of rapport experiences while in hospital, between people with palliative care needs, their families and health professionals. It became clear in early 2020 that the study in its original form was no longer feasible due to nationwide lockdowns, and the overload of hospital systems due to surges of admissions with critically ill people.

At the same time, there was a rapid uptake of telehealth across all health services, as in-person contacts were avoided due to public health and infection control precautions. This provided me with an opportunity to maintain my research interest in rapport, shifting my focus to the telehealth context. A new topic and methodology were chosen. Using a qualitative Interpretive Description approach (Thorne, 2016), this research set out to explore telehealth encounters from the viewpoint of the patients, families, and health professionals. I developed a research question that focused on participants' experience of rapport during these encounters. In this way, the research and its findings explore and pay homage to the everyday telehealth interactions between patients, families, and health professionals.

In this chapter, I introduce key topics related to the research in order to provide a rationale for, and demonstrate the significance of, the study. These topics include international trends in palliative care as well as the context for Aotearoa, New Zealand (NZ); how community palliative care is delivered in NZ; and the adoption of telehealth in palliative care both nationally and internationally. I then present the overall research aim, questions and objectives and provide an overview of the chapters covered by this study.

Palliative care trends

The World Health Organization (WHO) defines palliative care as "an approach that improves the quality of life of patients (adults and children) and their families who are facing problems associated with life-threatening illness. It prevents and relieves suffering through the early identification, correct assessment and treatment of pain and other problems, whether physical, psychosocial, or spiritual.” (WHO, 2023). An estimated 40 million people are in need of palliative care each year, but only 14% of those receive it (WHO, 2023). Globally, life expectancy has increased by almost 20 years over the last five decades, although overall morbidity rates have not changed (Hunter-Jones et al., 2023). However, due to the increase in non-communicable disease and associated co-morbidities the number of years lived without good health have also increased between 2000 and 2019 - from 8·6 years to 10 years (Sallnow, 2022). A “death boom” is predicted in some countries over the next two decades as a consequence of the post-war baby boom. The number of people experiencing serious health-related suffering is expected to double in the next four decades, increasing demand for palliative care (Sleeman et al., 2019).

Palliative care is recognised as a human right and providing palliative care should be considered an ethical duty for all health professionals (WHO, 2023). Yet, there is widespread inequity in who currently receives palliative care depending on where they live and what their social determinants of health may be (Mills et al., 2021). Other factors affecting the provision of palliative care are lack of public policy and budget, service unavailability, lack of awareness, inaccessibility, and low workforce knowledge and capacity (Lalani and Cai, 2022; Hunter-Jones et al., 2023).

Although most people prefer to die at home, hospital is still a common place of death in high-income countries (Jiang and May, 2021). Advances in medical care are also changing the nature of dying, with concerns that death is becoming increasingly medicalised (Gawande, 2014). Added to this, is a growing group of countries who have introduced Assisted Dying into law in the last twenty years, including NZ, nine states across United States of America and the District of Columbia, Canada, the Netherlands, Belgium, Luxembourg, Spain, Switzerland, and Australia (Sallnow et al, 2022).

In the recently published Lancet Commission on the value of death (Sallnow et al., 2022), the authors identified five principles that would contribute to a rebalancing of our relationship with death and dying. The second principle is particularly pertinent to this research: “Dying is understood to be a relational and spiritual process rather than simply a physiological event.” The Commission report described this principle as supporting the transition from curative medical care to palliative care when “relationships are prioritised and made central to care and support when dying or grieving, across all settings from care homes and hospitals to people’s homes. The quality of relationships between health-care professionals and patients shifts from the transactional to those based on connection and compassion” (Sallnow et al., 2022, pg. 870).

This principle aligns well with the concepts of rapport and person-centred care, which are considered integral to palliative care and are seen as important tasks for all health professionals (Storlie, 2015; WHO, 2023). The person-centered approach provides a context for rapport in this research, as it is characterised by interactions with compassion, dignity, empathy, and rapport (Epstein and Street, 2007; Grice et al., 2017).

New Zealand context

In NZ, the location for this study, the palliative care landscape has been shaped by a number of policy documents over the past two decades. Central government developed the New Zealand Palliative Care Strategy (Ministry of Health, 2001) and the more recent Palliative Care Action Plan (Ministry of Health, 2017). The action plan outlines five priority areas of palliative care in NZ:

1. To respond to the voices of people with palliative care needs and their families/whānau
2. To ensure strong strategic connections

3. To improve quality across all settings
4. To increase emphasis on primary/generalist palliative care
5. To grow capability of communities and informal carers.

This study aligns with priority areas 1 and 3, as it explicitly elicits the voices of people with palliative care needs and their families/whānau, as well as aiming to contribute to the improvement of quality in communication and care in the telehealth setting.

A national health system review in 2020, identified institutional racism and unacceptable health inequities for Māori, the indigenous people of NZ (Ministry of Health, 2022). For many years, Māori have experienced poor health outcomes compared to non-Māori, with evidence to indicate Māori often experience a public health system as hostile and alienating (Graham and Masters-Awatere, 2020). This review resulted in major health system reforms across NZ in 2022. The government established two new entities. One, Te Whatu Ora (Health New Zealand), is responsible for the day-to-day running of health services throughout the country (Te Whatu Ora, 2023). The second is Te Aka Whai Ora (Māori Health Authority) which is focused specifically on the health needs of Māori and is mandated to bring a major cultural paradigm shift throughout healthcare (Te Aka Whai Ora, 2023). Te Aka Whai Ora has the responsibility to educate, direct and guide the entire health system to understand and respond to the health and wellbeing needs of Māori. The main aim is to indigenise the health system and thereby improve health outcomes for Māori (Te Aka Whai Ora, 2023). This is a bold endeavour and will require a healthcare workforce that is adept at listening, communicating, and welcoming change in practices.

Viewed from an indigenous Māori perspective the purpose of palliative care is to provide comfort that encompasses the tinana (physical), hinengaro (mental and emotional), whānau (social and relational), and wairua (spiritual) domains to support the ill and dying person and their whānau (Moeke-Maxwell et al., 2019). To support education and the growing awareness of palliative care for Māori, “Mauri Mate: a Māori Palliative Care Framework” was developed that sets out a guideline for hospices with the aim in improving access for Māori to culturally appropriate palliative care (Hospice NZ, 2023). One of the recommendations is for “masterful” communication to be experienced as part of that care (Hospice NZ, 2023).

NZ has an estimated population of 5.1 million people. Of these approximately 38,574 people died in the year ended 2022 (Stats NZ, 2023). By 2045, the annual number of deaths in NZ is expected to rise to 45,000, with half of those dying being over the age of 85 years by 2037 (Coyle et al., 2021). The location of death, among New Zealanders who died of cancer between 2007 and 2018 was private residence (29%), followed by residential care facilities (27%), hospital (24%), hospice (19%), or other location (2%; Gurney et al., 2022). With the projected increase in older people with more comorbidities, palliative care needs will likely become more complex, and the need for community palliative care is also expected to rise (Coyle et al., 2021).

Community palliative care in New Zealand

Palliative care is provided in the community by primary palliative care and specialist palliative care teams in NZ. The aim for both is to provide integrated care that supports the person’s quality of life while also supporting their family. Primary palliative care is provided for those affected by a life-limiting or life-threatening condition as an integral part of standard clinical practice by any healthcare professional (Ministry of Health, 2015). Therefore, primary palliative care providers may include general practitioners (GPs), district nurses, aged care facilities, Māori health providers, and allied health teams.

When asked, people often state a preference to spend their last days in the comfort and familiarity of their own home, and community-based palliative care can help to make this possible (Van Dalen, 2021). Being cared for at home allows GPs and district nurses to address their patients' primary palliative care needs with the support of specialist palliative care as required, and as available. This integration of services aims to increase the sense of security of patients and caregivers at home with palliative care needs (Coyle et al., 2021; Frey and Balmer., 2022).

Specialist palliative care is palliative care provided by those who have undergone specific training and/or accreditation in palliative care/medicine, working in the context of an expert interdisciplinary team of palliative care health professionals (Ministry of Health, 2015). Specialist palliative care can be delivered directly or indirectly through providing advice, support, training, and education (Te Whatu Ora, 2023; Grundy and Vink, 2020; Coyle et al., 2021). Although there are specialist palliative care teams in some hospitals, specialist palliative care is mainly provided through hospice organisations. In a recent survey (Iupati et al., 2022), most NZ hospices provided direct hands-on community palliative care, whilst just over half also offered telehealth. Most hospices were also providing specialist palliative care for residents of aged residential care facilities (Iupati et al., 2022).

Access to specialist palliative care services appears to be inequitable in NZ. Disparities in access and utilisation is evident in two groups: that of Māori, who are not accessing specialist palliative care at the same levels as non-Māori, and rural communities with under-resourcing of specialist palliative care services in remote areas (Iupati et al., 2021). As the burden of non-malignant disease increases with the ageing population, and the anticipated increased need in palliative care, there is a call for community palliative care to become better funded and better staffed (Van Dalen, 2021). There is also a call to consider changes in the current model of care with different ways of engaging people with chronic conditions and palliative care needs anticipating increased needs and further pandemics (Iupati et al., 2022).

Telehealth and palliative care

The NZ Telehealth Forum defines telehealth in broad terms as “health care delivered using digital technology where participants may be separated by time and/or distance” (NZ telehealth.org, 2023). For this study, telehealth is contextualised more specifically as “personalised health care delivered via digital technology (i.e. telephone and video calls) to patients and their families at home.” In the last few years, hospices both internationally and in NZ, are making increased use of telehealth to deliver care in response to the COVID-19 pandemic (Frey and Balmer, 2022, Iupati et al., 2022). The use of telehealth increased as in-person consultations during the pandemic were severely restricted. Telehealth, through the use of video or phone call, became the safest way to consult and maintain contact with patients and families, (Frey and Balmer, 2022).

Pre-pandemic, a survey of telehealth activities across the District Health Boards in NZ reported two examples of active telehealth services within palliative care in Canterbury and Northland (Coyle et al., 2021). Then, during the pandemic, uptake of telehealth services increased, with half of all hospices providing some sort of telephone or video based telehealth service (Iupati et al., 2022). In the same survey, hospices were asked about their provision of after-hours services. There were 22 hospices with nursing support and 20 hospices with medical after-hours support, with four of these hospices offering telephone advice only. Six hospices reported no routine afterhours care was available for their patients (Iupati et al., 2022). The authors expressed concern for the lack of specialist telehealth services including after-hours services in some centres.

Telehealth seems to be an obvious choice to maximise a limited specialist palliative care resource. However, telehealth has not been the favoured way for palliative care professionals to work. Previous research shows that palliative care health professionals believe telehealth can offer an “added communicative value” but do not regard it as a replacement for in-person communication and home visits (Collier et al., 2016; Widberg et al., 2020). Indeed, palliative care health professionals consider in-person encounters to be the gold standard approach to patient consultations (Bradford et al., 2014).

There is growing evidence of telehealth being an effective mode of communication in palliative care. Several studies have found telehealth is an acceptable model of palliative care delivery in community and outpatient settings (Bandini et al., 2022; Calton et al.,2020; Keenan et al., 2021; Steindal et al, 2020; Gurp et al., 2015). Apart from being an effective infection control measure, telehealth also reduces travel and waiting times for patients. In addition, studies are reporting benefits for telehealth such as increased service efficiency and improved staff job satisfaction without increasing costs or compromising care within a community palliative care service (Haydon et al., 2021). However, concerns remain about difficulties developing rapport and connection during telehealth encounters from the perspectives of patients (Calton et al.,2020) and health professionals (Keenan et al., 2021; Lundereng et al., 2022; Jess et al., 2019). This is echoed in a recent NZ study reporting some hospice employees found it difficult maintaining a “human connection” when using infection control measures such as telehealth during the COVID pandemic (Frey and Balmer, 2022). The rapid growth of telehealth creates an imperative to understand the impact telehealth has on patient–family–health professional rapport.

Study Aim

The aim of this study is to explore patient, family, and palliative care professional’s perspectives of rapport in telehealth encounters. By doing so. the intention is to generate new knowledge and theoretical insights to improve the development of rapport during telehealth interactions in palliative care.

The scope of this study is to analyse the experiences of rapport during telehealth from the three identified participant groups. The scope does not include a comparison of telehealth to in-person consults, nor does it elicit patient and families satisfaction or acceptance with telehealth services as these are well served by other research studies.

Research Questions:

Two research questions guide the study presented in this thesis:

1. What are patients and families/whānau experiences of rapport with palliative care health professionals in telehealth encounters?
2. How do palliative care health professionals experience and manage rapport in telehealth encounters?

Research Objectives:

To address the research questions there are three distinct objectives:

1. To conduct approximately 20-30 semi-structured interviews with community hospice patients and their families to explore their experiences of rapport during telehealth encounters.
2. To conduct 4-6 focus groups with hospice healthcare professionals to explore their views of rapport within the context of telehealth.
3. To apply study findings to the Theory of Human Relatedness (Hagerty et al., 1993), to advance understanding of rapport during telehealth in palliative care.

To achieve the aims and objectives, a qualitative study using Interpretive Description design was conducted in three phases. Phase one included interviews with patient and family/whānau participants; Phase two included interviews and focus groups with health professional participants; and Phase three applied findings from phases one and two to the Theory of Human Relatedness (Hagerty et al., 1993).

Thesis overview

In this chapter, I have introduced the topic of rapport and telehealth in palliative care. I have provided a background for the study and highlighted why it is a critical subject for research at this time. I have also outlined an overall study aim, research questions and objectives.

In **Chapter 2**, I introduce myself and my interest in rapport by way of a researcher reflexivity statement. This includes a reflection on my reasons for undertaking this study, my personal and professional background, and my position on rapport. I provide examples of how reflexivity is embedded into the study process. This is followed by a published paper **“Being reflexive in research and clinical practice: A practical example.”** (English et al., 2022b), which examines the intersection of research and clinical practice through reflexivity.

Chapter 3 presents two literature reviews. The first review is a published scoping review on **“The meaning of rapport for patients, families, and health professionals.”** (English et al., 2022a). This review maps out the ways rapport is defined, conceptualised, and operationalised in the literature. A second literature review was undertaken and is entitled **“Exploring rapport during telehealth encounters for patients, families, and health professionals”**. This review synthesises the existing evidence on rapport during telehealth interactions. Further to this, I integrate the findings from both reviews and identify clear gaps in the literature.

In **Chapter 4**, I outline the philosophical and theoretical perspectives that underpin the study and inform the research design. The study employs an interpretive paradigm with a Symbolic

Interactionism perspective. I also describe the Theory of Human Relatedness and indicate how it is utilised in the study.

Chapter 5 describes the methodological approach of Interpretive Description. I provide details of the research design, the Reflexive Thematic Analysis approach used in data analysis and the ethical considerations for the study.

Chapter 6 includes the published paper **“Rapport: A conceptual definition from the perspective of patients and families receiving palliative care”** (English et al., 2023a) which describes the development of a conceptual definition of rapport. The definition is a major outcome of the study and is used as a framework for operationalising rapport.

Chapter 7 outlines the results from phases one and two of the study in two parts. Part 1 reports on the findings from patient and family/whānau member participants experiences of rapport during telehealth calls. This includes the paper currently in press, **“How are the vibes? Patient and family experiences of rapport during telehealth encounters in community palliative care.”** Part 2 reports on health professional findings which includes a published paper entitled, **“Health professionals’ experiences of rapport during telehealth encounters in community palliative care.”** (English et al., 2023b).

Chapter 8 outlines the results of applying the participant data from phases one and two to the Theory of Human Relatedness. This includes a paper under currently review **“Applying experiences of rapport during telehealth calls to the Theory of Human Relatedness.”**

Chapter 9 outlines the integration of study findings and discusses the major research outcomes. I reflect on the strengths and limitations of my research, the implications of the findings for practice, policy, and future research, and state my overall conclusions.

Chapter summary

This chapter has provided an introduction to the study, and an overview of the thesis chapters. Chapter 2 provides an introduction to the situatedness of the researcher and the approach to reflexivity in this study.

Chapter 2 Researcher Reflexivity

Chapter introduction

This chapter introduces how I situate myself within the research. I begin with an explanation for dedicating a chapter to reflexivity, I then provide examples of how I embedded reflexivity into various stages of the research process. I provide a reflexive statement which includes my reasons for conducting this study, my personal and professional background, and my position on rapport. This is followed by a published paper entitled **"Being reflexive in research and clinical practice: a practical example"** (English et al., 2022b).

Why a chapter on Reflexivity?

This chapter is dedicated to reflexivity as it plays a significant role in the study. A big part of qualitative research is understanding the meaning people make of their lives and a researcher's experience shapes how that meaning is understood (Smith et al., 2011). Reflexivity is considered inherent to qualitative research, as the researcher is a tool for data gathering and analysis (Burdine et al. 2021; Thorne et al., 2004). Engaging in reflexivity can make the researcher more conscious of not perpetuating power relations based on race, gender, class, sexual orientation, dis/ability, or religion, while also contributing to trustworthiness in qualitative research (Burdine et al., 2021).

Reflexivity is also part of phronesis or practical wisdom. In the research context phronesis has dispositions central to being a "good" researcher which include courage, respectfulness, resoluteness, sincerity, humility, and reflexivity (Macfarlane, 2010). The qualities of phronesis are the inspiration for this chapter, where the seeking of practical wisdom is pursued by using reflexivity as a researcher.

Embedding reflexivity into the research process

For this study, I have embedded reflexivity into all phases of the research, effectively "embedding reflexivity within" the research (Barrett et al., 2020; Olmos-Vega et al., 2022; Shaw, 2010). Table 2-1 outlines examples of how I have incorporated reflexivity into developing the research topic, the methodology and methods, data analysis and writing up.

Table 2-1 Embedding Reflexivity into PhD

Research topic	As a nurse I kept wondering what it was like for patients and families to meet health professionals and be on the other side of the rapport-building dyad. Reflexive writing helped me to determine that the topic and research question had to be centred around rapport.
Reflexive researcher statement	The first year of my PhD study included probing into my beliefs and pre-suppositions about rapport and nursing. I answered reflexive questions about gender, age, ethnicity and personal experiences, and political and professional beliefs (Berger, 2013; Etherington, 2004) which are included in the **Reflexive researcher statement** (see below).
Methodology	I wrote in my reflexive journal about the pivot-point taken in April 2020 as COVID-19 took hold. This was when it became obvious my study was no longer feasible during hospital "lock downs." I wrote how I felt about what was happening at that turning point for myself (including breaking my leg in two places), my study, and research during a pandemic. The topic and methodology of the research study had to change. I explored my feelings around having to release previous decisions and the many hours of learning about ethnography already undertaken. However, I found the Interpretive Description methodology (Thorne et al., 2004) both "resonated with my worldview" and my proposed new research question (Davis, 2020).
Methods	I wrote a reflexive memo after each interview and focus group. These memos included my thoughts about the interview itself, the participants, the setting, my own

	part in the interview and any insights or inspirations at the time. I also transcribed the interviews which can be considered a reflexive method (Berger, 2013). The published paper **Being reflexive in research and clinical practice: a practical example** (English et al., 2022b), describes using reflexivity to articulate the interface between research and practice.
Data analysis	I analysed the research data using the Reflexive Thematic Analysis approach which emphasises how themes and findings do not spontaneously emerge but are shaped by the study design and researcher decisions (Braun and Clarke, 2018; Davis, 2020). Included in the Data analysis section is **"Researcher reflection: Using NVivo with Reflexive Thematic Analysis to develop themes"** (Chapter 5, see Text Box 1).
Writing up	PhD with publication is a powerful way to provide reflexivity. Each manuscript submitted to a journal subjects my interpretation of the researched material to the rigours of peer review. Anonymous reviewers give critical feedback and question methodological decisions. Reviewer comments prompted reflection. In addition, during the writing process, I had regular and stringent supervision from my two academically accomplished supervisors. These meetings often resulted in me being reflexive, checking my writing against research objectives and aims.

Reflexivity Statement

Reflecting on the reasons for this study

At a simple level, this study is a response to curiosity about the human phenomenon of rapport. Creating rapport between patient and nurse is a human-to-human experience. With that human experience comes trust, care, and compassion for each other. I notice in the workplace how nurses and doctors develop rapport with patients and families/whānau. I notice the complexities around each interaction observed. I noticed that "nice" and "lovely" patients and families are desirable to care for, with perceived benefits for staff in these interactions. I noticed that “grumpy,” “angry,” “demanding” and “difficult” patients and families are not so desirable to care for.

In my clinical experience, the so-called grumpy patient needs more care and attention from the nurse to develop rapport. There is often a reason for the “grumpy” disposition such as pain, nausea, worry, grief, sadness, or even constipation. For some nurses this is a wonderful assessment opportunity and for others it is something to be avoided as unpleasant. The difference seems to me to be in how nurses approach rapport with patients.

Sometimes though patients are clear about not wanting to connect. They look at their laptops or out the window when the nurse is speaking. They avoid eye contact or refuse nursing help of any sort. Nurses described these types of encounters in my Masters study as frustrating and affecting their nursing as they felt unable to give these patients the "full service" (English, 2018). For the nurses the “full service” was person-centred, based on rapport and rewarding for both parties.

So, it appears that there are complexities in patient encounters. What the research does not tell us is what exactly is happening for the patients and their families/whānau in their interactions with health professionals. I wanted to understand more about rapport to be able to describe what is happening and why it is important for each person in the interaction. My aim was to produce research that health professionals can relate to and that can improve rapport in practice and in turn improve patient outcomes.

Personal and professional

I am a white cis female, and probably considered middle class with an above average education level. I am married with a young adult daughter. These aspects of my social identity are sometimes in line with who I care for as a nurse, but I am aware my background characteristics are often very different to many of the patients and families I care for.

I am also a registered nurse with knowledge and experience of nursing in mental health, renal medicine, primary care, and hospice. I adhere to the nursing code of conduct and meet the competencies of my profession (Nursing Council NZ, n.d.). My nursing practice is philosophically patient-centred and holistic. I consciously aim to provide the highest level of care possible to patients and families. I have learned from a Te Ao Māori (the Māori world) approach that everything I say, do, think, or feel affects the mauri (life force), mana (status, spiritual power) and wairua (spirit) of the people I care for. Therefore, I have a responsibility to be a warm caring presence for whomever I care for.

As I work in palliative care it is important to include here my approach to religion and spirituality. I was brought up as a Catholic, with nuns as teachers at boarding school and mass every weekday. I left the church at age 15. Despite this, I am grateful for what the Sufi teacher Rumi says is the experience of formal religion as a path to finding my own way "to believe in God and goodness."

I believe in goodness, hope, love, and kindness and even a karmic sense of doing good as a way to live and I value enthusiasm, humour, and a positive outlook. I love caring for people with Buddhist, Hare Krishna, Muslim, Christian, agnostic or atheist beliefs and learn from each encounter. I have had deep and profound experiences with patients around their faith, which may be because I have no blueprint for how it "should" look to believe in spiritual matters. However, I appreciate my personal worldview is fundamentally different to the people I care for as a palliative care nurse and the people I interviewed as patient participants of this study. I am not dying, I cannot "know" what it is like to be dying. I cannot put myself there, but at a human level I can relate to grief, loss, pain, and love.

Position on rapport

As a nurse with decades of nursing experience, my belief is that rapport is important. I understand rapport to be a positive warm healing experience that can fill the potential space between two people in any interaction and create connection. As a result of believing this, I personally experience rapport like this in my interactions every day. In my clinical practice I intentionally create rapport to be in partnership with my patients and their families.

My experience of rapport was not always like this though. I was unconscious of rapport and its potential at the beginning of my nursing career. Rapport was often talked about as something that needed to happen as part of being a nurse. Indeed, I cannot remember being asked if I felt I had established rapport with patients or families. The assumption was that establishing rapport is what nurses do. I thought that smiling and "being nice" were enough. When I felt awkward with a patient it meant I was more guarded and reduced my exposure to them. I became "busy" doing tasks and other things. These uncomfortable interactions were often with dying patients and families in complex situations. As a young nurse I was so affected, unprepared, and disappointed in my failures to connect and alleviate suffering, I decided to leave nursing.

Ironically, I learnt more about rapport outside of nursing. I sought training in communication techniques that emphasised rapport building skills such as Neurolinguistic Programming (NLP), transformational coaching and advanced sales communication courses. I also had "real life" application of rapport building throughout my work experiences, with the most rewarding coming as a café owner in the centre of a large city. This is where a set of rapport skills became a craft, which I exercised daily. I learnt about the joy of making rapport with fellow humans in simple and profound ways. These experiences are what I brought to my return to nursing and draw on as a researcher today.

Currently, I use my practice of rapport in palliative care nursing. Palliative care is a specialty that places value on communication and rapport with patients. Perhaps this comes from Cicely Saunders saying, "You matter because you are you and you matter until the end of your life" (Saunders, 2000). Something about this quote gives permission to care about each person and connect with them, because it is important to do so. Having rapport with patients and families is at the heart of what being a nurse is for me, and there is still much to learn.

Being reflexive in research and clinical practice

The following published paper was written in response to my reflexive findings during the research process. I became aware that research was somehow affecting my clinical practice and experiences. It took quite some time to identify the research-clinical practice interface, which acts much like an osmotic membrane between the two realms. The publication outlines the process undertaken and my analysis of the benefits to my practice. This paper is reproduced here in its entirety with permission from *Nurse Researcher* and cited as (English et al., 2022b) in following chapters.

English, W., Gott, M., & Robinson, J. (2022). Being reflexive in research and clinical practice: A practical example. *Nurse Researcher*, 30(2).

https://doi.org/10.7748/nr.2022.e1833

Being reflexive in research and clinical practice: a practical example

Introduction

Reflexivity is an invaluable skill for both nurses and researchers to help close the research-practice gap and improve nursing practice (Freshwater and Rolfe, 2001). Reflexive research can bring the academic researcher and the practicing nurse closer together. Nursing researchers with higher degrees have reflexive and critical thinking skills which can be applied to benefit their clinical practice (Ramsden, 2000; Peerson and Yong, 2003).

Indeed, the question posed in qualitative research is no longer whether to be reflexive, but how to go about ‘doing’ or practicing reflexivity (Finlay and Gough, 2003). However, whilst there is agreement as to the importance of being reflexive conceptually (Etherington, 2004; Dowling, 2006) it is sometimes difficult to determine what “being reflexive” means or how to demonstrate reflexivity in research (Doyle, 2013; Engward and Davis, 2015). Since Lincoln and Guba (1985), reflexivity has been discussed as being necessary for developing rigour in qualitative research. Reflexivity encourages the researcher to self-monitor beliefs, and personal experiences and their impact on research; while enhancing congruency and trustworthiness throughout the research process (Attia and Edge, 2017; Berger, 2013). Being reflexive is also important to understanding how to situate one’s biography and insider-outsider viewpoints in the context of the research (Hellawell, 2007; Davis, 2020).

Reflexivity is also a component of nursing praxis and holds benefits in terms of building clinical knowledge and improving practice (Timmins, 2006; Newman et al., 2008). However, reflexivity may be conflated with reflective practice in day-to-day nursing and be poorly understood (Peerson and Yong. 2003). Practical examples of reflexivity in nursing literature could assist in differentiating reflexivity from reflective practice and highlight the former to both nurses and patient care.

Academics and clinicians support closing the gap to bring research and nursing practice closer together (Leach and Tucker, 2018; Freshwater and Rolfe, 2001). One way to do this is to consider reflexivity in the context of the skills needed to “do” research and articulate the flow on effects for nursing practice. As there is little written about applying reflexivity between research and nursing, the aim of this article is to provide an example of reflexivity in research to demonstrate that knowledge and experiences are transferable to nursing practice.

Reflexivity and reflecting in research

The term reflexivity means turning the research lens back onto the researcher for constructive self-scrutiny (Finlay and Gough, 2003). By doing this, the researcher can recognise and take responsibility for their own positioning within the research in a type of self-monitoring during the research process. This means reflexivity is an active process that challenges the status quo, where the researcher examines their assumptions, decisions, interactions, and the potential impact they have on others (Berger, 2013; Barrett et al., 2020).

Reflexivity still has uncertainty associated with it and no agreed specific process to follow. As such, it is for the researcher to develop their own way of being reflexive (Braun and Clarke, 2022; Dowling, 2006). However, there appears to be three components that comprise reflexivity: 1) to reflect upon a situation using reflection-in-action and reflection-on-action, 2) having an outcome or action from the reflection, and 3) consideration of outcomes in context (Barrett et al, 2020; Schön, 1983).

Therefore reflexivity requires reflection but is different to reflection. Where reflection is intended to provide insight by looking at an action before or after it took place, reflexivity involves a more dynamic application of the reflected insight to new knowledge and understandings (Davis, 2020; Finlay and Gough, 2003).

Reflexivity and reflecting in nursing

Reflection and reflective practice are built into professional competencies (Nursing Council of New Zealand n.d.; Nursing and Midwifery Board of Australia 2021; Royal College of

Nursing, 2021) as a recognised way to access the knowledge embedded in practical experience (Stein-Parbury, 2018). Reflection encourages nurses to think about their actions and interactions in clinical practice and how practice may improve (Taylor, 2010; Johns, 2017). However, nurses tend to reflect on their clinical experiences with other nurses informally and this type of reflection may not always be critical. A lack of critique makes it questionable if such reflection results in the development of new knowledge or improved nursing practices (Fowler and Mc Garry, 2011).

Being “reflexive” on the other hand requires nurses to go beyond the superficial level of reflecting on incidents, to deeper levels of reflection, in which nurses interrogate their own values and understandings (Nairn et al., 2012; Jenkins et al., 2019). However, it is doubtful that nurses undertake this level of reflective depth, perhaps due to unconsciously holding opposing values at the same time (e.g. holistic care and victim blaming) and lacking the work time or supervision to undertake being reflexive in practice (Nairn et al., 2012).

Yet, reflexivity is clearly articulated as a component of nursing knowledge development in the literature (Rolfe, 2006; Timmins, 2006; Reed and Shearer, 2011). One approach to reflexivity is examining the biases, assumptions. and values underpinning nursing practice (Peerson and Yong, 2003). Another approach to reflexivity is a process that has nurses reflecting on clinical situations, considering outcomes, acting on the resulting outcomes, and these actions contributing to nursing knowledge (Fowler and McGarry, 2011; Barrett et al, 2020). As such reflexivity is an approach to nursing that can enhance human-centred nursing practice and can ease what Benner (1982) saw as a tension between theory and the complex realities of clinical practice (Peerson and Yong, 2003; Timmins, 2006).

Finding the interface: Being reflexive about research and nursing

The term “gap”, as in closing the gap, between research and practice, is interesting as it refers to a space between research findings and everyday clinical practice. The gap refers to the long known challenge to engage clinicians in research findings and applying them to practice (Rolfe, 1993; Seymour et al., 2003). Reasons for this challenge, include nurses being time-poor and over worked, succumbing to the influence of custom and tradition on nursing rituals and nurses not being aware that knowledge has changed (Leach and Tucker, 2018).

Researchers who are also nurses are well positioned to consider an interface rather than a gap between the two domains of research and clinical practice (Wendler et al, 2011). Conceptually an interface is a meeting point. Finding this interface requires seeing things from a different viewpoint and being reflexive. Reflexivity requires taking a meta-reflective stance, which is like the view from a hot air balloon ride over the domains of research and nursing practice. This balloon ride provides a panorama above the distractions of daily clinical life and makes it easier to identify the research-practice interface and make insights over both domains.

Below, I provide an example of exploring the research-practice interface with reflexivity drawn from my own experience of working as a palliative care nurse, whilst undertaking a PhD. The process involved a series of three reflexive activities that investigated a change in clinical interactions that I noticed while also conducting research. The first reflexive exercise involved noticing the change in patient and family reactions and identifying the role of research in this change (see Reflexive exercise 1). The second activity related to the communication skills developed and enhanced by using research skills (see Table 2-2); and the third activity examined an example of how the insights gained during a home visit were integrated into practice (Reflexive exercise 2).

Reflexive exercise 1:

Noticing a change in practice and exploring the reason

I began noticing a change in my nursing interactions visiting palliative patients and families at home. I found myself thinking, “That’s interesting, that is the third time recently a patient has given me that kind of feedback.”

The change in my patient interactions was confusing, as for the first time in my years as a nurse I was getting unsolicited verbal feedback from patients about the benefits to them from our first meeting. Something had changed or transformed in how I related with patients and families- they really wanted to tell me what they experienced in our interactions.

What became obvious when I began investigating this further was that the changes in my communication happened in parallel to my research experiences. I was researching full-time, with 1-2 days a week as a nurse in community palliative care. This meant I was interviewing participants and analysing data as a researcher at the same time as meeting patients and their families at home as a nurse. As a nurse researcher, I asked myself, **“*How is what I am learning in the research process affecting my nursing communication practice?”***

I adopted a meta-reflective position of reflecting on my reflections to determine what had changed in my communication (Freshwater and Rolfe, 2001; Verdonk, 2015), and to view how researching was influencing my nursing. I considered the research activities of interviewing, transcribing and analysis as potential influences on my thinking and behaviour in clinical practice. Table 2-2 outlines with reflexive journal notes how each of these research activities developed qualities in my communication practice.

Table 2-2 Communication skills developed during research

Research Activity	**Reflexive notes**	**Qualities developed**
Interviewing	As a researcher I attune to the participants' verbal and non-verbal responses during interviewing. I often explored the response participants gave and asked for more information with phrases like "That is interesting, Tell me more about that." Taking this approach of "exploring" into clinical practice has been like opening a door for people to talk about their experiences more freely. This works well when I am listening deeply.	• Exploring and Curiosity • Deep listening
Transcribing	Transcription provides opportunities for practicing reflexivity as a researcher. By listening to the recorded verbal (all utterances) and nonverbal (silences, pauses, volume, tone of voice and laughter, breathing), I recalled the participant's body language. I learnt about myself and my rapport-building style by listening to my questions and comments as the researcher. I heard my quickness to fill the void and hurry things along at times. Transcription of the spoken word can pick up a pause, or the moment a hidden thing is being spoken of. I can hear a turning point in the dialogue. As a result, I have expanded my listening abilities beyond hearing just the words spoken.	• Holistic listening • Self-critique of interviewing and rapport building
Analysis	I am building experience with analysis of data and constructing meaning. The analysis process saw many ideas and codes come and go. This was an exercise on being fluid and flexible in my thinking which was different to many clinical problem solving situations. Bringing this sense of flexibility to clinical interactions relieves me of the self-expectation of having to solve all the problems presented by patients and allows deeper listening to the meaning of what is being said. Researching encourages listening to understand.	• Flexibility of thinking and expectations • Finding meaning • Listening to understand

Reflexive Exercise 2: Distilling reflection into practice

After reflecting on recent clinical encounters with patients I could see how each of the research activities of interviewing, transcribing and analysis influenced my communication practice with patients and families. The following is an example of a patient and family encounter where I identified two of the qualities developed during researching: listening to understand and finding meaning (from table 2-2).

The conversation occurred with a dying woman and her partner who was experiencing great conflict as “the carer”. I met them in their home for an initial visit and we had a complex conversation about the disruption the patient’s dying caused to their lives and their relationship. During the conversation I was aware of a “shift” in both the patient and her partner. It was in later interactions that each person independently spoke to me of the benefits to them of that first conversation:

Patient: “You know that first visit to our house, I told you things I had not spoken before, I saw myself differently after that. It has helped me accept things as they are a bit more”

Partner: “That first time you came and talked with both of us… was when I felt really listened to and seen. It changed things for me, I could see I needed to get more help for myself.”

During our initial meeting I felt I had rapport with them both and a sense of trust established. I provided a space for an intimate conversation, giving each of them time to talk and be listened to, that seemed to help them to make realisations about themselves and the difficult situation they were in. We had many other conversations together, but it was that first in-depth encounter that allowed some sort of healing to occur for them both (as reported by them to me).

I reflected at the time that “something happened” but not quite sure what, alerting myself to reflect more deeply on this later. I have no sense of saying anything clever or profound. In fact, the moment I perceived that “something happened” was in a pause between the three of us, a silence. It seems that my listening with the intention of meeting them as people and understanding how things were for them was enough to allow some sort of meaning making for them.

Reflexivity helped me to identify that the skills I developed in researching had moved seamlessly into my practice:

Listening to understand- In the reflective memo after this visit I wrote that I was not doing or saying anything “clever” or giving advice. This is an insight for me as a nurse, as I can have a lot of important things ready to tell people! Before, I may have been superficially hearing and composing the next question or answer, whereas now, I relax my position as a problem-solver to one of listening better and longer. Researching has changed my listening. I want to understand more about who I am with and their experiences.

Finding meaning- One of the most impactful changes I now observe is when patients and families find their own meaning in these interactions, evidenced by the feedback they give to me. This feedback seems important for them to give and adds meaningfulness to my nursing practice.

Learning research skills and being reflexive as a researcher has had a transformational influence on my relational practice as a nurse. The changes are sustained and integrated into my nursing practice.

In this example, being reflexive helped generate knowledge about research skills filtering across the interface between a research project and clinical practice. The most difficult part of the process was teasing out what research skills were involved and what was different in the interactions with patients. On the other hand, when these skills and behaviours were identified the concept of an interface made it easier to think about the transferability of skills and knowledge from one domain to another. Reflexive journaling also provided clues and helped make sense of the changes and insights gained. Being reflexive as a researcher prompted being reflexive about nursing.

One view of reflexivity is that it can result in “communication into the deeper domains of human experience” (Freshwater and Rolfe, 2001, pg. 530). The qualities of listening to understand and finding meaning developed in the researching process, transferred into nursing, creating a sense of really being with the person. "Being with" patients demands a capacity in the health professional to be comfortable with their own feelings, thoughts, and reactions, and to manage them appropriately (West, 2015). Reflexivity is one way to for nurses to become more comfortable with themselves and thereby the patients and families they interact with.

Just as who we are and what we bring to research shapes and informs research (Braun and Clarke, 2022), the same is true for nursing. Who we are as individuals, what we believe, our values, social identities, training, and experiences shape and inform each individual nursing practice. When adopting a reflexive approach to nursing the first step is to decide to "be reflexive" and to take an active reflective approach starting with oneself. Taking a self-inventory to explore the taken-for-granted aspects of social position, education, gender, culture, and political influences is considered the essential beginning to becoming a reflexive researcher (Braun and Clarke, 2022). A self-inventory could be argued to be equally essential for nursing professionals interacting with any patients and families. Reflexive journaling is a recommended way to capture thinking, feelings, and changes in approaches in or about clinical situations (Etherington, 2004). As well as learning about self in relation to others, the notes and memos in journals can also become the basis for research projects, discussions, and teaching.

Reflexivity encourages critical thinking, lateral thinking, and innovation. As a practice, it is well placed to develop the critical *and* creative thinking needed by researchers and nurses to transfer knowledge into person-centred nursing care (Peerson and Yong, 2003; Seymour et al., 2003). Taking the plunge into a more reflexive practice will likely be rewarding to both practitioners and their patients.

Conclusion

Reflexivity is important in research and nursing practice, although there is some doubt how well reflexivity is implemented in nursing. This article provides an example of being reflexive that helps generate knowledge about research skills filtering across the interface between a research project and clinical practice. Being reflexive as a researcher and a nurse can have a transformational influence on improving nurse-patient interactions.

Chapter summary

This chapter has demonstrated how I have embedded reflexivity throughout the research process. I included a researcher reflexivity statement and a published paper which examines the intersection of research and clinical practice through reflexivity.

Chapter 3 provides an overview of the current literature through two literature reviews. Firstly a scoping review on **“The meaning of rapport for patients, families, and health professionals”** and secondly an integrative review entitled **“Exploring rapport during telehealth encounters for patients, families, and health professionals.”**

Chapter 3 Literature review

All nurses know that they are supposed to have rapport with their patients but how many know just what this word means?

Joyce Travelbee - Nurse, Professor, Theorist.
“What do we mean by rapport?” 1963.

Chapter introduction

This chapter includes two literature reviews. Firstly, a published scoping review entitled **“The meaning of rapport for patients, families, and health professionals”** (English et al., 2022a). The aim of this review was to map out the existing literature on definitions, conceptualisations, and operationalisations of rapport in clinical settings.

This is followed by an integrative review, presented as an unpublished paper, entitled **“Exploring experiences of rapport during telehealth encounters for patients, families, and health professionals.”** An integrative review was undertaken to build on the knowledge gained from the scoping review and to synthesise the literature on rapport and telehealth.

I then provide an integration of the findings from both reviews, identifying gaps for further research and provide evidence to support the research question and objectives of this project. Finally, I present an update to the telehealth review which was conducted in December 2022. The purpose of the review update was to explore the impact of the pandemic in palliative care in relation to rapport and telehealth.

Preamble to scoping review

To begin a study about the experiences of rapport, it is important to know what rapport means in the context it is experienced. Developing rapport with patients and families is regarded as essential in palliative care (Seccareccia et al., 2015), however, after a preliminary search of the literature there seemed little evidence to support this assumption. Furthermore, it was difficult to identify a commonly used definition of rapport that could support operationalising rapport for the purposes of the study. A scoping review method was chosen as it accommodates a broad question and aims to map out the literature to provide a cohesive picture of the topic being explored (Peters et al., 2015). The scoping review is presented here as published in *Patient Education and Counseling*, with permission from the publisher. This is the first of two published papers in 2022 and is therefore cited in following chapters as (English et al., 2022a).

English, W., Gott, M., & Robinson, J. (2022). The meaning of rapport for patients, families, and healthcare professionals: A scoping review. *Patient Education and Counseling*, *105*(1), 2–14. https://doi.org/10.7748/nr.2022.e1833

The meaning of rapport for patients, families, and healthcare professionals: a scoping review.

Introduction:

“Establish rapport" and “build rapport” are phrases familiar to health professionals. Establishing rapport is an expected outcome of first meetings with patients. It is also a measure of professional communication competencies (Nursing Council of New Zealand, n.d.; Royal College of Nursing, 2020; Royal College of Physicians and Surgeons of Canada, 2020). Doctors, nurses, and allied health professionals cite rapport as important to establishing effective patient relationships (Duchan and Kovarsky, 2011; Hall et al., 2009; Leach, 2005; Ross, 2013). Rapport is considered an antecedent to trust (Leslie and Lonneman, 2016; Epstein and Street, 2007) and aligned to empathy and respect (Lang, 2012; Ali and Ndubisi, 2011). It has been found to have a positive impact on patient outcomes (Duchan, J. F. & Kovarsky, 2011; Lang, 2012; Ross, 2013) improving patient satisfaction, treatment adherence and reducing the risk of medical errors and complaints (Lang, 2012; Leach, 2005). However, despite rapport being in common use and described as fundamental to professional-patient relationships, it seems to have a presumed meaning in the healthcare setting (Ali and Ndubisi, 2011). Literature reviews have recently attempted to define other complex terms in common use in healthcare, such as resilience (Aburn et al., 2016), caring (Gillespie et al., 2017) and person-centred care (Byrne et al., 2020). It is therefore timely, to identify and critically synthesise evidence regarding how rapport between patients and health professionals is defined and understood.

Since being described in 2001, patient-centred care (IOM, 2001) is now included in the WHO Integrated people-centred health services framework (WHO, 2016). This framework supports the ideal that everyone deserves to be the centre of the care they receive from healthcare providers. For patients to be at the centre of their care requires health professionals to use patient-centred communication (Epstein et al., 2005) which can be a sophisticated procedure taught and honed throughout a career (Levinson, 2011). If patients are to develop trust with health professionals, patient-centred communication and the ensuing relationship must begin with rapport (Becker, 2020).

Terms like rapport are used colloquially in healthcare as if everyone understands what is meant (Ali and Ndubisi, 2011). It has been suggested that everyone has “rough and ready” definitions of rapport (Tickle-Degnen and Rosenthal, 1990). For example, rapport is said to occur when people “click” or are “on the same page” (Kromme et al., 2016; Bernieri, 2005).

Despite acknowledged difficulties defining terms like rapport (Bernieri, 2005; Guthrie and Beadle-Brown, 2006) there are good reasons to define, conceptualise and operationalise such terms. Without a commonly agreed definition of rapport in research or practice, the concept is open to interpretation and potential confusion (Byrne et al., 2020). A definition provides coherence and assurance to readers and clinicians that the same concept can be compared over different studies. However, defining a concept alone can still leave “fuzzy imprecise notions” (Allen, 2017 pg.4], whereas conceptualisation specifies the concept precisely and identifies its characteristics (Allen, 2017; Martin et al., 2013). Further to this, operationalisation of a concept specifies the variables and measurement tools that result in empirical observations (Allen, 2017).

In 1963, Joyce Travelbee argued rapport is at the heart of the nurse-patient relationship. However, she also identified the lack of research on the topic and no “operational definition” of rapport (Travelbee, 1963). Travelbee’s question “what do we mean by rapport?”, provides a focus for this scoping review to explore how the concept of rapport is defined, conceptualised, and measured in clinical interactions.

This scoping review aims to identify the nature and extent of literature relating to rapport in the healthcare setting, by 1) ascertaining how rapport is defined, conceptualised, and operationalised; 2) exploring the factors that hinder and facilitate rapport between patients, families, and health professionals, and 3) identifying gaps in the current evidence to inform future research.

Methods

A scoping review methodology can clarify working definitions and provide conceptual boundaries for a topic of complex nature (Peters, 2015). Scoping reviews also contribute to academic knowledge (Arksey and O’Malley, 2005) by mapping literature and providing a richly informed starting point for further research (Peterson et al., 2017). No existing scoping or systematic review on rapport was identified in either Joanna Briggs Institute (JBI) Database of Systematic Reviews and Implementation Reports, or Cochrane Database of Systematic Reviews.

Search methods

Population, Concept, and Context (Joanna Briggs Institute, 2019) guided the research question and selection criteria. “Population” was defined as the patient, family/whānau, and health professionals, the “Concept” was rapport, and the “Context” was rapport in the healthcare setting. As appropriate for a scoping review, a broad question was posed to scope the breadth of evidence on the topic of rapport (Arksey and O’Malley, 2005).

The question that directed this review is: How is rapport defined, conceptualised, and operationalised in healthcare within the context of patients, families, and health professionals?

Data sources

To identify potentially relevant documents, the following databases were searched CINAHL plus, psychINFO, and Medline Ovid with date limit 2000-present. This time period marks the release of Institute of Medicine “Crossing the quality chasm” (IOM, 2001), and a corresponding increase in research concerning rapport. The search strategy was developed with the support of an experienced university librarian.

Inclusion Exclusion criteria

The following inclusion and exclusion criteria were adopted:

Table 3-1 Inclusion Exclusion Criteria

Inclusion criteria	Exclusion Criteria
• Available in English. • Healthcare professionals including physicians, nurses, allied health professionals who have direct patient interactions • Patients, defined as persons >19 years receiving care from health professionals • Family members or caregivers of patients • Rapport had to be defined and/or indicate how rapport was characterised, conceptualised, or operationalised in the study and include rapport in the findings or discussion. • Any adult healthcare settings where direct interactions between patients families and health professionals occur.	• No patient of family interactions with health professionals • Only interprofessional communication • Solely within the context of telehealth or technology communication • patient sample was < 19 years or included simulated patients

Search terms

Key words and their variations and subject headings related to the four main search areas: 1. rapport, 2. patient OR family, caregiver 3. healthcare professional, professional, allied health professionals, physician, doctor, nurse, nurs*.

Search Strategy

The Joanna Briggs Institute (JBI) three-step approach (Joanna Briggs Institute, 2019), to searching the literature was followed.

1. Initial limited search of two databases relevant to the topic (CINAHL, Medline).

2. Keywords and index terms searched across all included databases.
3. Hand searching of reference lists of identified papers for additional studies.

Data Extraction

A data extraction table was adapted from JBI (Joanna Briggs Institute, 2019) to record key information relevant to the review question from the selected studies (Appendix 1.1). Table 3-2 defines the terms definition, characterisation, conceptualisation, and operationalisation as used in the review.

Table 3-2 Defining terms used in the Review

Defining terms used in the Review– definition, characterisation, conceptualisation, and operationalisation of rapport for this review		
Dimension of research question:	Definition used for this dimension	Boundary for data extraction
- **Definition**	A statement expressing the essential nature of rapport.	Defines concept of rapport and may have differentiating characteristics
- **Characterisation**	To mark or distinguish as a characteristic of rapport	Identifies potential indicators of rapport
- **Conceptualisation**	Specified concept and set of indicators identified	Includes both concept and indicators of rapport
- **Operationalisation**	The process through which the concepts are translated into measurable variables.	Includes both concept and indicators of rapport with measurement tool identified.

Synthesis

Knowledge synthesis was undertaken using a thematic analysis to collate, summarise and map data. Thematic analysis was used to identify commonalities in the way rapport is written about in these studies (Braun and Clarke, 2019). The six steps of thematic analysis were used as outlined in Braun and Clarke (2006). Analyses were undertaken by the lead author with support from the co-authors.

Results

The initial search yielded 510 studies; 61 duplicates were removed. Title and abstract were screened, and a further 333 studies did not meet the inclusion criteria and were removed. A full text review of 116 studies was undertaken by WE. This reduced the selected number of studies to 34. A PRISMA-ScR (Scoping review extension) flowchart (Equator network, n.d.; Tricco et al., 2018) was used to record the selection process. Where there was uncertainty as to whether the studies met the inclusion criteria, further discussion with JR and MG was undertaken to ensure rigour.

General characteristics of studies

Twenty-five studies were published since 2011. Most of the studies were from western countries (n=30), with the remainder from Africa (n=2), Japan (n=1), and UAE (n=1). The selected papers studied clinical relationships in the following contexts: 1) physician/patient (Albahri et al., 2018; Beach et al., 2018; Beach et al., 2006; Eksteen and Marsh, 2019; Flickinger et al., 2016; Gilbert and Hayes, 2009; Ghods et al., 2008; Gudzune et al., 2013; Henry et al., 2017; Hurley et al., 2018; Insua-Summerhays et al., 2018; Jonassaint et al., 2013; Lelorain et al., 2014; Martin et al., 2103; Ogrin et al., 2020; Paasche-Orlow and Roter, 2003; Raingruber, 2001; Ratanawongsa et al., 2008; Shaw et al., 2012; Song et al., 2020), and 2) patient/family/health professional (Cené et al., 2017; Segaric et al., 2015; Seccareccia et al., 2015). Other studies interviewed or surveyed patients (Gehenne et al., 2020; Leonard and Kalman, 2015; O'Lynn and Krautscheid, 2011; Umihara et al., 2016; Williams and Ogden, 2004; Zink et al., 2017). While other studies focused on health professionals (Belcher and Jones, 2009; Dean and Oetzel, 2014; Kromme et al., 2016; Tracey, 2008), and family (Adams et al., 2014). Twenty studies were quantitative methods and fourteen were qualitative methods.

Key Findings:

Thirty-four studies met the selection criteria. A thematic analysis of the selected studies resulted in identification of two main themes: 1) "The meanings of rapport" which maps out the various definitions, characterisations, and operationalisations of rapport, and 2) "Implications for building rapport" which identifies the factors that facilitate or hinder rapport.

The meanings of rapport

"The meanings of rapport" included three sub-headings: The scarcity of definitions and conceptualisations of rapport; the quantitative operationalisation of rapport; and the qualitative characterisations of rapport. To analyse the diverse nature of the operational definitions and characteristics of rapport, it was decided to initially analyse the studies in methodological groupings of quantitative or qualitative.

The scarcity of definitions and conceptualisations of rapport:

Five studies used some form of definition for rapport (Eksteen and Marsh, 2019; Henry et al., 2017; Insua-Summerhays et al., 2018; Kromme et al., 2016; Lelorain et al., 2014). Four credited references to previous theory or studies which included Bernieri et al., 1996; Bernieri, 2005; Epstein and Street, 2007; Hall et al., 2009; and Leach, 2005 (Henry et al., 2017; Insua-Summerhays et al., 2018; Kromme et al., 2016; Lelorain et al., 2014). The study without a reference, simply stated "Rapport is the ability to form a therapeutic relationship" introducing rapport as a subscale in a questionnaire (Eksteen and Marsh, 2019). The definitions of rapport included three components: 1) a term to describe the type of relationship, 2) a key concept, and 3) listed characteristics of rapport. Henry et al, (2017) and Kromme et al, (2016) included three components and shared three of the characteristics listed, i.e. positive affect, mutual attention, and interpersonal coordination. There were no conceptualisations (as per table 3-2 definitions) in any of the reviewed studies.

Quantitative Operationalisations:

All twenty quantitative studies had some attempt to operationalise rapport. Thirteen used the Roter Interaction Analysis System (RIAS; Roter and Larson, 2002) for coding rapport-building (Beach et al., 2013; Beach et al., 2013; Cené et al., 2017; Flickinger et al., 2016; Gilbert and Hayes, 2009; Ghods et al., 2008; Gudzune et al., 2013; Henry et al., 2017; Jonassaint et al., 2013; Martin et al., 2013; Paasche-Orlow and Roter, 2003; Ratanawongsa et al., 2008; Shaw et al.,2012). The RIAS is a widely used medical interactions coding system with an established reliability (Roter and Larson, 2002; McCarthy et al., 2013). These studies used RIAS trained observers who listened to recorded dialogue and placed each "complete thought" into categories of talk. The categories relating to rapport-building were positive rapport, negative rapport, emotional rapport, and social rapport (Table 3-3). Further to the categories of talk, four studies also rated the affect of the physicians and patients (Beach et al., 2006; Flickinger et al., 2016; Gehenne et al., 2020; Henry et al., 2017). The RIAS coding system was used either alone or in combination with other measurement tools such as questionnaires. The additional questionnaires in these cases did not generally have rapport related items but were used to capture different aspects of the research questions being studied.

Five studies, however, did use questionnaires to operationalise rapport. Two studies used the Medical Interview Satisfaction Scale (MISS) questionnaire designed to determine the patient satisfaction of the physician-patient consultation (Eksteen and Marsh, 2016; Williams and Ogden, 2004). Another study assessed the Consultation and Relational Empathy (CARE) questionnaire for patients rating clinicians' rapport-building (Gehenne et al., 2020). A study in emergency departments used a questionnaire for patients to assess physician self-disclosure and its impact on rapport-building (Zink et al., 2017). An interesting stance taken by Albahri et al, (2018), was for physicians and patients to answer a questionnaire to look at "failure of rapport-building".

Two studies included one item on their questionnaires to measure rapport (Lelorain et al., 2014; Umihara et al., 2016). Yet, both studies had findings on rapport such as: rapport was the key rated behaviour for patient satisfaction Umihara et al., 2016) and making a link between physician self-rated rapport and empathetic accuracy (Lelorain et al., 2014).

The thirteen studies that used the RIAS coding system had trained observers recording the results as observer-rated items relating to rapport-building which gave a third-person viewpoint to findings. Five studies reported findings from the perspective of the patients. However, in each case the patients assessed the rapport-building of the health professionals they had engaged with and not the patients' own experiences of rapport (Eksteen and Marsh, 2019; Gehenne et al., 2020; Umihara et al., 2016; Williams and Ogden, 2004; Zink et al., 2017).

Table 3-3 Quantitative operationalisations and measurements

1.Roter interaction Analysis System (RIAS)	**Types of talk and utterances that reflect engagement by patients or health professionals in the encounter.**
Positive rapport	Laughter, approval, compliments, agreement/understanding (Cené et al., 2017; Gudzune et al., 2013; Jonassaint et al., 2012; Martin et al., 2013; Paasche-Orlow and Roter, 2004; Ratanawongsa et al., 2008; Shaw et al.,2011). (Authors used some or all of the items listed) Example: “You look fantastic.” “You’re doing great”
Negative rapport	Criticism, disagreements, concern (Cené et al., 2017; Jonassaint et al., 2012; Martin et al., 2013; Ratanawongsa et al., 2008; Shaw et al.,2011). “I think you are wrong; you weren’t being careful.” “No, I wouldn’t want that.”
Emotional rapport	Empathy, legitimation, concern/worry, partnership/ reassurance, optimism, or self-disclosure (Beach 2006; Cené et al., 2017; Flickinger et al., 2016; Ghods et al., 2008; Gudzune et al., 2013; Jonassaint et al., 2012; Martin et al., 2013; Paasche-Orlow and Roter, 2004; Ratanawongsa et al., 2008; Shaw et al., 2011). (Authors used some or all of the items listed) Emotional talk examples: concerns- “I’m worried about your leg”; reassurance- “I’m sure it will get better”; empathy- “It sounds like you are angry about it”; partnership- “We’ll get through this together”; legitimation- “Anyone going through this would feel that way” (Paasche-Orlow and Roter, 2004).
Social rapport	Chit-chat, or personal remarks (Cené et al., 2017; Gudzune et al., 2013; Jonassaint et al., 2012; Martin et al., 2013; Paasche-Orlow and Roter, 2004; Ratanawongsa et al., 2008; Shaw et al.,2011). (Authors used some or all of the items listed) Example: “How about those Red Sox last night?”
Patient-physician rapport	Overall rapport; liking; attention; coordination; mutual trust (Henry et al.,2017).
RIAS Emotional tone Global affect	Physician positive affect, which was the sum of ratings of interest, friendliness, responsiveness/ engagement, sympathy, and +/- hurried/rushed (Beach, 2006; Ghods et al., 2008).
Patient affect	Warm/ friendly, tense/anxious, engaged/attentive, disagreeable/antagonistic, upset/distressed, sad/depressed, dominance/assertiveness behaviors. Included in addition for

Physician affect	physicians: hesitant/uncomfortable and rushed/ hurried (Flickinger et al., 2016; Ghods et al., 2008; Henry et al., 2017).
Patient negative affect	Anxiety, irritation, depression, and emotional distress behaviors (Ghods et al., 2008).
2.MISS rapport subscale:	The health worker seemed interested in me as a person. The health worker seemed warm and friendly to me. The health worker seemed to take my problems seriously. I felt free to talk to this health worker about private matters. The health worker gave me a chance to say what was really on my mind. I felt that the health worker understood me. This is a health worker I would trust with my life. The health worker seemed to know what (s)he was doing. I would like to be seen by this health worker again. (Modified MISS-21, Eksteen and Mash, 2019; Williams and Ogden, 2004).
3.Nonverbal Checklist	Gazes, nods, or shakes of the head, eyebrow movements, smiles, direct interpersonal orientations, interpersonal touches, and back-channels (Gilbert and Hayes, 2009).
4.Dimensions of relationship	Non-dominance -2 items Trust and receptivity- 2 items Affection, depth, and similarity- 6 items (Gilbert and Hayes, 2009).
5.Establishing rapport process. **From the CARE questionnaire,**	3 items joined for the “establishing rapport process”. Patients assessed clinicians on: • Making you feel at ease • Letting you tell your story • Really listening (Gehenne et al., 2020).
6.Failure of rapport building	The physician is not showing interest in the patients issues The physician is not being empathetic The physician’s manner is unsatisfactory Patient’s lack of interest in building a partnership with physician

	Patient’s lack of trust with physician Difficulty establishing rapport (Albahri et al., 2018).
7.Patient Rating provider rapport	4 questions rated for rapport • Provider communication skills: excellent- very poor • Provider rapport: excellent- very poor • Importance of building good relationship with provider: very important- not at all important • Satisfaction with provider communication skills: very satisfied- very dissatisfied (Zink et al., 2017).
8.Physician-perceived rapport with patient	‘What is the quality of your relationship with this patient?’ rated from 1 ‘very difficult relationship’ to 7 ‘very easy relationship’. *Rapport was assessed by a single 7-point Likert ad-hoc item (Lelorian et al., 2014).
9.Patient-scored rapport	Please score communication levels between you and your doctor on a scale of 0 to 10 with 10 being the highest. *One item in a patient questionnaire (Umihara et al., 2016)

Qualitative Characteristics:

No operationalisations were identified in the fourteen qualitative studies, instead each study detailed characteristics of rapport which were found in the results sections of the studies. Thematic analysis of the characteristics resulted in six different categories: Interpersonal coordination, positivity, connector qualities, verbal talk, nonverbal behaviours, and health professional specific (see table 3-4). The total number of characteristics of rapport identified was 72.

The qualitative studies reported findings in relation to rapport from the point of view of the participants. Patients reported their views on the value of rapport (O’Lynn and Krautscheid, 2011) and the importance of rapport when being touched by health professionals during procedures (Leonard and Kalman, 2015; Ogrin et al., 2020). Health professionals reported views on their role as rapport builder (Tracey, 2008), and the role of rapport in productive interactions (Kromme et al., 2016). In addition, health professionals described the tensions of building rapport in emergency departments (Dean and Oetzel, 2014), and developing rapport and trust with patients (Belcher and Jones, 2009).

Four studies reported both patient and health professional views on establishing rapport (Hurley et al., 2018; Song et al., 2020), verbal and nonverbal congruence and rapport (Raingruber et al., 2001), and rapport in one-on-one observations (Insua-Summerhays et al., 2018). Two studies reported viewpoints on rapport-building from patient, families, and health professionals (Seccareccia et al., 2015; Shaw et al., 2012). One study reported solely on family members views, focusing on identifying the rapport-building strategies nurses used that helped the family cope (Adams et al., 2014).

Table 3-4 Categories of rapport characteristics from qualitative studies

Interpersonal coordination: **between the members of the dyad.**	Agreement Harmony Accord Synergy Reciprocity Engagement Reciprocal engagement	Emotional Congruence Attunement Mutuality Mutual support Positive interpersonal dynamics Clicking
Positivity: **demonstrated by patient, family, or health professional**	Affirming Giving full attention Giving support Offering a welcome Turn taking Listen and hear with thoughtful attention Responsiveness	Personalising the interaction Social closeness by drawing on common culture Humour /telling jokes Taking the time Understanding Showing concern Caring

	Liking each other Positive regard	Knowing the other on a personal level Find common ground
Connector qualities: **Either personal or relationship qualities. Could be demonstrated by patient, family, or health professional**	Honesty Openness Authenticity Transparency Comfortable Friendliness Personable Positive affect	Companionship Sympathetic Empathetic Acceptance Recognition Building trust Reassurance Listening
Talk/verbal:	Small talk Using names, remembering names Kind words and assurances Using a common language (not jargon)	
Nonverbal behaviours:	Making eye contact Sitting close Symmetry Physical mirroring	Matching speech Shared cadence and rhythm Using touch, interpersonal touches, Nonverbal communication
Health professional specific:	Professional credibility Professionalism Will “be there” for patients See patient as human being Encouraging patients and families to talk and ask questions. Being approachable Holding family members in high esteem	Being affable Acknowledge family member Demonstrate patience Be willing to engage Be willing to admit mistakes Doing the job with heart

Implications for building rapport

Thematic analysis of all the studies identified two key factors that enable rapport-building and three factors that hindered rapport-building.

Factors that facilitate rapport-building

The two sub-themes that facilitated rapport-building were "deceptively simple acts" and "taking the time to connect as human beings."

Deceptively simple acts

A "good welcome" was considered by patients and health professionals to be crucial to the success of the consultation and subsequent adherence to treatment (Hurley et al., 2018). A good welcome included a patient being greeting with a smile, perhaps a handshake and knowing the persons' name, and a few small details about them, such as asking about the well-being of their family (Hurley et al., 2018; O'Lynn and Krautscheid, 2011). Patients described other simple acts that enhance rapport such as being hugged, made cups of tea, or taken for walks (Insua-Summerhays et al., 2018). Both health professionals and patients highlighted that talking about topics such as patients' lives and interests outside the hospital facilitated rapport-building (Insua-Summerhays et al., 2018).

For family members in an intensive care unit study, staff demonstrated concern for patient and family by making eye contact, facing the family, and coming to the phone when family members called. These behaviours were crucial for establishing rapport with families (Adams et al., 2014). In Céne et al (2017), patients valued having a companion present in consultations with health professionals, and this was generally perceived by health professionals as helpful for facilitating rapport. Other studies concluded simple techniques such as health professionals giving warning before touching patients (Leonard and Kalman,

2015) and matching the vocabulary used by patients (Williams and Ogden, 2004) could facilitate rapport. Similarly, health professionals who used mindfulness (Beach et al., 2013) self-disclosure (Zink et al., 2017), or the simple gesture of holding a person’s hand were perceived as behaviours that can facilitate rapport (Segaric et al., 2015).

Take the time to connect as human beings

Patients and health professionals in six studies identified “taking the time to make human connections” as a key behaviour that enhanced rapport-building (Belcher and Jones, 2009; Insua-Summerhays et al., 2018; O’Lynn and Krautscheid, 2011; Segaric et al., 2015; Seccareccia et al., 2015; Tracey, 2008). According to patients, health professionals facilitate rapport when “staff sit down, have a cup of tea with them, talk to them and start to understand them as people” (O’Lynn and Krautscheid, 2011). Staff participants in three studies concluded that by “actually sitting down with somebody trying to seek understanding from them is a normal human connection that can help someone” and made rapport-building easier (Belcher and Jones, 2009; Insua-Summerhays et al., 2018; Segaric et al., 2015; Seccareccia et al., 2015). Results from a study of physical therapists showed that both touch and spending adequate time to help clients were essential to building rapport and to having a positive influence in their ongoing therapy (Tracey, 2008).

Factors that hinder rapport-building

Seventeen studies provided evidence of factors that hinder rapport-building. The three sub-themes encompassed: workplace time tensions, a sense of awkwardness and health professionals avoiding patients, as well as patients and families being judged and uncared for.

Workplace time tensions

Five studies identified workplace time tensions which resulted in health professionals deferring or avoiding building rapport. Patients and health professionals perceived time pressure as a major barrier to communication (Albahri et al., 2018; Belcher and Jones, 2009; Dean and Oetzel, 2014; Hurley et al., 2018; Seccareccia et al., 2015). Patients felt hesitant to speak of their concerns when providers seemed rushed or when the provider focused on the phone, computer, or paperwork (Hurley et al., 2018). An emergency department study identified one workplace tension as “efficiency versus rapport”. The findings showed health professionals consistently chose efficiency and completing tasks over establishing rapport with patients due to a perceived lack of time (Dean and Oetzel, 2014).

A study of general practice physicians found response to time pressures resulted in either limited rapport-building during a consultation, or no rapport-building during low quality consultations (Albahri et al., 2018). A nursing study in acute care, identified the tension between spending time with patients versus schedules (Segaric et al., 2015). Increases in patient acuity, higher nurse-patient ratios and lack of staff continuity meant task completion was prioritised over time spent building rapport with patients. Patients and families felt ignored and viewed nurses as incompetent when nurses were too busy to establish rapport (Segaric et al., 2015). Balanced with these time limitations were suggestions that some health professionals may choose to spend their time poorly on tasks and choose to step back from patient interactions (Belcher and Jones, 2009; Segaric et al., 2015).

Sense of awkwardness and avoidance

Patient participants expressed a sense of awkwardness or discomfort with health professionals which created a barrier to building rapport in seven studies (Hurley et al., 2018; Insua-Summerhays et al., 2018; Lelorian et al., 2014; Leonard and Kalman, 2015; Ogrin et al., 2020; O’Lynn and Krautscheid, 2011; Williams and Ogden, 2004).

Not surprisingly patients felt distanced from health professionals who did not offer a warm welcome or who had a “grimace on their face” saying they did not feel comfortable or inclined to listen to the advice given (Hurley et al., 2018). Patients also reported feeling uncomfortable with health professionals who did not match their vocabulary, resulting in less rapport and less patient satisfaction (Williams and Ogden, 2004). Sometimes, the patient and health professional did not understand one another due to language, cultural differences or using medical jargon (Albahri et al., 2018; Belcher and Jones, 2009; Hurley et al., 2018).

Patients felt uncomfortable without rapport during times of silence between patient and health professionals when procedures required touch, or when a procedure took precedence over the relationship (Ogrin et al., 2020). Patients reported not feeling at ease expressing their emotions when staff attempted to hold conversations without rapport (Insua-Summerhays et al., 2018; Lelorian et al., 2014; O'Lynn and Krautscheid, 2011).

Barriers to rapport-building occurred when health professionals avoided interacting with patients. Family members (Adams et al., 2014) identified staff demonstrating non-rapport-building behaviours such as looking at the computer and not making eye contact, turning their back to the family member, and not introducing themselves when the family member entered the room or at shift change. Another barrier was a lack of explanation given by health professionals to patients and family members about what is planned for them, leading to a lack understanding and trust that impeded the process of building rapport (Adams et al., 2014; Belcher and Jones, 2009; Seccareccia et al., 2015).

Feeling judged and uncared for

Four studies provided evidence of patients being affected by health professionals showing a prejudice towards them and the impact this had on rapport-building. These studies included persons of certain race, or patients with conditions like obesity and depression (Gilbert and Hayes, 2009; Gudzune et al., 2013; Jonassaint et al., 2013; Martin et al., 2013).

Two USA based studies involved aspects of race and rapport-building. Physicians uttered significantly fewer rapport-building statements during visits with patients of colour, compared to those with white patients (Martin et al., 2013). Additionally, when patients of colour presented as depressed or expressing anxiety or irritation, this emotional distress was identified as a barrier to physicians making rapport-building statements (Gilbert and Hayes, 2009). Although race was not a factor in Jonassaint et al (2013), depression symptoms were. Patients attending HIV outpatient clinic who reported more depressive symptoms, felt less respected and were less likely to report that their provider knew them as a person, than patients with mild depressive symptoms (Jonassaint et al., 2013). Similarly, patients in primary care with a body mass index (BMI) indicating obesity received less emotional rapport-building statements from their physicians (Gudzune et al., 2013).

Three studies provided evidence of patients feeling judged or uncared for by health professionals which not only impeded rapport-building significantly but also placed patients and families at risk of poor outcomes (Adams et al., 2014; Insua-Summerhays et al., 2018; Segaric et al., 2015). Some health professionals demonstrated non-rapport-building behaviours, which family members described as condescending, dismissive, or impatient (Adams et al., 2014). These non-rapport-building behaviours resulted in family members having dissatisfaction, difficulty coping, lack of trust and confidence in care, hesitancy to ask questions, and anger. When family members perceived a nurse as uncaring, or unprofessional, they voiced mistrust and distress at that nurse’s attempts to engage in end of life discussions (Adams et al., 2014).

Patients and family members characterised a lack of interaction or negative interpersonal dynamics between nurses and themselves as feeling they had “fallen through the cracks” (Segaric et al., 2015). This meant patients were potentially without caring professional relationships or adequate care (Kromme et al., 2016; Segaric et al., 2015). In extreme cases, an interaction was characterised by mutual resentment and staff who did not care about patients. One patient quote describes this lack of rapport with staff as “sometimes they’re a bit unapproachable, because you just feel that they don’t really give a shit.” (Insua-Summerhays et al., 2018).

Discussion

In this scoping review, we sought to identify the definitions, conceptualisations, and operationalisations of rapport within the context of patients, families, and health professionals. Thirty-four studies identified five definitions of rapport while no conceptualisations of rapport were identified. Quantitative studies operationalised rapport using coding systems and questionnaires and observer viewpoints, while the qualitative studies identified characteristics of rapport using participant viewpoints. Patients, families, and health professionals identified “deceptively simple acts” that facilitated rapport-building, along with health professionals “taking the time to connect as human beings” with patients. However, there was more evidence about the factors that hinder rapport-building with examples of time tensions, awkwardness leading to health professionals avoiding patients, and patients and families feeling judged and uncared for. Therefore, a key finding of this review is the knowledge gap between the theoretical definitions of rapport and the reported findings from participants when rapport is hindered.

No commonly shared definition of rapport was identified in this review, and only two definitions offered a context of relationship, concept, and indicators to define rapport. Where definitions were included, there were other limitations, namely, definitions not labelled as definitions making them difficult to find in the text (Eksteen and Marsh, 2019; Henry et al., 2017; Insua-Summerhays et al., 2018; Lelorain et al., 2014). Arguably, as readers we were left to surmise what is meant by rapport in most studies. It appears rapport may still be suffering from an assumed meaning among health professionals.

Even though rapport is a complex concept, it is surprising that no conceptualisation was identified in the review. In social science, conceptualisations are frameworks for constructing meaning about phenomena that form the basis for theories, research, policies, and practices (Guthrie and Beadle-Brown, 2006). In 1990, Tickle-Degnen and Rosenthal, offered a conceptualisation of rapport with three essential inter-relating nonverbal components: positivity, mutual attentiveness, and behavioural coordination (Tickle-Degnen and Rosenthal, 1990). Interestingly, these components echo through the reviewed studies and are in two of the definitions found (Kromme et al., 2016; Henry et al., 2017) but are credited to the work of Bernieri (Bernieri et al., 1996, Bernieri, 2005). Both studies (Tickle-Degnen and Rosenthal, 1990, Bernieri, 2005) focused on the nonverbal aspects of rapport as the “best place to look for and access rapport” (Grahe and Bernieri, 1999). Few nonverbal characteristics or operational measures were identified in the reviewed studies. One study used a nonverbal checklist (Ghods et al., 2008) and another study examined nonverbal markers in interviews (Raingruber, 2011). The prevalent RIAS coding system is based on the spoken word and the vocal and emotional tone of the interactants. It is therefore interesting to consider, that in healthcare currently, rapport maybe a verbal and nonverbal communication phenomenon that is predominately measured by verbal coding.

The operationalising of rapport was attempted in each of the quantitative studies, with seven different measurement tools identified. It is clear in each of the thirteen studies using the RIAS, what was measured as rapport and how it was measured. The RIAS gave examples for each category of coding (Table 3-3) and the results showed complex dialog dynamics between the patient and health professional. An advantage of a commonly used operationalisation can be analysing results of different studies. For example, one type of talk labelled “emotional rapport” was reported in the results of five studies (Cené et al., 2017; Gudzune et al., 2013; Jonassaint et al., 2013; Ratanawongsa et al., 2008; Shaw et al., 2012). The Roter system defined, observed, and recorded “emotional rapport” in a reliably similar way in all five studies allowing for a potentially meaningful analysis. Being mindful of contexts of study questions and settings, it would be interesting to analyse different types of rapport statements across studies using RIAS. This kind of data could provide a macro view on rapport during patient-health professional interactions.

The qualitative studies may have operationalised rapport, but this was not explicit in the study designs. The characterisations of rapport (Table 3-4) were all findings from interviews or focus groups. They illustrate the diverse nature of rapport but were not linked to commonly defined concepts or indicators of rapport. The result is a scattering of valuable data that could be collected into conceptual frameworks to construct meaning and consistency (Guthrie and Beadle-Brown, 2006).

Patients were asked to rate health professionals’ rapport-building performances (Beach et al., 2013; Beach et al., 2006; Eksteen and Marsh, 2019; Gehenne et al., 2020; Henry et al., 2017; Jonassaint et al., 2013; Williams and Ogden, 2004; Zink et al., 2017) and patient perspectives were sought about aspects of rapport-building (Hurley et al., 2018; Insua-Summerhays et al., 2018; Ogrin et al., 2020; Raingruber, 2001; Segaric et al., 2015; Seccareccia et al., 2015; Song et al., 2020). No studies explored patients and families lived experiences of rapport or how rapport (or a lack of rapport) affected their desired outcomes. However, there are examples of health professionals avoiding contact with patients and families, as well as subjecting patients to unkindness and unconscious bias that affect rapport-building (Adams et al., 2014; Gudzune et al., 2013; Insua-Summerhays et al., 2018). These types of interactions reflect what Halldorsdottir called “biocidic” interactions (Halldorsdottir, 2008). The danger of not exploring patients’ experiences leaves the impact of these negative behaviours hidden.

Rapport is more than the list of characterisations and measurements found in this review. Rapport is more than just a “click” that occurs spontaneously and more than the number of times that a health professional leans forward in an interaction with a patient. In fact, rapport has been described as a gestalt relational state between two or more people (Tickle-Degnen and Rosenthal, 1990) and as such provides a challenge to researchers to be explicit defining the dimensions of rapport being researched.

One definition from this review states “rapport is a perception of connection with another individual based on respect, acceptance, empathy and a mutual commitment to the relationship” (Epstein and Street., 2007) and a dictionary definition of rapport is (Merriam-Webster, n.d.) “a friendly harmonious relationship characterised by agreement, mutual understanding, or empathy that makes communication possible or easy.” Both definitions refer to a type of relationship and how it is characterised, both referring to empathy and a sense of mutuality. The inclusion of empathy is supported by a study where the medical and patient participants identified empathy as key to developing rapport (Norfolk et al., 2007). Others define rapport using the components of shared positive feeling, mutual involvement or focus of attention as identified by Tickle-Degnen and Rosenthal (Hall et al, 2009), while Spencer-Oatey (2007), simply refers to harmoniousness as reflected in smoothness and coordination in interactions.

When the definitions include terms such as harmony and empathy, it can be difficult to apply quantifiable measures to these terms (Grahe and Bernieri, 1999). Nonetheless, it is important to define and identify conceptualisations and operationalisations of rapport to build knowledge and understanding in a cohesive way. Consistent conceptual and operational definitions can assist health professionals to translate research into improved ways of practicing rapport clinically.

Research gaps

It was difficult to determine the effect rapport-building has on patient outcomes in this review. Along with the lack of definition as to what was measured as rapport, the concept of “patient outcome” was also not defined, making it problematic to analyse studies comparatively. Having commonly used definitions, conceptualisations and operationalisations of rapport may also improve the measurement of the effect rapport-building has on patient outcomes. Links between rapport-building and patient outcomes needs more investigation.

The review findings point to the need for more research that reflects the experiences of rapport from the perspectives of patients and family members. Further, this review identifies the lack of an operationalisation of the nonverbal aspects of rapport and in the same way as Huber et al, (2016) has re-operationalised health as patient-centred, it is worth considering developing further operationalisations of rapport as patient-centred.

The factors that hinder rapport, highlight the knowledge gap between the few theoretical definitions of rapport and what the clinical reality can be at times for patients and families. The studies in this review gave examples of health professional behaviours that are opposite to how rapport is conceptualised nonverbally (Tickle-Degnen and Rosenthal, 1990), with interactions that are not positive, not mutually attentive and with no interpersonal coordination. Research is needed to develop understanding of the impact of rapport-facilitating and hindering behaviours. These areas of research are also necessary for understanding the relationship between rapport and patient-centred communication.

Limitations

As the search was limited to the last 20 years, earlier studies relevant to the aim may have been missed. However, the research related to rapport has been increasing since the publication of IOM (2001) and has increased noticeably in the last 10 years with 25 of the reviewed studies published since 2011.

Despite having no limits on data types, the studies selected are all empirical studies. This is likely due to the inclusion criteria requiring rapport to be defined or operationalised. The studies selected were mostly from western countries which may limit the cultural context related to rapport from other countries.

This review was conducted as part of a higher degree (PhD), with the search strategy completed by one person (author 1). All elements of the review were discussed at length with academic supervisors to ensure adequate rigor and accuracy throughout the search, review, and analysis process.

Conclusion

This scoping review found no commonly shared definition or conceptualisation of rapport. While verbal coding was well represented, few nonverbal operationalisations of rapport were identified. Evidence showed that rapport is facilitated by simple, kind, human interactions that value the person, their family, and the health professional. Contrary to this, rapport is hindered by a lack of these human courtesies and this review provides examples of health professionals avoiding contact as well as subjecting patients to judgements and uncaring. Along with research into the patient and family experiences of rapport, having commonly used definitions and conceptualisations may improve measuring the effect both rapport and lack of rapport has on patient outcomes. Consistent conceptual and operational definitions can assist health professionals to translate research into improved ways of experiencing and practicing rapport clinically.

Implications for practice

Patients and families indicated that a lack of kindness and courtesy, or worse, actions perceived as judgemental or resentful from health professionals are impediments to rapport-building (Adams et al., 2014). These results from the review are concerning but can provide opportunities for health professionals to reflect and examine their practice and invite feedback from patients and family about their rapport-building experiences.

Despite tensions related to workplace time and tasks, health professionals have a choice how they spend their time with patients. Investing time to establish rapport with patients and families is both effective and rewarding (Segaric et al., 2015). If, however, health professionals genuinely do not have enough time to greet their patients warmly and find out about how to care for them as people, questions need to be asked about whether organisations value rapport-building as essential for patient and family care. Heavy workloads with high patient turnover or unrealistic time constraints for interactions have a negative effect on staff morale and patient care (Segaric et al., 2015), and do not provide a milieu for patient-centred communication (Epstein and Street, 2007). On the contrary, patients and families indicated that simple, kind gestures are crucial to facilitate rapport-building and creating ease with health professionals (Insua-Summerhays et al., 2018). It is essential for health professionals therefore to incorporate these acts of human connection into their interactions with patients and families.

Preamble to integrative telehealth review

The integrative review that follows resulted from a pivot in topic and methodology due to COVID-19 and the difficulties it placed on in-person hospital based research at the time. A new topic related to rapport experiences during telehealth interactions required a second literature review.

At the time of reviewing the research topic and methodology due to the impact of COVID-19, telehealth and telemedicine were suddenly being considered by health professionals in many disciplines as a safe way to communicate with patients and families. The timing of this review occurred on the rising tide of COVID-19 research, as the world was scrambling to study the effects of the new pandemic. Various countries were contending with disruptions to usual care delivery with nation-wide or state-wide lockdowns, quarantine periods and social distancing. An integrated review method was chosen to synthesise what was known to date about telehealth and rapport. The context of the literature search question was kept broad, and not specific to palliative care, as only one palliative care study had been identified in the scoping review. The full integrative review, undertaken in July 2020, appears here as an unpublished paper.

Exploring experiences of rapport for patients, families, and health professionals during telehealth calls: an integrative review.

Introduction

After steady growth over the last two decades, the use of telehealth has surged in response to the current COVID-19 pandemic and telehealth is now heralded to become an everyday part of healthcare delivery (Cloyd & Thompson, 2020; Wosik et al., 2020). Technology-based communication is likely to continue to grow in order to manage the projected increase in aging and multi-morbid populations throughout the developed world (WHO, 2011; WHO, 2015). Telehealth is predicted to shift some healthcare services from hospitals and clinics to people’s homes (Dorsey and Topol, 2020) It is therefore important to understand how technology-enabled healthcare influences fundamental aspects of the patient-provider relationship, such as rapport (Parish et al., 2017).

Telehealth uses a spectrum of telecommunications activities to deliver health care at a distance to populations with limited access to care (Sirintrapun and Lopez, 2018; Wosik et al., 2020). Evidence shows that telehealth is equivalent to in-person care in terms of patient and health professional satisfaction across multiple clinical settings (Sirintrapun and Lopez, 2018). The benefits of telehealth are reported to include a reduction in adverse patient events, improved health outcomes, increased patient choice of service delivery, and improved access to services for rural areas (Wade et al., 2012). However, some health professionals question the effects telehealth has on establishing rapport with patients (Glueck, 2013; Poulsen et al., 2015). Building rapport is an important part of health professional-patient telehealth communication and implementation (Henry et al., 2017). This review seeks to explore the empirical literature on the impact of telehealth when building rapport for patients, families, and health professionals.

Aim of review

This integrative review aims to explore the effects of telehealth encounters on rapport-building between patients, families, and health professionals.

Methodology

An integrative review methodology was employed as described by Whittemore and Knafl (2005). This method allows for the examination of evidence from qualitative and quantitative studies, and to synthesise the literature on an emerging topic that can inform practice (Torraco, 2016).

Search Strategy

This review used the PEO (population, exposure, outcome) framework to form the research question and to identify the key concepts.

Search Terms

Relevant MeSH subject headings and keywords used: rapport, patients, patient*, family, whānau, caregiver, doctor, physician, nurses, nurs*, allied health personnel, healthcare professional, telemedicine, telehealth, digital health and tele*.

Databases

Four databases Medline Ovid, CINAHL plus, psychINFO and Embase were searched in July 2020. Search was open for dates. No systematic reviews involving rapport and telehealth were found in Joanna Briggs Institute or Cochrane Review by title, abstract or keyword search.

Study Selection

Studies were selected using the inclusion and exclusion criteria outlined in Table 3-5. A PRISMA Flow Diagram was used to record the study selection process.

Table 3-5 Inclusion Exclusion Criteria

Inclusion criteria:	**Exclusion Criteria**
• Adults (>18) participants	• Studies that involve participants under 18 years
• Rapport is discussed in findings or conclusion	• Rapport is not discussed in findings or conclusion
• Telehealth- applying to provider-to patient communication that took place using telephone, videocalls, patient portal messages or e-consults).	• Telehealth was not used by health professional participants
• Any health professional who used telehealth directly for patient care- not interprofessional.	• Interprofessional communication or education where telehealth was not directly between patient/family and health professional

- Any patient, or family/whānau member, or caregiver who used telehealth	- Telehealth was not used by patient or family/whānau participants 1.
- Available in English	- Study not in English

Data Synthesis

A constant comparison technique was used for analysing the data implemented (Glaser, 1965). Thematic analysis followed Braun and Clarke's six phases (2006), to develop themes and interpret these for new knowledge about the topic.

Results

The search produced 165 studies. Duplicate studies were removed (n= 67) along with a non-English language study (n=1) and studies that included children (n=5) or were interprofessional rather than patient focused (n=4).

The 84 remaining studies were screened eliminating 63 studies which did not meet the inclusion criteria. The excluded studies were not related to telehealth (n= 33) and not related to rapport in the findings or discussion sections (n= 30). There was a research team of three making decisions about study selection and review analysis.

Characteristics of Articles

Twenty-one articles (Appendix 1.2) met the inclusion criteria. Of these eighteen were research studies (Agha et al., 2009; Beebe and Tian, 2004; Burgess et al., 2016; Devadula et al., 2020; Elliot et al., 2020; Flickinger et al., 2019; Frueh et al., 2007; Grady and Singleton, 2011; Innes et al., 2006; Martinez et al., 2017; McKinstry et al., 2010; Pettinari and Jessopp, 2001; Poulsen et al., 2015; Stevens et al., 1999; Wade et al., 2012; Ward et al., 2013; Warner et al., 2019; Williamson et al., 2015)and the remaining three studies were reviews (Henry et al., 2017; Parish et al., 2017; Simpson and Reid, 2014). Ten studies were qualitative, 8 were quantitative and 3 used mixed methods.

Year of publication: Studies were pre-2000 (n=1), between 2000-2009 (n=5) and the majority 2010-2020 (n=15).

The countries of origin: The studies were conducted in USA (n=10), UK/Scotland (n=4), Australia (n=6), and Canada (n=1).

Research Settings: The research settings included mental health (Beebe and Tian, 2004; Grady and Singleton, 2011; Frueh et al., 2007; Parish et al., 2017; Simpson and Reid, 2014; Stevens et al., 1999), primary care (Innes et al., 2006; McKinstry et al., 2010), a variety of medical and outpatient clinics (Agha et al., 2009; Burgess et al., 2016; Devadula et al., 2020; Flickinger et al., 2019; Martinez et al., 2017; Poulsen et al., 2015; Ward et al., 2013; Williamson et al., 2015), a call centre (Pettinari and Jessopp, 2001), an urgent care clinic (Elliot et al., 2020), and general telehealth providers (Wade et al., 2012).

Participants: Studies included patients and health professional participants. There were no studies with family members or caregivers as participants.

Type of telehealth modality

Video: Video based studies (Agha et al., 2009; Devadula et al., 2020; Elliot et al., 2020; Frueh et al., 2007; Grady and Singleton, 2011; Martinez et al., 2017; Poulsen et al., 2015; Stevens et al., 1999; Ward et al., 2013), were set up in two ways. Firstly as “hosted” sites with patients and staff members at one site video calling specialists in another site. The second method was “direct-to-patient” with health professional video calling patients directly. Six of the video studies compared video calls to in-person visits (Agha et al., 2009;

Devadula et al., 2020; Frueh et al., 2007; Grady and Singleton, 2011; Poulsen et al., 2015; Stevens et al., 1999).

Telephone: Of the 8 studies using telephone, five were telephone only (Beebe and Tian,2004; Burgess et al., 2016; Innes et al., 2006; McKinstry et al., 2010; Williamson et al., 2015), one was text-based (Flickinger et al., 2019), and two were mixed (Wade et al, 2012; Warner et al., 2019). All were delivered direct to patients at home. Half of the telephone studies compared telephone calls to in-person visits (Beebe and Tian,2004; Burgess et al., 2016; Innes et al., 2006; McKinstry et al., 2010).

Definitions of rapport

Only one study provided a description for rapport (Elliot et al., 2020), which was: "a sense of affective connection, is developed and communicated verbally, and particularly, nonverbally through facial expressions, gestures, posture, and by paralinguistic elements of speech such as pitch, pace, tone, and volume" (Elliot et al., 2020). The same grounded theory study operationalised rapport with codes to identify rapport building activities in the data. These included: affective connection, comments of appreciation, trust-building, concerned bedside manner and caring nonverbal gestures (Elliot et al., 2020).

Two quantitative studies used the Roter Interaction Analysis System (RIAS), (Roter and Larson, 2002), to code dialogue in a patient-provider interaction (Innes et al., 2006; McKinstry et al., 2010). The "rapport building" codes in one study were: personal remarks, laughter/ jokes, approval, empathy, concern, reassurance (McKinstry et al., 2010). Without providing an explicit definition, the RIAS codes give guidance as to how rapport was operationalised. The remaining studies were not explicit about how they defined or operationalised rapport.

Thematic findings

Analysis of the study findings identified three key themes relating to the effect that telehealth has on rapport building between patients and health professionals.

1. **Telehealth rapport is the same but different:** Although rapport building was identified during telehealth interactions, patients and health professionals had different perspectives about the rapport building.
2. **Adaption to telehealth:** Health professional participants adapted their verbal and nonverbal behaviour for both video and telephone calls to establish rapport.
3. **Telehealth interpersonal skills:** Health professionals identified a lack of specific training and research in rapport building and interpersonal skills for telehealth.

Telehealth rapport: the same but different

Several studies found rapport building during telehealth to be equivalent to in-person interactions (Agha et al., 2009; Devadula et al., 2020; Frueh et al., 2007; Parish et al., 2017; Poulsen et al., 2015; Simpson and Reid, 2014; Stevens et al., 1999; Wade et al., 2012). However, there were differences in how patients and health professionals perceived rapport building in telehealth encounters.

Patient perspectives

Six studies sought patient perspectives on telehealth encounters, including rapport building with health professionals (Agha et al., 2009; Devadula et al., 2020; Elliot et al., 2020; Poulsen et al., 2015; Warner et al., 2019; Williamson et al., 2015).

In three studies, patient participants agreed that they could develop rapport in video calls with physicians by talking openly and in a similar way to in-person appointments (Agha et al., 2009; Devadula et al., 2020; Poulsen et al., 2015). In one study, patient participants reported higher satisfaction with physician rapport building during telehealth video consultations as compared to in-person consultations (Agha et al., 2009).

In another study, patient participants who were “highly satisfied” with telehealth video encounters, commented most frequently on the health professionals’ ability to build rapport (Elliot et al., 2020). This study also found that patients felt rapport and relationships can be established during video-first consults, without a previous in-person encounter. This was more likely if the providers had strong relational and communication skills (Elliot et al., 2020).

Patient participants, in two studies, viewed telephone appointments as conducive to building rapport (Warner et al., 2019; Williamson et al., 2015). Patient participants reported a degree of privacy on the telephone which enabled them to talk more freely (Williamson et al., 2015) and found the health professionals “easy to talk to,” and like “one of the family” (Warner et al., 2019). Although, some patients on telephone calls with health professionals said they wanted to put a “face to the voice”, this did not affect their satisfaction with rapport or care (Williamson et al., 2015).

Health professional perspectives

Health professionals on the other hand, were more circumspect than patients regarding rapport building during telehealth encounters (Burgess et al., 2016; Frueh et al., 2007; Innes et al., 2006; McKinstry et al 2010; Wade et al., 2012).

Two studies involved primary care practitioners comparing in-person with telephone consults (Innes et al., 2006; McKinstry et al 2010). The telephone calls in both studies were assessed by researchers for evidence of rapport building comments from the physicians, but not from the patients. Both studies showed less rapport building in the telephone calls than in-person consulting as the calls were shorter, with less psychosocial content, less information gathering, less counselling and less patient-centred talk (Innes et al., 2006; McKinstry et al 2010).

Several health professionals found rapport building to be adequate, despite concerns about patient rapport over video communication (Wade et al., 2012). However, genetic counsellors rated rapport building as the “most different” and difficult activity between telehealth and in-person patient sessions, due to the lack of nonverbal communication (Burgess et al., 2016).

One study compared group therapy delivered in-person and in video calls (Frueh et al., 2007). The study had independent observers who rated the therapists in both groups as identical on the critical therapy components of “rapport” and “empathy” with no compromise to the therapists' ability to build rapport with patients (Frueh et al., 2007).

Three studies compared satisfaction between health professionals and patients regarding telehealth and rapport building. The results also reflected different perspectives between health professionals and patients (Grady and Singleton 2011; Stevens et al., 1999; Ward et al., 2013). Patient participants rated their satisfaction highly and health professionals rated their satisfaction as less than that of the patients.

Face-to-face first?

Patients in one study suggested a face-to-face meeting with the specialist could improve the quality of rapport. This study recorded that 25% of the patient group agreed or strongly agreed that a face-to-face appointment would enable a better rapport during the telehealth sessions, even though 88% of patient participants indicated a preference for telehealth appointments over face-to-face appointments (Devadula et al, 2020).

Health professionals in two studies suggested face-to-face meetings before telehealth sessions (Beebe and Tian, 2004; Williamson et al., 2015). The expert nurse in one study felt rapport building on the telephone added strain, which an initial clinic visit could address (Williamson et al., 2015). Authors of the other study, recommended staff made two face-to-face sessions to facilitate rapport building before beginning telephone interventions with schizophrenic patients. Interestingly, after 3 weeks of the 6 week course, there was no statistically significant difference in rapport building between the two groups (Beebe and Tian, 2004).

Adaption to telehealth

Seven studies provided evidence that health professionals adapt their verbal and nonverbal behaviour to facilitate the development of rapport when using telehealth (Agha et al, 2009; Burgess et al., 2016; Henry et al., 2017; Pettinari and Jessopp, 2001; Simpson and Reid, 2014; Ward et al, 2012; Williamson et al., 2015). No information was available in the studies to indicate if any of these adapted behaviours were effective for rapport building.

Adapting to video

Health professionals made adaptions to their nonverbal behaviours to facilitate rapport and dialogue etiquette for video calls (Agha et al., 2009). The audio lag during video calls created pauses that resulted in better turn-taking and not over-talking each other (Agha et al., 2009; Simpson and Reid, 2014; Wade et al, 2012). Changes were made by exaggerating voice volume, inflection, and tone, as well as gestures and mannerisms (Henry et al., 2017; Simpson and Reid, 2014). Therapists asked more questions in video calls than in-person consults to clarify the meaning of clients' facial expressions and body language (Simpson and Reid, 2014). Other therapists created a 'telepresence' by using virtual eye contact and ensuring a clear view of their face and body language (Henry et al., 2017).

There was little detail of adaptions patients made to video calls, with two studies indicating patients may need a period of adjustment and some explanation and planning pre-telehealth sessions (Devadula et al., 2020; Martinez et al., 2017). One study reported that although some patients were initially uncomfortable at the start of video therapy, this did not interfere with the development of rapport with their health professionals (Simpson and Reid, 2014).

Adapting to telephone.

A key factor affecting rapport building for health professionals using telephone calls with patients was the lack of visual cues (Burgess et al., 2016; Pettinari and Jessop, 2001; Williamson et al., 2015). The studies highlighted health professionals dependence on making eye contact to establish connection and to read body language. Touch was also believed to be an important aspect of establishing patient rapport by health professionals. Without vision and touch, nurses in one study, were concerned about being able to build a relationship or determine if the caller understood them (Pettinari and Jessopp, 2001).

However, health professionals developed telehealth skills in an informal way to compensate for a lack of visual and touch cues. In doing so, they felt able to build trust and rapport (Burgess et al., 2016; Pettinari and Jessop, 2001; Williamson et al., 2015). Genetic counsellors encouraged patients to ask questions, to check details, and to say what they were thinking and feeling so the counsellors had more information. The counsellors also found they needed to put more attention on non-verbal cues like interpreting patients' silence and changes in voice intonation to maintain rapport Burgess et al., 2016).

Conversely not seeing the health professional may not necessarily be a problem for patients, although there was little evidence in the reviewed studies from a patient's perspective.

Telehealth Interpersonal skills: Training and research

While health professionals were adapting their verbal and nonverbal behaviour to facilitate rapport and relationship building, there was no evidence to support which of these adapted behaviours was effective for telehealth services. Eight studies made recommendations for further research into the effects of telehealth on patient-provider communication including rapport building (Parish et al., 2017; Agha et al., 2009; Henry et al., 2017; Flickinger et al., 2019; Innes et al., 2006; Martinez et al., 2017; McKinstry et al., 2010).

Currently, training health professionals in the use of telehealth is ad hoc (Pettinari and Jessop, 2001). Seven studies identified a need for interpersonal skills and rapport building training in telehealth services (Henry et al., 2017; Burgess et al., 2016; Elliot et al., 2020; Grady and Singleton, 2011; Williamson et al., 2015). Only one study expressly mentioned that the physicians had undergone extensive training and education in video platformed telemedicine prior to the study (Elliot et al., 2020).

Discussion

This integrative review explores the effects of telehealth on rapport building between patients and health professionals. Findings suggest that rapport established during telehealth encounters is equivalent to in-person interactions and that patients are generally more satisfied with rapport building during telehealth than health professionals. Studies compared telephone to in-person and compared video to in-person interactions (Wade et al., 2012; Poulsen et al., 2015; Agha et al., 2009; Beebe and Tian, 2004; Burgess et al., 2016; Devadula et al., 2020; Frueh et al., 2007; Grady and Singleton, 2011; Innes et al., 2006; McKinstry et al., 2010, Stevens et al., 1999; Williamson et al., 2015). The conclusion in general, was that building rapport during videoconferencing compares well and even surpasses rapport building during in-person interactions from the patients’ viewpoint. However, telephone studies show rapport building has shortfalls that may be related to health professionals needing new skills, more practice and time to adapt to loss of visual and touch cues.

During telehealth video consultations health professionals are making eye contact, slowing down their speech, using more pauses, turn-taking deliberately, with longer periods of listening and checking in with patients about what they see and hear (Wade et al., 2012; Agha et al., 2009; Henry et al., 2017; Simpson and Reid, 2014). Health professionals are also noting telehealth generates real responses and that patients cry and laugh in their sessions just as patients do during in-person care (Glueck, 2013). This may suggest the focus and attention from health professionals adapting their behaviours during telehealth is improving their rapport building skills. However, this does not align with a key finding from this review which shows that in general health professionals perceive the development of rapport less positively when on a telehealth call than patients did. More research is needed to explore why health professionals and patients' perceptions of rapport building differ during telehealth consultations.

Entrenched and unconscious beliefs held by health practitioners that "face-to-face is best" or that telehealth is "disembodied" and inferior, may be hampering the widespread use of telehealth as a core component of accessible healthcare. Bauer (2004) brings Merleau-Ponty's concept of embodiment into the realm of telehealth and argues that "cybermedicine" has a disembodying effect on the clinician-patient interaction. Bauer's view is that tele-relationships are harder to construct and inferior to most in-person relationships and "should be viewed as a potential threat to the moral integrity of the physician–patient relationship" (Bauer, 2004).

However, the telehealth and disembodiment argument is countered by Lupton and Maslen (2017) who claim, "telemedicine is far from disembodied". Their claim refers to the “invisible work” of telehealth Oudshoorn, 2008) which they offer as a framework for health professionals to adjust their way of working with patients when using telehealth (Lupton and Maslen, 2017). “Invisible work” is exemplified in one of the reviewed studies when digitally engaged patients met digitally engaged health professionals with resulting high levels of rapport and patient satisfaction (Elliot et al., 2020).

Glueck (2013), suggests that health professional perceptions about telehealth are key determinants for how patients will perceive telehealth. Yet, some health professionals may be lagging behind patients in terms of accepting the use and efficacy of telehealth in practice. In fact, some health professionals actively doubt that telehealth services would enhance the doctor-patient relationship (Wernhart et al., 2019). This doubt about the quality of rapport in telehealth encounters is reflected in the call for face-to-face visits prior to telehealth services to “establish rapport” (Beebe and Tian, 2004; Williamson et al., 2015). Doubt about the effectiveness of telehealth may also be coming from health professionals’ unconscious comparison of their own telehealth and in-person rapport building experiences (Agha et al., 2009).

Health professionals’ acceptance of telehealth services is found to be closely related to any telehealth programme’s success (Henry et al., 2017; Wade et al., 2014). Three beliefs identified to enhance clinician acceptance when implementing a telehealth service are: Telehealth is effective, telehealth is safe, and telehealth is normal (Wade et al., 2014). Before these beliefs can become more mainstream however, it seems more research into rapport and telehealth is required.

Research gaps

A key finding from this review identified a lack of information about the differences in perceptions between health professionals and patients regarding telehealth and rapport building. Research is also needed to understand the beliefs and attitudes of health professionals towards the use of telehealth. Furthermore, understanding how these attitudes influence the therapeutic relationship and rapport building is essential for telehealth programmes to be successful (Simpson and Reid, 2014).

In addition, this review identified a significant research gap with the absence of family/whānau involvement in rapport and telehealth studies. As telehealth can reduce strain on family and care givers, it will be important to include family/whānau in research on rapport building in telehealth (Quinn et al., 2018). Further studies which focus on the triad between patient-family and health professionals are required in order to develop evidence-based guidelines to support the use of telehealth across all aspects of healthcare (Parish et al., 2017).

Limitations of this review.

In a quickly evolving research environment there may be telehealth terms that are not included in our search strategy, which may have affected the studies retrieved in this search. Also, as we limited our search to English language studies only studies from western countries met the criteria. Focus was on the interpersonal effects of telehealth on rapport building, so analysis did not include the technological or logistical effects of telehealth on rapport.

Conclusion

This review has identified some of the effects telehealth has on rapport building between patients and health professionals. Despite study participants being positive towards telehealth generally, there was a key difference in how patients and health professionals perceived rapport building during telehealth encounters. Health professionals were less satisfied than patients and rated rapport building as less than in-person consultations. Patients on the other hand, were more satisfied with telehealth and rated health professionals' rapport building highly.

More research into rapport building in telehealth encounters is needed. Equally, there are indications for specific training in interpersonal skills and developing guidelines around telehealth communication. Health professionals need this information in order to better understand how to enhance rapport building and maximise the benefits of technology-based communication.

Review and integration of literature review findings

This section integrates the findings from the two literature reviews and, in doing so, identifies opportunities for future research.

Integration of findings from two literature reviews

Findings from both reviews highlighted how rapport was poorly defined in the literature with the lack of a conceptual definition within the clinical setting. Both reviews included studies which identified a range of positive and negative encounters as reported by participants. The review findings highlighted a lack of studies that incorporated the patient and family/whānau experiences of rapport, instead there was focus on the health professionals performance in a telehealth encounter. Health professionals identified a lack of specific training and research in rapport building and interpersonal skills required for telehealth interactions. This may impact on health professional acceptance and confidence using telehealth. Perhaps, most interesting in the context of this study, there was a paucity of research from palliative care in the important area of rapport and no studies identified in the field of rapport and telehealth in palliative care.

In summary the key research gaps from both of these literature reviews were:

1) Rapport was poorly defined conceptually.
2) A gap existed between the participant experiential findings that included interactions without rapport, and the theoretical understanding of rapport.
3) A lack of studies of patient and family/whānau experiences of rapport and little emphasis on the effects of rapport (or lack of rapport) on their desired outcomes.
4) Notably only one study from both reviews was set in a palliative care context (Seccareccia et al., 2015).
5) Health professionals identified a lack of specific training and research in rapport building and interpersonal skills for telehealth which may affect their clinical confidence and acceptance.

Updated telehealth literature search

An update to the telehealth literature search was undertaken in December 2022, searching for empirical papers published since the review was undertaken in July 2020. The primary aim was to ascertain if there were any further studies published from the palliative care setting as a result of COVID-19 and its impact on rapport and the use of telehealth. This subsequent search was conducted using Medline and CINAHL databases using the same search parameters as previously described (including open dates), with the addition of palliative care related terms (palliative care, end of life care, terminal care, cancer care, oncology care). The terms “cancer care” and “oncology care” were added to widen the search, as without them there were zero results. The search yielded 8 studies with 2 studies that met the inclusion criteria (Aung et al., 2022; Koppel et al., 2022). Both studies were in the oncology setting and published in 2022 (Table 3-6). Both studies used a qualitative design and included the patient and doctor/nurse perspectives. No family members were included.

Table 3-6 Rapport Findings from updated telehealth search

Title/Author/year	Purpose	Methods	Results related to rapport
The role of telehealth in oncology care: A qualitative exploration of patient and clinician perspectives. Aung et al., 2022	A qualitative study to explore physician and patient perspectives of telehealth in cancer care.	Semi-structured interviews with 7 physicians and 11 patients, recruited from an Australian hospital oncology department. Data was thematically analysed.	Both cohorts expressed deep dissatisfaction with the inability to build strong rapport or connection over telehealth, which included phone and video. Consultations were noted to be shorter and more transactional.
Exploring nurse and patient experiences of developing rapport during Oncology Ambulatory Care videoconferencing visits: Qualitative Descriptive study.	To investigate the nature of nurse-patient rapport in ambulatory cancer care telehealth videoconferencing visits (VCV).	A qualitative descriptive study, interviews with 22 participants, including patients with cancer (n=10) and oncology nurses (n=12), about their experiences of rapport building	Patients and nurses considered rapport essential to the nurse-patient relationship and high-quality care. Contrary to concerns that videoconferencing would be impersonal and inhibit rapport and relationship building, this study

Koppel et al., 2022		during VCVs. All interviews were analysed using conventional content analysis.	indicated that rapport can be established during VCVs and that many of the strategies used during in-person visits s are equally successful in videoconferencing.

One study sought to explore the nature of rapport in telehealth, (Koppel et al., 2022) from the patient and nurse participant findings. Patients and nurses valued interactions where rapport was established during a telehealth consultation (Koppel et al., 2022). When rapport was present, patients felt seen and heard as people with lives, rather than just someone with a serious illness. The nurse participants, without exception, considered developing rapport with patients was important to their nursing practice and essential to providing high-quality care (Koppel et al., 2022).

In contrast to the positive experiences described by Koppel et al (2022), the Aung et al. study found that both patient and physician groups expressed how telehealth weakened the strength of their rapport and connection (Aung et al., 2022). The participants' desire for the intimacy and familiarity of in-person consultations influenced the return to an in-person or hybrid model of care. The researchers speculated this desire for in-person consultations remains a key challenge to telehealth delivery going forward in their area (Aung et al., 2022).

Given the limitations of the reviewed studies related to rapport and telehealth, there are clear gaps in the current research relating to: 1) developing rapport during telehealth calls in palliative care and, 2) the experiences of rapport from the patient, family/whānau, and health professional participants in telehealth in palliative care.

Chapter summary

This chapter has presented two literature reviews. Integrating findings from both reviews showed several gaps in the literature. Furthermore, an update to the telehealth review shows that even with a pandemic affecting the rate of uptake of telehealth in healthcare throughout the world, there remains very little research available that intersects the areas of palliative care, telehealth, and rapport. The literature reviews in this chapter therefore form a solid rationale for the study, with clear gaps in the literature identified. From here, Chapter 4 outlines the philosophical and theoretical perspectives that are used to guide this study. This includes the theoretical framework that provides structure throughout the study.

Chapter 4 Philosophical and theoretical perspective

> All real living is meeting
>
> Martin Buber, 1923

Chapter introduction

Chapter 4 outlines the philosophical and theoretical perspectives used to guide the study design. This chapter includes a description of the Interpretivist paradigm as an approach to making meaning from relatedness. I then outline Symbolic Interactionism as the theoretical perspective for this study and finally describe the Theory of Human Relatedness as the theory that provides structure throughout the study.

Interpretivist Paradigm

There are many ways to view the world and many ways to approach researching the world, therefore it is important for a researcher to know and become comfortable with their philosophical and theoretical stance on research (Crotty, 2015). A research paradigm is a set of commonly held beliefs and assumptions within a research community about ontological, epistemological, and methodological concerns (Johannesson and Perjons, 2014). As the researcher, I reflected on the research paradigm that resonates with my own world view while also considering that which best serves the study. My choice of research paradigm aligns with meaning being constructed through the interactions people have in their everyday lives and in the interplay of relatedness between people (Crotty, 2015; Saunders et al., 2009; Tower et al., 2012). This is congruent with an Interpretivist paradigm which emphasises that social interaction is the basis for knowledge and that knowledge is socially constructed (O'Donoghue, 2018).

In the 1920s, Max Weber argued there are no inherent meanings of things by nature, rather, the meanings of all objects are imposed by humans as individuals or in groups (Burger, 1977). From his anti-positivist thinking the paradigm of Interpretivism emerged in early twentieth-century Europe and developed into the strands of Hermeneutics, Phenomenology, and Symbolic Interactionism (Burger, 1977; Crotty, 2015). The Interpretivist paradigm recognises "that reality is a product of human intelligence interacting with experience in the real world" (Elkind, 2005. p.334). In the context of this study, I understand the Interpretivist paradigm to be ontologically intersubjective and epistemologically interpretive (Schwartz-Shea and Yanow, 2020). Intersubjectivity is the proposition that "human experience occurs in a world of shared and embodied understandings, mediated by culture and language" (Tembo et al., 2022, p.1). Intersubjectivity defines a space for patient and family-centred interactions and in this study is influenced by Buber's philosophy of I-Thou (1970). This ontological approach fits well with palliative care, which is fundamentally relational, with therapeutic interactions occurring in an intersubjective space (Tembo et al., 2022).

Although Interpretivists seek to understand aspects of life from the participants' point of view, the researcher can never be completely separate from their own values and beliefs. These values and beliefs will inevitably inform the way in which they collect, interpret, and analyse data (Ryan, 2018). Qualitative researchers like to make explicit the values they bring to a study. This is the axiological assumption that characterises qualitative research (Creswell and Poth, 2018) often referred to as the positioning of the researcher in the study (as in Chapter 2). This inseparable relationship between the inquirer and the "object" of that inquiry is explored in more detail in Chapter 5. In particular, it informs sections which outline the

Interpretive Description approach (Thorne et al., 2004; Thorne, 2016), the use of Reflexive Thematic Analysis (TA; Braun and Clarke, 2006, 2022) and strategies to enhance quality and rigour. The Interpretivist researcher believes that to understand the meanings embodied in language and actions one must analyse and interpret them using empathic skills and interpretivist methodologies (Schwandt, 1994; Schwartz-Shea and Yanow, 2020). Interpretive research aims to depict the complexity of the chosen topic, even as that knowledge is understood to be inevitably partial (Schwartz-Shea and Yanow, 2020).

An Interpretivist paradigm has been applied across many disciplines, such as business (Chowdhury, 2014), politics (McAnulla, 2006), sports coaching (Potrac et al., 2014), and telehealth (Filbay et al., 2022). Arguably, Interpretivism aligns with many of palliative care’s principles and values, including patient-centred, holistic, and personalised care (Ryan, 2018). Interpretivism is generally considered to have helped our understanding of the contemporary social world to a great extent (Chowdhury, 2014). However, there are critiques of Interpretivism for producing subjective research results that are highly dependent upon the skills and experiences of the individual researcher (Johannesson and Perjons, 2014). Amidst calls for greater use of critical realism there are more recent calls for using Interpretivism with caution in the post-truth era of the 2020’s (McAnulla, 2006; Johannesson and Perjons, 2014; Schwartz-Shea and Yanow, 2020).

Notwithstanding these latter considerations, this study uses an Interpretivist approach with the purpose to create new, richer understandings and interpretations of rapport during telehealth in the palliative care context (Table 4-1).

Table 4-1 Philosophical, theoretical, and methodological overview of this study

Ontology	**Intersubjective**

The nature of being	
Epistemology - **Philosophy of knowledge**	Interpretivism- making meaning from relatedness
Theoretical perspective - **The theoretical stance behind the methodology**	Symbolic Interactionism- meaning interpreted from interactions between people
Theory	The Theory of Human Relatedness
Methodology (Chapter 5)	Interpretive Description
Methods (Chapter 5)	Qualitative interviews and focus groups Reflexive Thematic Analysis

Symbolic Interactionism

This study uses the theoretical perspective of Symbolic Interactionism as it provides insights into human health, actions and meaning making, which are constructed from interactions between people (Benzies & Allen, 2001; Thorne, 2016).

Mead (1863-1931) considered that an individual’s concept of self relates directly to the way people attach meaning to, and act towards, particular objects and phenomena (O'Donoghue, 2018). This approach influenced Blumer to name the new theoretical perspective “Symbolic Interactionism” which came under the Interpretivist paradigm and marked a move away from the dominant positivist stance (Carter and Fuller, 2015; O'Donoghue, 2018). Symbolic Interactionism considers that meaning is not inherent in objects but arises from the encounters between subject and object through language patterns, symbolic communication, and shared meaning (Denzin, 2004; Oliver, 2012). There are three principles that guide Symbolic Interactionism based on Blumer (1969):

1. Human beings develop their attitudes and act towards objects based on the meanings that the objects have for them
2. The meanings are inferred from social interaction with these objects
3. These meanings change within an interpretive process which involves self-reflective individuals symbolically interacting with each other.

Central to Symbolic Interactionism is the idea that individuals use language and symbols in their communication with others to make sense of their world from their unique perspective (Carter and Fuller, 2015; Schwandt, 1994). Symbols include objects, words, and behaviour which have meaning attached to them by the people involved in the interaction (Tower et al., 2012). Symbolic Interactionists, also known as Interactionists, are often less concerned with objective structure than with subjective meaning. This leads interactionists to study how narratives, connected to interviews, stories, rituals, and myths represent the meanings and forms of everyday experience (Denzin, 2004). Traditionally, Symbolic Interactionism addresses the ways individuals make meaning in face-to-face interactions (Carter and Fuller, 2015). However, recent studies have used Symbolic Interactionism in their exploration of remote interactions in telehealth and technology related contexts such as e-health and telemonitoring (Evered et al., 2023; Nickelsen 2023).

As Symbolic Interactionism is an approach to research that is person-centred and sensitive to the lives and circumstances of the participants (Benzies and Allen, 2001), it is well suited to health care settings such as palliative care. Researchers using Symbolic Interactionism are concerned with wanting to know and understand the person’s point of view, with the focus on understanding the connection between shared meaning and human health behaviour. To do this, Interactionists prefer to write text that remains close to the experiences of the people participating in the research and to ask “How” rather than “Why” questions (Denzin, 2004).

As with other interpretive approaches, it is important that interactionist research is conducted in the context of the participants’ environment (Benzies and Allen, 2001; Denzin, 2004).

Symbolic Interactionism was chosen as the theoretical perspective for this study, as it focuses on the way people act and interact with language, symbols, and each other in their daily lives (Oliver, 2012). For this study, the symbols are the linguistic and relational elements of rapport that patients and families and health professionals encounter in telehealth interactions.

The Theory of Human Relatedness

A theory can provide specific structure that can guide and support a research study. Grant and Osanloo (2014), use the analogy of theory being a blueprint for a research study, the way plans are used to build a house. In their view, a theory-as-blueprint provides structure and support for the study and aligns the purpose, research questions, literature review, methodology, methods, and analysis. Having a theory can also help define the scope of the study in relation to specific concepts and viewpoints (Hall and Schmid Mast, 2009). In addition, just like blueprints for a house that can be adapted to improve the design, so too, theory can be adapted. In this way, theory can apply parameters to the data collected, analysed, and interpreted, while the research findings can extend or challenge the theoretical framework. This study approaches the use of theory as a flexible analytical tool to guide research processes, rather than a rigid tool to be followed prescriptively (Chiu et al., 2022; Thorne, 2016). This flexible approach is in line with Interpretive Description methodology (Thorne, 2016) outlined in Chapter 5.

To decide which theory would provide the blueprint for this study, I looked at existing communication theories. After an extensive search, I agree with Goebel and Goebel (2021), that rapport seems to be a relatively undertheorized concept. However, there were three interesting theories that I explored more fully. Firstly, the Communication Accommodation

Theory or CAT (Giles and Soliz, 2014), which is focused on how people use convergence and divergence in accommodation or non-accommodation of the person being spoken with. Although CAT is a framework for relational, family, and intergroup dynamics (Giles and Soliz, 2014), it does not specifically mention rapport and has very specific measures which do not seem to allow for the insertion of the concept of rapport. The second theory was the Rapport Management Model (Spencer-Oatey, 2002), which is based on politeness theory and is conceptualised as having two motivational sources: concerns over face and concerns over sociality rights (Spencer-Oatey, 2002). This theory is based on rapport, but the definition was limited and shorthanded to “harmony” in relations. It also has a strong focus on face-to-face interactions which limited its applicability to a study set within the context of telehealth.

The third theory was the Theory of Human Relatedness. Although rapport is not specified in this theory, relatedness is defined as “an individual’s level of involvement with persons, objects, groups, or natural environments and the concurrent level of comfort or discomfort associated with that involvement” (Hagerty et al., 1993, p.292). Relatedness is also defined by the American Psychological Association (APA) dictionary as “a feeling of connection with other people, often accompanied by affection, trust, and a sense of personal security” (apa.org, 2023). These definitions of relatedness held potential for an exploration of rapport as a type of relatedness and one which could look beyond the “warm fuzzy folklore” that rapport is sometimes subjected to (Goebel and Goebel, 2021).

The Theory of Human Relatedness (Hagerty et al., 1993) was chosen for this study for three key reasons. Firstly, the Theory of Human Relatedness specifies the key variables that influence relatedness, and arguably influence the development of rapport. These were 1) the axes of the states of relatedness model: comfort/discomfort, involvement/lack of involvement; 2) the resulting quadrants of the State of Relatedness model: connectedness disconnectedness, parallelism, and enmeshment (Figure 4-1). Secondly, the quadrant format of the model allowed for a range of relatedness possibilities including developing rapport during telehealth. Thirdly, the Relatedness social competencies: sense of belonging, reciprocity, mutuality, and synchrony (Hagerty et al., 1993) echoed the nonverbal components of rapport identified by Tickle-Degnen and Rosenthal (1990).

The Theory of Human Relatedness is based on how humans establish and maintain relatedness to others and was designed in the context of the nurse-patient relationship (Hagerty et al 1993; Hagerty and Patusky, 2003). The theory's key premise is that individuals assign meaning to their experiences of relatedness based on the level of comfort or discomfort associated with that involvement (Hagerty et al., 1993). This conceptualisation of relatedness is grounded in the work of interactional nurse theorists such as Peplau (1997) Travelbee (1971), and Paterson & Zderad (1976). It draws on Attachment Theory (Bowlby, 1969) and acknowledges that more than one theory is needed in the complex interactional field (Hegarty and Patusky, 2003). When developing their theory, Hagerty and colleagues analysed existing nurse-patient relationship models. They noted the theories made the following assumptions about the relationship between nurses and patients: 1) the relationship developed in a linear way; 2) the relationship was time dependent; 3) the relationship had an assumed foundation of trust; and 4) the relationship had certain role expectations of the nurse and the patient (Hegarty et al., 1993). The Human Relatedness theory sought to challenge these theoretical assumptions as Hagerty and colleagues held concerns they may limit patient autonomy (Hagerty and Patusky, 2003).

Instead of linear phases of relationship building (Peplau, 1997) Hagerty and Patusky took the view that each encounter with nurse and patient was dynamic and iterative with some notion of relatedness (Hagerty and Patusky 2003). They explored the assumption that nurse-patient relationships took time to develop. Hagerty and Patusky challenged this status quo to ask how a nurse can best use each interaction in a therapeutic way in a limited time (Hagerty and

Patusky, 2003). They questioned the foundation of trust that Peplau and other theorists thought was needed before a relationship could begin. Instead their Theory of Human Relatedness allows for interactions where trust may not develop, and care can still be negotiated (Hagerty and Patusky, 2003). Hagerty and colleagues, also questioned the role expectations for nurses and patients in the nurse-patient relationship. Their investigation identified assumptions that patients are “vulnerable”, they should want to get better, and patients should accept treatment and assistance from nurses (Hagerty and Patusky, 2003).

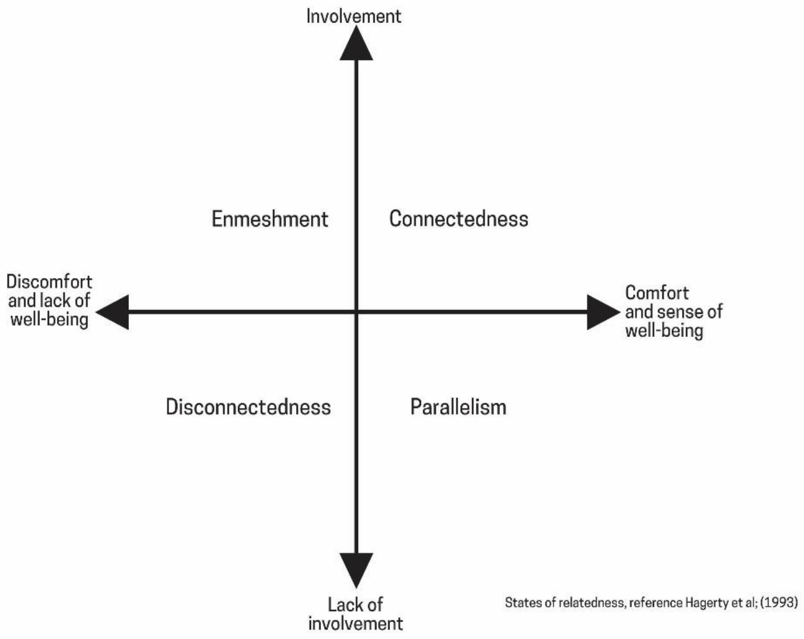
The Theory of Human Relatedness therefore, provides a conceptual way to think of relationships from a different perspective (Hagerty and Patusky, 2003). The theory emerged as interaction-based and nonlinear, able to accommodate brief but crucial interactions between patients and nurses and provide a framework for all possible interaction types in a wide range of settings. Furthermore, Hagerty and Patusky (2003) propose the framework of Theory of Human Relatedness also provides a theoretical basis for nursing research into relatedness.

Since it was developed, the Theory of Human Relatedness has been used across different research topics including paediatric nursing (Betz, 2004), alcohol dependency (Strobbe et al., 2012), and relatedness during student placements (Coleman, 2022). To the best of my knowledge, this is the first time The Theory of Human relatedness has been utilised in either a palliative care or a telehealth setting. From the viewpoint of this study, the Theory of Human Relatedness arguably provides a theoretical basis to explore rapport during clinical interactions that occur either in-person or via telehealth.

The next sections describes the two main components to the theory: 1) the states of relatedness model and, 2) the relatedness social competencies.

The states of relatedness

The state of relatedness model has two intersecting continua, that of involvement/lack of involvement and that of comfort/discomfort. Together these create the four quadrants of relatedness: Connectedness, Disconnectedness, Enmeshment and Parallelism (Figure 4-1). The horizontal axis refers to the continuum from “Discomfort/lack of well-being” to “Comfort/sense of well-being” that occurs in an interaction. The vertical axis represents the range of involvement that can be experienced in an interaction (Figure 4-1).



States of relatedness, reference Hagerty et al; (1993)

Figure 4-1 States of Relatedness

The four resulting states of relatedness that are created in each quadrant are identified as:

1. **Connectedness**- when a person is actively involved with another person and that involvement promotes a sense of comfort, well-being, and anxiety-reduction.

2. **Disconnectedness**- experienced when a person is not actively involved with another person and when lack of involvement is associated with discomfort, anxiety, and a lack of a sense of well-being.
3. **Parallelism** - occurs when a person's lack of involvement with another person, object, group, or environment is experienced as comfortable and as promoting a sense of well-being.
4. **Enmeshment** - when a person is involved with others, objects, groups, or environments and this involvement is coupled with discomfort, anxiety, and lack of well-being.

Relatedness social competencies

According to the theory, there are four social competencies essential to establishing relatedness: sense of belonging, reciprocity, mutuality, and synchrony (Hegarty et al., 1993); Hagerty and Patusky, 2003).

Sense of belonging was identified by Maslow as a basic human need (1943) and is identified when people feel valued, needed, and important within relationships or groups. ***Reciprocity*** relates to the nature of exchange in relationships and is an individual's perception of an equitable exchange with another person object or environment. ***Mutuality*** is an individual's real or symbolic perception of shared commonalities and shared acceptance of differences during an interaction. ***Synchrony*** is a sense of shared movement through space and time. Synchrony occurs when a person experiences congruence between their internal rhythms and their external interaction with persons, objects, groups, or environments (Hagerty & Patusky, 2003).

Utilising the Theory of Human Relatedness

In this section, I outline the compatibility of the Theory of Human Relatedness with the philosophical and theoretical underpinning this study. I also describe how the theory has been utilised in data collection, analysis, integration of data, and in the final discussion.

The Theory of Human Relatedness (Hegarty et al, 1993) offers a theoretical framework that aligns to the philosophical paradigm, theoretical perspective, and methodology of this study. The theory has an interpretive approach as influenced by humanistic nursing theories. As an interaction and relationship based theory the Theory of Human Relatedness fits comfortably with Symbolic Interactionism. Furthermore, the theory fits well with the clinically applied nature of the Interpretive Description methodology (Chapter 5).

As identified earlier in this chapter, the Theory of Human Relatedness has the following key variables that were utilised at various stages of this study: comfort/discomfort, involvement/lack of involvement, connectedness, disconnectedness, enmeshment, parallelism, sense of belonging, reciprocity, mutuality, and synchrony (Table 4-2).

Table 4-2 Utilising the theory of Human Relatedness

Stage of study	Key variables of relatedness theory	How the theory was utilised
Interviews	Comfort/discomfort Involvement/lack of involvement	Informed interview questions and focus group topic guide
Coding and analysis	Comfort/discomfort Involvement/lack of involvement Connectedness Disconnectedness	Informed the scope of data coding and analysis

Phase three	Comfort/discomfort Involvement/lack of involvement Connectedness Disconnectedness Parallelism (relabelled Warm parallel) Enmeshment (relabelled Cool parallel) Sense of belonging Reciprocity Mutuality Synchrony	Contributed to the analysis framework for integrating data from phase one and two (Chapter 8).
Discussion	Comfort/discomfort Involvement/lack of involvement Connectedness Disconnectedness Parallelism- Warm and Cool	Informed aspects of the discussion (Chapter 9).

Chapter summary

This chapter has presented the philosophical and theoretical underpinnings of the study. I have described how this study sits within an Interpretivist paradigm and the importance and relevance of Symbolic Interactionism as the theoretical perspective. I then outlined the Theory of Human Relatedness and how it guided the study through various stages. The following chapter provides an outline of the study design including the methodology, methods, and ethical considerations.

Chapter 5 Methodology and Study Design

Chapter introduction

This chapter presents the methodological approach, and study design. I begin this chapter by situating the study within an Interpretive Description methodology (Thorne et al.,2004) and describing how the methodology is applied. In addition, I provide an overview of the study design including the study setting, sampling approach, the process used for data collection, and data analysis. I then describe the approach to enhancing research quality and conclude with the ethical considerations for this study.

Methodology:

This is a qualitative study using an Interpretive Description methodology (Thorne et al., 2004).

Qualitative approach

A qualitative approach was chosen to explore how social experience is created and how people make sense of their experiences and the world that they live in (Roller and Lavrakas, 2015). According to Denzin and Lincoln, qualitative research is "multimethod in focus, involving an interpretive, naturalistic approach to the world" (2005, p. 3). A key foundation of qualitative research is that it enables the study of people in their natural settings rather than in an artificial or experimental setting (Denzin and Lincoln, 2005; Pope and Mays, 2006). Adopting a qualitative approach also requires the researcher to question assumptions and create new ways of understanding concepts that may be taken for granted (Pope and Mays, 2006).

As with Symbolic Interactionism (Chapter 4), qualitative research questions tend to ask "How" and "What" questions (Denzin, 2004). In this study, the research questions ask, "What are patients and families/whānau experiences of rapport…?" and "How do palliative care health professionals experience and manage rapport in telehealth encounters?" These questions lend themselves to a qualitative approach with a focus on exploratory and experiential meaning (Guest et al., 2013).

Interpretive Description

Interpretive Description (Thorne et al., 1997) is a methodology developed for generating knowledge around complex questions in the applied health sciences (Thorne et al., 2004; Thorne et al., 1997). This methodology was developed in response to the needs of nursing researchers to generate knowledge with the aim of benefitting clinical practice (Hunt, 2009). As such, Interpretive Description research usually pertains to subjective, experiential, and patterned aspects of human health when there is not extensive existing knowledge of a phenomenon (Hunt, 2009; Thorne, 2016). Since it was first developed, the Interpretive Description methodology (Thorne et al., 1997), has been widely used in research on diverse topics such as: aphasia and Kaupapa Māori (Brewer et al. 2014); medical education (Burdine et al., 2021); motherhood and university (Draper, 2015); and moral experiences in humanitarian work (Hunt, 2009). The Interpretive Description methodology is recognised as an acceptable methodology for qualitative health research (Teodoro et al., 2018).

Interpretive Description requires an integrity of purpose that derives from: 1) an actual real-world question, 2) an understanding of what is known and not known about the topic from empirical evidence, and 3) an appreciation for the conceptual and contextual realm within which the research results are received (Thorne, 2016 pg. 40). For example, when considering a research question Thorne (2016) urges the researcher to think beyond their own curiosity and clinical situation. It was important for me as a researcher and a nurse to conduct an applied study, which has the potential to add value to practice for health professionals, as well as contribute to current evidence.

The following are the epistemological underpinnings of Interpretive Description which I have drawn on throughout the research process (Thorne, 2016, pg. 82).

- Conduct studies in a naturalistic context in a manner that is respectful of the comfort and ethical rights of all participants.
- Explicitly attend to the value of subjective and experiential knowledge as one of the fundamental sources of clinical insight.
- Capitalise on human commonalities as well as individual expressions of variance within a shared focus of interest.
- Reflect issues that are not bounded by time and context, but attend carefully to the time and context within which the current expressions are enacted.
- Acknowledge a socially “constructed” element to human experience that cannot be meaningfully separated from its essential nature.
- Recognize that, in the world of human experience, “reality” involves multiple constructed realities that may well be contradictory.
- Acknowledge an inseparable relationship between the knower and the known, such that the inquirer and the “object” of that inquiry interact to influence one another.

As a methodology, Interpretive Description strongly endorses the use of reflexivity for researchers. This is for researchers to become aware of how their values, opinions and experiences affect the process and outcomes of the research (Burdine et al., 2021; Thorne et al., 2004; Thorne, 2016). Reflexivity informed the decisions made for designing this study, situating the researcher within the field (Chapter 2), identifying theoretical perspectives (Chapter 4) and methodology (Thorne, 2016).

Interpretive Description is compatible with the philosophical and theoretical perspectives of this study (Chapter 4). It fits within the Interpretive paradigm and there is a high degree of compatibility between Interpretive Description and Symbolic Interactionism (Oliver, 2012). They share epistemological assumptions, as well as having a similar pragmatic approach to research (Oliver, 2012). Interpretive Description has been developed as a theoretically flexible methodology. Although theory and techniques in this methodology are not prescriptive, Thorne balances this flexibility with the need for the researcher to make explicit the rationale for design decisions when using Interpretive Description (Thorne, 2016). In the following section, I outline the rationale for key design decisions and how this links to Interpretive Description methodology.

Research Design

The study was designed to be conducted in three phases using different methods of data collection (See table 5-1).

Although, when in the field, phases one and two occurred sequentially at times and concurrently at other times, the design elements of both phases are outlined here in each section. Phase three occurred after phases one and two were completed.

Table 5-1 Overview of the three study phases

Phase	Key activity	Research question (RQ)/objective
Phase one:	Interviews with patients and families to explore their experiences of rapport with palliative care professionals via telehealth.	Relates to RQ1 and objective 1
Phase two:	Focus groups/interviews with palliative care health professionals to explore their experiences of rapport with patients and family/whānau members during telehealth interactions.	Relates to RQ2 and objective 2
Phase three:	Findings from phases one and two were applied to the key variables of the Theory of Human Relatedness to improve understanding of rapport during telehealth in palliative care.	Relates to objective 3

Design: Phase One and Two

Phase one sets out to explore patients and family/whānau members experiences of and perspectives on rapport during telehealth calls while receiving palliative care.

Phase two sets out to explore the experiences of rapport from the perspective of health professionals during telehealth encounters with patients and families. Preliminary findings from the interviews in phase one were used to inform topics discussed with health professional participants.

Telehealth Definition

Telehealth is defined in this study as health care delivered using digital technology where participants may be separated by time and/or distance (NZ telehealth.org, 2023). This definition is contextualised more specifically in this study to include "personalised health care delivered via digital technology (i.e. telephone and video calls) to patients and their families at home."

Study Setting

This study was set in the community with providers of specialist palliative care who offer telehealth services. In Aotearoa NZ, specialist palliative care community services are provided by a hospice that serves a specific geographical area. The hospice specialist teams work in conjunction with primary palliative care providers such as general practitioners (GPs) and district nurses. The four participating hospices were situated in different locations: Northland, Waikato, Canterbury, and Southland (Figure 5-1). Two regions were in the North Island and two were in the South Island, with a mix of rural and metropolitan areas represented (Table 5-2).

Figure 5-1 Participating hospice regions

Table 5-2 Population information by region

Statistics NZ **Census 2018**	**Northland** **North Island**	**Waikato** **North Island**	**Canterbury** **South Island**	**Southland** **South Island**
No. of people	179,076	458,202	599,694	97,467
Median age	42.6	37.4	38.7	39.8
Male	88,701	226,386	299,397	48,705
Female	90,375	231,816	300,297	48,765
European	73.1%	74.4%	82.4%	86.5%
Māori	36%	23.9%	9.4%	14.9%
Access to internet	80%	83.7%	86.5%	80.5%
Access to cell phone	90%	92.0%	92.5%	91.5%

Estimated Decile range (NZiDep2018)	7-10	1-10	1-5	2-8

From: (Stats NZ 2020)- Census 2018.

There were similarities across study sites in terms of gender and age. The four study sites demonstrate diversity in terms of the proportion of Māori within the population ranging from 9.4% in Canterbury to 36% in Northland: this compares to the national average of 16.5% (Stats NZ, 2020).

Relevant to this study, the NZ Census 2018 measured telecommunication access for the first time in 2018 (Stats NZ, 2020). A high level of accessibility to cell phones (90-92.5%) and a lower range (80-86.6%) for access to internet is noted across the regions. The estimated decile figures (Table 5-2) relate to the NZ deprivation index 2018 figures and were estimated from Territory areas (University of Otago, n.d.). The deprivation index looks at the socioeconomic factors of a population that indicate poverty and deprivation. Higher levels of deprivation are associated with poorer health and higher death rates with 1 indicating areas with the least deprivation and 10 representing areas with the highest rate of deprivation.

Eligibility criteria

Phase one consisted of patients and family/whānau members receiving (or who had received) community specialist palliative care provided by one of the participating hospices.

Phase two consisted of palliative care health professionals who were employed by a participating hospice. Table 5-3 outlines the inclusion and exclusion criteria used for phase one and two.

Table 5-3 Inclusion Exclusion Criteria

Phase one participant inclusion criteria:	
Patients	• >18 years • Able to communicate in English • Able to give informed consent • Diagnosed with a life limiting illness • Receiving (or have received) hospice care in their home via telehealth
Family/whānau members	• Family/whānau of a person with a diagnosed life limiting illness aged >18 years of age • Able to communicate in English • Able to give informed consent • Participated in telehealth calls with health professionals from a participating hospice
Phase one exclusion criterion:	
• People who could not converse in English, as there was no resource for interpreters • Children and young people under 18 • Patients and family/whānau who had not had telehealth interactions. • Patients and families who could not give informed consent, for example because of cognitive impairment as assessed by hospice staff.	
Phase two inclusion criteria	
• Palliative care health professionals from any discipline employed by a participating hospice • Health professionals with experience of using telehealth with patient and family/whānau in community palliative care	
Phase two exclusion criteria:	
• Health professionals with no telehealth experience. • Senior management were excluded as their presence may have hindered the flow of discussion in the focus group.	

Sampling strategy

Although saturation of data is a commonly adopted concept to justify sample size in interviewing, Interpretive Description has a more relaxed stance to sampling (Thorne, 2016). It is justifiable for a smaller Interpretive Description study to "set arbitrary sample limits, as long as they show recognition that there would always be more to study" (Thorne, 2016). This approach to sampling is similar to Braun and Clarke (2019), who advocate that researchers provide an upper and lower limit of participant sample size in advance, with a rationale for the numbers chosen. The sample range indicates the scope of the study and the need to set limits while considering data adequacy and appropriateness of the composition and size of the sample group (Vasileiou et al., 2018).

Braun and Clarke also advocate for an estimation of the "information power" of the data being gathered. Information power takes into consideration the study as a whole with key factors such as the study aim, specificity, theory, dialogue, and cross case analysis informing sample size (Malterud et al., 2016). In the case of this study, the aim was narrow, the specificity of the target sample's experience and knowledge was dense, a theory was applied, the dialogue was likely to be strong, all indicating a smaller sample size (Malterud et al., 2016). The only information power indicator of a larger sample was the cross case analysis (Malterud et al., 2016). Therefore, the goal for sample size in phase one was between 10-15 patients and 10-15 family/whānau members with a combined total of between 20-30 participants. The exact number was determined by the response to recruitment over the four sites and consideration of information power during early analysis.

A purposive sampling method was used for the selection of potential participants in phase one. Purposive sampling is widely used in qualitative research for the identification and selection of information-rich cases related to the phenomenon of interest (Palinkas et al., 2015). Potential participants are selected based on meeting predetermined selection criteria, in this case, experience with telehealth (Table 5-3). At each hospice site, clinical notes were selected by a senior hospice staff member with no vested interest in participant selection. The clinical notes were then checked by the same person and used to confirm eligibility for patients and family/whānau members (Table 5-3). Purposive sampling was also used to support adequate Māori representation. Sampling continued across the four sites until the desired total number of participants was reached for each participant group.

In phase two, the approach to sampling was pragmatic. In an Interpretive Description study, focus groups are considered most effective if they are not too large, with a suggested upper limit of 6-8 people (Thorne, 2016). Data saturation commonly guides the number of focus groups; however saturation can be difficult to operationalise and is often poorly reported in clinical studies (Carlsen and Glenton, 2011). The anticipated number of focus groups was one per research site (4), with approximately 5-8 health professionals per focus group (20 to 32 total participants). Where health professionals wanted to participate but could not attend a focus group, individual interviews were offered. The exact number of interviews was not pre-determined as the interviews were supplementary to the focus groups but were anticipated to be 2 per site (n=8). Therefore the planned sample size for health professionals was between 28 and 40.

Recruitment phase one: patients and family/whānau

A senior staff member from each hospice made contact with eligible participants by phone or in-person. The purpose of this initial contact was to inform potential participants about the study and to invite them to find out more or participate if they wished. The potential participants were provided with an information sheet and consent form prior to the interview. The information sheet explained the project, participant involvement, their ability to withdraw easily, and how their information would be stored and used. There was one information sheet and consent form for patient participants and one for family/whānau participants (Appendix 2.1 and Appendix 2.2). It was made clear that participation in the study was voluntary, there was no disadvantage regarding treatment received by not participating and withdrawing from the study was possible at any point with no reasons given. Once verbal consent was given, the senior staff member asked the patient's or family/whānau member's permission to give their contact details to me to arrange an interview time with them.

Recruitment phase two: health professionals

I met with the senior staff member involved with recruitment at each site to present the proposed research study and the health professional information sheet and consent form (Appendix 2.3). A poster with study details and contacts was sent via email to the staff member with the aim to promote and remind staff of the focus groups details. Posters were placed on staff noticeboards if required (Appendix 2.4). The senior hospice staff member at each site emailed potential staff participants about the study. Included in the email were an information sheet and consent form. The first 6-8 respondents at each site were selected to attend the focus group, as indicated on the recruitment email.

Data Collection: Phase One and Two

In phase one, data were collected in two ways: 1) Semi-structured interviews and 2) memoing. Data were collected for phase two in three ways: 1) Focus groups; 2) semi-structured interviews; and 3) memoing.

Semi-structured Interviews

Semi-structured interviews were chosen because they are a key data collection method for Interpretive Description studies (Thorne, 2016). The aim of interviewing in research is to elicit information to know what the participants know in the way that they know it (Copland and Creese, 2015). It was therefore important to give participants time to relax and talk about their experiences. The participants were asked about their experiences of rapport during telehealth calls.

A single semi-structured interview was conducted in-person and involved asking open-ended questions. An interview schedule (Appendix 2.5) was developed from the findings of the literature reviews (Chapter 3). In addition, questions were informed by components of the Theory of Human Relatedness related to comfort and involvement. The interviews were audio-recorded, and the digital recordings were transcribed verbatim.

For patient and family/whānau participants, interviews took place at a time and place of their choosing, most often in their home. The duration of the interviews was expected to be around 30-60 minutes. The first three interviews were treated as pilot interviews to test the interview schedule. No changes were made to the interview schedule and therefore all interviews were analysed together.

For health professional interviews, an appointment was made for a time and place that suited the interview participant. A quiet private room away from clinical areas was booked at each site. The interviews were expected to take between 45-60 minutes. The health professional interview schedule (Appendix 2.6) was developed and informed by literature review findings (Chapter 3). Similar to the patient/family interview schedule, there were also questions informed by the components of the Theory of Human Relatedness related to comfort and involvement.

Focus Groups

Focus groups are commonly used in health research to explore the perspectives of patients or health care professionals providing rich and detailed data in their own words (McLafferty, 2004). Interpretive Description regards focus groups as a strategic way to generate certain kinds of social knowledge, such as beliefs and attitudes, that might underlie behaviour patterns (Thorne, 2016).

A topic guide (Appendix 2.7) was developed and informed by the literature reviews as well as the preliminary findings from phase one. The purpose of the focus group guide was to facilitate group discussion and to stimulate conversation about the research topic (McLafferty, 2014). The first focus group was treated as a pilot to test the topic guide and estimate the length of time required to obtain rich and meaningful data. No changes were made to the topic guide after the pilot focus group was completed and therefore all focus group data was analysed together.

Focus groups were undertaken in a room onsite, at a day and time that suited the hospice and staff participants. Whilst hosting focus groups in-person was preferred, it was recognised that focus groups may not be feasible due to COVID-19 restrictions, or difficulties getting health professionals together in one place. Video-conference technology was therefore identified as an option as it is considered an acceptable method for data collection using focus groups, for example when participants are geographically spread (Tuttas, 2015).

Memoing

Memoing is an informal way for a researcher to track and record reflections (Thorne, 2016). This is done by recording or writing memos as personal insights and reflections about the data being gathered, to check interpretations of observed actions, and to capture impressions as they occur (Glaser, 2013). In this way, memos can take the form of questions, remarks, or “lightbulb moments” that contribute to theoretical understanding (Thorne, 2016). Memos were used throughout this study and these observations and reflections were used to assist data analysis. A debrief memo was written after each interview and focus group to reflect on the process, noting any changes that may be indicated for future data collection (Thorne, 2016).

Data analysis: Phase One and Two

The data analysis method used in phase one and two was Reflexive Thematic Analysis (TA; Braun & Clarke, 2006, 2019, 2022).

Data analysis method

Reflexive TA was chosen as it is a qualitative interpretive approach that provides flexibility in the choice of a theoretical framework. In addition, Reflexive TA suits studies which are interested in patterns of meaning across the data set (Braun & Clarke, 2019). As such, this method accommodated both the experiential nature of the interview data and the approach to reflexivity taken throughout the research.

As one of several thematic analysis approaches, I appreciate the specific focus that Reflexive TA has on developing themes. Themes have a specific meaning and character and are defined as patterns of shared meaning underpinned by a central concept or idea (Braun and Clarke, 2006). I found the analogy of a dandelion helpful for conceptualising a theme as described by Braun and Clarke (2022). The central concept of the theme is like the central seed head that holds the seeds in place. Reflexive TA is conceptually congruent with the Interpretive Description methodology. Both are theoretically flexible with a strong focus on reflexivity and encourage an exploration below the surface of the data to develop themes and meaning (Braun & Clarke, 2019; Thorne, 2016). There are six phases of Reflexive TA (Braun and Clarke, 2006, 2022): 1) familiarisation with the data, 2) coding, 3) generating initial themes, 4) developing and reviewing themes, 5) refining, defining, and naming themes, 6) writing up. As for any method, the steps for Reflexive TA are more iterative than consecutive.

Approach to analysis

Braun and Clarke have continued to update their approach to thematic analysis since their landmark paper (Braun and Clarke, 2006). They now refer to their method as Reflexive TA in recognition of the position the researcher has as a reflexive research tool; this overt reference to reflexivity aligns with the embedded reflexive approach taken towards this study (Braun and Clarke, 2019, 2022). This researcher-as-tool position is constantly affirmed by Braun and Clarke as a positive quality if handled with transparency. The request Braun and Clarke make of researchers is to have a sense of "theoretical knowingness" with their analysis method and use it in a conscious, transparent way to achieve high quality results. This requires the researcher to decide on and document how Reflexive TA will be used in their study (Braun and Clarke, 2006, 2019).

Theoretical assumptions should be addressed before conducting Reflexive TA. These assumptions include experiential versus critical orientation to data, inductive versus deductive analyses, and semantic versus latent coding of data (Braun and Clarke, 2022). The orientation of this study towards Reflexive TA was experiential and concerned with exploring the truth(s) of participants' experiences, perspectives, and behaviours in the context they are situated (Braun and Clarke, 2022). This aligned with the focus on collecting data and analysing the participants' various experiences of rapport. As part of this experiential orientation, I considered the study's conceptual approach to language as active and symbolic, as influenced by Symbolic Interactionism. Language was the primary way of exploring the participants' experiences in this study.

An inductive approach to coding and theme development was used. Coding began as semantic, with codes identified through the surface meanings of the data and taking the participants words as they were stated to describe their experiences. Latent coding occurred in latter stages of the analysis. Latent coding goes beyond the descriptive level of the data to identify more hidden meanings of the data (Braun and Clarke, 2022).

Data Interpretation

Braun and Clarke assert the quality of a thematic analysis depends on the researcher's analytic insights. Conducting a "good TA" is a combination of using a robust process, having an analytic eye to the data, and interpreting data in the light of what is already known about the issue (Braun & Clarke, 2019). Interpretation is the process of making sense of qualitative data and sets the researcher on the quest of addressing the "so-what" question once themes are developed.

An Interpretive Description study requires analysis *and* interpretation of the themes and concepts developed to discern new meanings for what is being investigated. The challenge for researchers using Interpretive Description methodology and Reflexive TA is to go beyond reporting themes and the qualities of the pattern, to interpreting data for a new level of understanding (Braun & Clarke, 2019; Thorne, 2016). However, the move from analysis to interpretation does not occur at an exact point. Interpretation can be subtle and iterative, but it can also be marked by an in-depth understanding of data that allows the researcher to move from asking "what" the data is revealing to asking "why" (Madden, 2017). Interpretation precedes understanding, which Denzin describes as "relational and dialogical" (2001). The two elements of understanding are interpretation and shared experience. Denzin states the researcher who seeks to understand must be able to interpret the dialogue, the context of the experience and be able to see the experiences of the other from the other's point of view (Denzin, 2001).

I found two techniques particularly helpful navigating analysis and interpretation. One was to ask questions of my analysis and challenge my own (perhaps latent) assumptions. The second technique was to check if the analysis and interpretation had moved too far beyond the data (Braun and Clarke, 2022). I therefore returned to the data to recapture the sense of the participants' experience. I used these techniques when I felt stuck in a phase of analysis or attached to a theme that had wandered away from the central ideas.

Researcher reflection NVivo 12

The following text box presents an example of how I approached the ongoing reflexivity required during analysis. I reflect on my experience of using NVivo 12 with Reflexive TA during the six phases of analysis (Braun and Clarke, 2022).

Text Box 1: Researcher reflection: Using NVivo 12 with Reflexive Thematic Analysis to develop themes

In their 2022 book, “Thematic Analysis: a practical guide” Braun and Clarke discuss the pros and cons of qualitative data assisted software (QDAS) and Thematic Analysis (TA).

In this study using Reflexive TA, I made the choice to use NVivo 12 as a way to manage the data and assist with analysis. As a PhD candidate still developing skill as a researcher, I knew nothing about QDAS in general or NVivo 12 in particular, so I attended workshops and started reading online resources. Apart from Braun and Clarke's texts, the information I found most useful to this analysis was a You-tube video (Meehan, 2021) which outlined how to apply NVivo 12 to support analysis with Reflexive TA (Braun and Clarke, 2006, 2022). I outline below how NVivo 12 was used to assist the analysis during the six phases (Braun and Clarke, 2022).

Phase one: Familiarisation with the dataset. Once all of the data was uploaded, I set up files with the names of the six phases of Reflexive TA. Braun and Clarke. Having all of the data in one place made it feel manageable and gave a sense of cohesion across the data set. I made each of the transcriptions into case files. This meant I could read the dialogue of the transcript between researcher and participants as a file, or I could choose to read the participant responses as a case file. The case file function also proved useful throughout the analysis as the basis to view the coding in tables and figures.

Phase two: Coding. At first, using the NVivo 12 interface was cumbersome, but I quickly adapted and found using NVivo 12 to be a really interesting and satisfying experience. Initial coding was line by line over the whole dataset. Coding was loose and bountiful. At one stage there were 172 codes with many codes unique and seemingly unrelated to others. At this point, I realised the coding was too fine grained and recoded with a broader scope to give the codes more substance (Braun and Clarke, 2022).

Phase 3: Generating initial themes. From this recoding, I initially formed topics rather than themes as a way to look at the data. Examples of this was the grouping of coding into obvious headings such as: Details of calls; Experiences of phone calls; Experiences of video calls; Important aspects of calls; Palliative care; and Rapport and relational aspects. From this structure it was easier to discern what coding was relevant to support the research question. Further rounds of coding were done and slowly the topics were dropped, split, or combined into four place-holder themes: Making the call; Navigating the liminal space; How we get on together; and Roles being played (Figure 5-2).

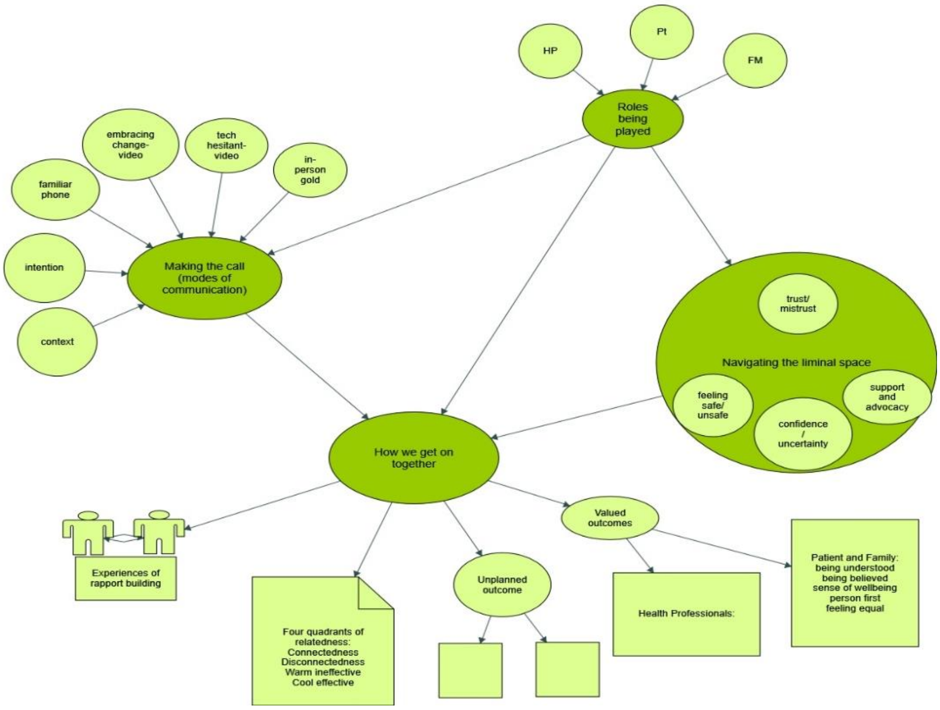


Figure 5-2 Concept Map example from analysis using NVivo 12

Phase 4: developing and reviewing theme. Concept maps such as figure 5-2 could then be used as a discussion point to review progress during research team meetings with MG and JR. Another useful tool to check themes across the dataset was the framework matrix function. For example, I could create a framework matrix to see all the coding for “feeling comfortable” and where each code sat in the context of each transcript. This made contrast comparisons of data more manageable.

Phase 5: Refining, defining, and naming themes. This phase took months. I moved from NVivo 12 at one point to working on large flip charts, with “post-its” under theme headings to introduce a more analogue approach to refining themes. I then returned to use NVivo 12 to capture updated themes and check my logic with concept mapping. Throughout phases 2-6, I had regular meetings with the research team to ensure a rigorous analysis. Eventually, I decided on the three themes presented in the study: “Rapport is a personal experience"; "How we get on together"; and "Navigating the palliative liminal space." (See figure 9-1).

Phase 6: Writing up. This was not managed in NVivo 12. All writing was done using Word documents. However, during this writing phase, data, and memos on NVivo were referred to and re-read, and theme development checked and adjusted.

Concluding thoughts- Using NVivo 12 was an invaluable way to manage data in this study and also provided a creative visual way to explore the development of themes. Sometimes the language of NVivo 12 tools was potentially problematic as in "Framework matrix" which has different epistemological meanings in different settings. This could be overlooked by using NVivo 12 as a toolbox to present data in a variety of ways to gain new perspectives and insights. The development of themes was a challenging, complex, and dynamic process made more manageable by using NVivo 12 alongside Reflexive TA.

For Reflexive TA, the written account is a vital part of the analysis and interpretation (Braun and Clarke, 2022). The process of writing is key to developing analysis and certainly helped me to refine themes. The writing process began early in the study and continued throughout. The written account of an Interpretive Description study aims to provide coherent and meaningful understanding of the experiential data to yield insights that can guide and inform clinical practice (Hunt, 2009; Thorne et al., 2004). Results from phases one and two are reported in Chapter 7.

Design of phase three

Findings from phases one and two were applied to the key variables of the Theory of Human Relatedness in order to:

1) to test the theoretical constructs of the Theory of Human Relatedness with the data using findings of phase one and two
2) to utilise the Theory of Human Relatedness as a framework to integrate the findings from phase one and two.

Data analysis: Phase three

As outlined in Chapter 4, the components of the Theory of Human Relatedness (Hagerty et al., 1993), were used as the variables which formed the framework for data analysis in phase three. The primary source of data for this analysis was the Central theme "How we get on together" developed from the phase one and two analysis (see Text Box 1 above). This theme included the coding for "relational aspects" from all participants. This data was further analysed, which involved an iterative process of moving back and forth between the coding and the theoretical components as the framework for analysis. A constant comparison analysis technique was also used throughout analysis (Glaser, 1965). This technique involved taking one piece of data and comparing it with all others in the dataset that may be similar or different to develop possible relations between data (Thorne, 2016). Phase three results are reported in Chapter 8.

Enhancing quality

Measures have been taken to enhance the quality of the research and outcomes in all three phases of this study. In the search for research quality, trustworthiness and rigour, terms such as credibility, transferability, dependability, validity, and confirmability are used commonly in qualitative research (Lincoln & Guba, 1985; Denzin and Lincoln, 2005). The debate about terminology and how to measure the rigour and quality of data continues (Noble and Smith, 2018). Researchers are encouraged to articulate their findings using clear logical processes which are accessible to a reader, show the relationship between the data and the conclusions, and present the claims in relation to the data set in a believable way (Thorne, 2016).

According to Oliver (2012), credibility rests on the researcher's ability to analyse, evidence, and justify the relationships between the research question, methodology and epistemology in a logical way. To assess credibility in research remains difficult, but credibility and quality are often acknowledged to be when the reader recognises the similarities between the experiences of participants and their own experiences (Lincoln & Guba, 1985; Sandelowski, 1986).

Interpretive Description methodology encourages building quality and credibility into the study design. The methodology has developed general principles to assess quality in research: epistemological integrity, representative credibility, analytic logic, and interpretive authority (Thorne, 2016). I have applied these quality principles to this study in the following ways:

Epistemological integrity

For research findings to be assessed as credible, the research process and methodology must have epistemological integrity and be congruent with the stated epistemological standpoint (Thorne, 2016). I demonstrated the cohesiveness of the research design elements of this study with the congruence between the research question, data collection, data analysis, interpretation, and the Interpretive Description methodology.

Representative credibility

Another way to demonstrate research quality and integrity is through the concept of representative credibility which requires the theoretical claims of the study to be consistent with the participant group sampled (Thorne, 2016). This can be demonstrated by triangulation of data sources, such as when multiple sources of information are used to consider the phenomenon from different perspectives (Fusch et al., 2018; Thorne, 2016). The data for this study came from different sources and methods of data collection, namely patient and family/whānau interviews, focus groups and interviews with health professionals, and researcher memos.

The research team can also provide a source of triangulation by having different investigators observing the same data (Fusch et al., 2018). For this study, having three members of the research team involved in data analysis (WE, MG, and JR) resulted in dynamic and interesting discussions that provided rigour.

Analytic logic

Analytic logic makes the researcher's decision-making process explicit throughout the study (Thorne, 2016). This is typically referred to as an audit trail (Lincoln and Guba, 1985; Nowell et al., 2017). Reflexivity is considered to be central to making a transparent audit trail (Nowell et al., 2017). I used a reflexive journal to track decision making for this study. I also wrote reflexive memos after each interview and a debrief after each focus group. In addition, a memo was written at each stage of the analysis using NVivo 12, and regular analysis meetings were held with research team members. Analytic logic was also considered as part of writing up the study. To this end, I have adopted a clear coherent style so that the reader is not left to make assumptions about decision making or findings related to the study.

Interpretive authority

Interpretive authority acknowledges the researcher's perspective and importance in qualitative research, but at the same time is concerned with the trustworthiness of the researcher's interpretation of data (Thorne, 2016). Regular meetings took place with research team members where analysis was subjected to rigorous interrogation over many months. A second check on interpretive authority came from the peer review process adopted through publication in academic journals. Submitting papers from this study for publication to peer reviewed journals (English et al., 2022a, 2022b, 2023a, 2023b, 2023c and one currently under review), has provided external perspectives to the data analysis and interpretation. Each review has been helpful to refine and define explanations of process and reasoning throughout the study.

Quality criteria

In addition to these quality principles, Interpretive Description also utilises five quality criteria (Thorne et al., 2004; Thorne, 2016). I outline below how I have addressed each of these criteria in my study (Table 5-4).

Table 5-4 Quality Criteria

Moral defensibility - refers to undertaking a study with the aim of not only generating knowledge about a certain phenomenon but also contributing to the alleviation of suffering and harm and promoting well-being.	I have only collected data relevant to the research objectives with the intention of promoting well-being by improving communication for palliative care patients and families.
Disciplinary relevance - the knowledge produced in an Interpretive Description study must have disciplinary relevance.	The knowledge produced is applicable to practitioners using telehealth in palliative care and perhaps more widely generalisable to other telehealth settings.
Pragmatic obligation - qualitative research can resonate with clinicians who may adapt	I have presented findings “as if” they might be applied in practice (Thorne, 2016). I have

their practice based on the research as presented.	developed reflexive tools in Chapters 2,6,7 and 8 for pragmatic use clinically.
Contextual awareness - the researcher presents their findings as contextual.	The findings of this study are contextual to the community palliative care and telehealth settings. However, I acknowledge that this study represents a moment in time in participants experiences.
Probable truth - this recognises the ambiguous zone of validity for qualitative findings.	This study provides contextual insights and understandings related to rapport and telehealth encounters.

Checklists

There is mixed support for using checklists in qualitative studies. The argument in favour, is checklists counter the lack of quality measures in some studies or the misrepresentation of methodologies and methods (Braun and Clarke, 2022; Tong et al., 2007). The argument against checklists, is that they can be reductive and stifle the creative side of research as well as doing little to ensure the excellence of qualitative studies (Barbour, 2001; Denzin, 2009; Thorne, 2016). Therefore, checklists need to be used with caution and be accompanied by thoughtful engagement and understanding of the immersive nature of analysis and theme development (Barbour, 2001; Braun and Clarke, 2022). However, there is often a requirement to complete a quality checklist when submitting articles for publication. This is related to concern that inadequate reporting of qualitative research can lead to inappropriate application of research in decision-making, health care, health policy and future research (Tong et al., 2007). By improving the quality of reporting qualitative research, the readers can be more informed when they critically appraise studies (Tong et al., 2007; de Jong et al., 2021).

For this reason, I used the Equator Network (n.d.) guidelines to enhance the quality and transparency of the published papers reported in this study. These guidelines included the Consolidated criteria for reporting qualitative research (COREQ) for studies with interviews and focus groups which I used for the papers presented in Chapters 7 (English et al., 2023b; English et al.,2023c), and the PRISMA guideline for the integrative review and the PRISMA extension guideline (PRISMA-ScR) for the scoping review (English et al., 2022a). Further to these checklists, I used the Braun and Clarke 15-point checklist to assess data analysis quality, the Reflexive TA method integrity, and to guide the analysis phase (Braun & Clarke, 2022).

Ethical considerations

As this study was conducted with human participants, it is essential to provide a clear account of the ethical considerations. In the context of a study set in Aotearoa, NZ, I outline how Te Tiriti o Waitangi (the Treaty of Waitangi, see below) principles are integrated into the study. I then outline the handling of informed consent, potential conflict of interest, and privacy and identity protection.

Ethical Approval

A full proposal of the ethical considerations for this study was approved by the Health and Disability Ethics Committee (HDEC; ref: 20/CEN/165) in New Zealand (NZ), on 9th September 2020 (Appendix 2.8).

Te Tiriti o Waitangi

Te Tiriti o Waitangi (in English, the Treaty of Waitangi; Hobson, Busby, and Freeman, 1845), became NZ's founding document in 1840. It aimed to represent a partnership between Māori and the British Crown. Although it was intended to create unity, there were two versions of the document one in English and one in Te Reo Māori (the Māori language). The different versions resulted in different understandings of the treaty that led to the colonisation of Māori and resulted in loss of land and disruption to language and culture. Along with colonisation came longstanding health inequity for Māori (Ministry of Justice, Hauora report, 2023). Today, Te Tiriti o Waitangi should guide all aspects of the relationship between Māori and the NZ government, including the health sector. All health research conducted in NZ also needs to incorporate Te Tiriti o Waitangi in study design. This includes providing evidence of responsiveness to Māori to promote participation and inclusion of Māori voices (Reid et al., 2017). Being responsive to Māori in health research contributes to developing knowledge that may improve Māori health and reduce health inequities (Reid et al., 2017). Under Te Tiriti o Waitangi, health is recognised as a taonga (treasure) that should be protected (Came et al., 2019).

As a researcher of European descent, it was critical that I understood my responsibilities to Te Tiriti o Waitangi, as part of the ethical considerations for a study including persons with life limiting illness, situated in NZ. I provide here an overview of how I integrated the guiding principles of te Tiriti o Waitangi into the study design. The guiding principles are often referred to as Protection, Participation, and Partnership (Hudson and Russell, 2009; Moeke-Maxwell et al., 2013).

Protection: Under Te Ara Tika (a Māori ethical framework) a key research principle is consultation with Māori (Hudson et al, 2010; Moeke-Maxwell et al., 2013). I sought advice from experienced researchers and Māori leaders to clarify culturally appropriate research methods and best practice regarding data collection from Māori participants. I discussed this subject with my supervisors (MG and JR) and with Dr TMM (Ngāi Tai, Ngāti Pōrou) a Senior Research Fellow and Co-Director of the of Te Ārai Palliative Care and End of Life research group. I also consulted with a Kaihautū Māori (a Māori leader) at my place of work.

I was asked by Dr TMM to consider if I was the right person to be asking questions of Māori participants. In addition, I was advised to introduce more Kaupapa Māori (Māori approach) research principles into the study, such as offering karakia (prayer), waiata (song), kai (food), and koha (a gift or offering of hospitality) at the Māori person's home. It was suggested that I be accompanied when visiting a Māori participant's home, where possible by kaumātua (local elder) or kaiāwhina (Māori liaison) with connections to the hospice and local iwi (tribe). This was to ensure tikanga Māori (correct cultural protocols and practices) be observed during the interview.

Participation: includes involving Māori in the design, governance and management, implementation, and analysis (Hudson and Russell, 2009). Every effort was made to ensure each stage of the study was inclusive of Māori. For example, arranging the meeting time and place for interviews with Māori participants was done with assistance of kaiāwhina (Māori liaison) where available from the participating hospices.

Partnership: Another way to honour partnership was to incorporate Te Ara Tika (a Māori ethical framework) into the research design based around the four principles of: Whakapapa (relationships), Tika (to be correct, research design), Manaakitanga (care of others, cultural and social responsibility), and Mana (justice and equity reflected through power and authority; Hudson et al., 2010). I provide examples of how these principles were applied in this study.

- ***Whakapapa*** in this context is concerned with relationships. During the research process I consulted and built relationships with the health personnel, kaiāwhina, and senior management at the four hospice sites. To have more successful whakapapa I identified needing more time and being more available in each location. I plan to return to each site this year to report on the findings and build these relationships further.

- ***Tika*** refers to research design. Oral narratives are a valued traditional way of communicating knowledge for Māori and qualitative research. In this way, semi-structured interviews aligns with Tika by placing value on the perspectives, voices, and experiences of participants
- ***Manaakitanga*** embraces cultural and social responsibility. In the spirit of partnership, it was important to talk with participants about how the study may benefit Māori. As the study aimed to look at how rapport is experienced by participants, at its essence it was a korero (conversation) with palliative care health professionals about how mana, tika, manaakitanga and whakapapa can be improved.
- ***Mana*** is concerned with justice and equity. As a researcher this includes demonstrating respect for the mana tangata (personal autonomy) of each person involved in the study. Mana also relates to the researcher's duty of care of participants when obtaining consent, handling potential conflict, and protecting the privacy of participants.

Informed Consent

At the core of informed consent is respect for the principle of autonomy or self-determination, which emphasises respect for the person and their determinism of their own life (McGrath and Phillips, 2008). For indigenous people, the principle of autonomy alone may not be enough according to traditional values. For example, Māori, Aboriginal, and Pacifica cultures, emphasise the importance of collective decision making involving familial and cultural groups over individual autonomy (McGrath and Phillips, 2008). It is also important to provide assurance that patients and others are neither deceived nor coerced

(O'Neill, 2003). The consent process therefore, needs to embrace the same four Te Ara Tika principles outlined above and consider informed consent and decision-making capacity as elements of a study's design (Casarett, 2003).

In palliative care, the need to ensure participants have the capacity to consent can be challenging. People with palliative care needs may experience fluctuating/declining physical and mental capacity related to disease, medication, or treatment effects (Gysels et al., 2013). A continuous process of consent during interviews is recommended for the researcher to gauge changes in an individual's attitude and ability to participate. This requires careful monitoring of signs of verbal or nonverbal distress especially when capacity is rapidly declining (Gysels et al., 2013).

In this study, I consulted with senior hospice staff on the day of patient interviews regarding the person's ability to consent and participate. I then telephoned the patient participants checking how they sounded and whether they still wished to participate before confirming the interview time. For all participants, I ensured full information was provided to the participants about their rights, ease of withdrawal at any time, confidentiality, and the care taken with data handling. Written consent was obtained from each person prior to start of the interview/focus group. I checked the participants' comfort and consent at the beginning and end of the interviews.

Potential conflict of interest

At the time of the interviews a potential conflict existed at my place of work which was one of the study sites. As well as being a researcher, I was a palliative care nurse and at that time, worked in an inpatient hospice setting. My dual role of nurse and researcher was declared in the participant study information sheets for that site.

Privacy and Identity protection

The privacy of participants was maintained at all times. As an experienced palliative care nurse, I was aware of the confidentiality and privacy requirements relating to visiting patients and families in their homes. Data collected from participants was de-identified, and a code assigned to replace each participants name. No details of participants involved in this research were revealed in any correspondence relating to the project. Transcriptions and data files containing any names and addresses were password protected and access was restricted to the researcher. Hand written notes and memos were kept in securely locked files. Only WE, the researcher, and the supervisors had access to data from the study. Research results included in published manuscripts or appearing in this study did not include any potentially identifying participant details.

Chapter summary

In this chapter, I have outlined the methodology and design of the study. I have provided detail on the rationale for using Interpretive Description methodology. I have outlined the three-phase research design and described how I addressed research quality and ethical considerations. The next three chapters report the results of the study.

Chapter 6 Results: A conceptual definition of rapport

Chapter introduction

This is the first of three chapters that together make up the results section of the study. The purpose of the chapter is to provide an overview of the process undertaken to develop the conceptual definition of rapport from the phase one data. The chapter contains a published paper: **Rapport: A conceptual definition from the perspectives of patients and families receiving palliative care.**

Preamble to Paper

The literature reviews presented in Chapter 3 highlighted a key evidence gap, namely the lack of a conceptual definition of rapport which is informed by patient and family/whānau experiences of clinical interactions. None of the existing definitions of rapport, identified in the reviews, were informed by patient, family/whānau or even health professional viewpoints of rapport. The lack of a robust conceptual definition of rapport was a barrier to the analysis of the phase one and phase two data. A decision was therefore made to develop a definition of rapport that would benefit this study as well as future research and clinical practice. An important principle in the development of the definition was grounding it in the perspectives of the patient and family participants.

The process used to develop a conceptual definition of rapport is outlined in the published paper that forms the body of this chapter. The conceptual definition paper was published by *Patient Education and Counseling* in 2023. It is reproduced here in its entirety with permission from the publishing journal. This publication is cited in further chapters as (English et al., 2023a).

English, W., Robinson, J., & Gott, M. (2023). Rapport: A conceptual definition from the perspective of patients and families receiving palliative care. *Patient Education and Counseling*, *106*, 120–127. https://doi.org/10.1016/j.pec.2022.10.012

Rapport: a conceptual definition from the perspective of patients and families receiving palliative care.

Introduction

Healthcare professionals recognise rapport as an essential part of communication that centres on patients and their families (Epstein and Street, 2007; Norfolk et al., 2007). Ideally rapport is initiated from the first moments of meeting through actions such as a warm introduction, finding common ground, and exploring the patient's experience of their illness (Cavallaro and Cavallaro, 2016). Having rapport indicates a high functioning connection with patients and families which helps to develop trust and facilitate difficult conversations (Cavallaro and Cavallaro, 2016). As rapport is essential for interpersonal relations (Chan et al., 2018), it would seem necessary to have a conceptual definition of rapport that can improve health professional understanding and clinical expertise of rapport building in their interactions with patients and their families.

However, for all its stated importance, rapport is a poorly defined concept (Guthrie and Beadle-Brown., 2006). Our recent scoping review found no conceptual definitions of rapport across thirty four studies (English et al., 2022a). Indeed, few definitions were reported in the studies and no commonly agreed definition of rapport was identified**.** Most definitions drew on Tickle-Degnen and Rosenthal's conceptualisation of the nonverbal components of rapport including positivity, mutual attentiveness, and coordination (Tickle-Degnen and Rosenthal, 1990). One such definition defined rapport as "a perceived connection with another individual based on respect, acceptance, empathy, and a mutual commitment to the relationship” (Epstein and Street, 2007, pg. 19). Tickle-Degnen and Rosenthal’s conceptualisation of the nonverbal components of rapport has also informed a body of research on rapport using observation and video clips of people interacting (Bernieri et al., 1996; Grahe and Bernieri, 1999; Puccinelli et al., 2003).

Our scoping review also identified a key gap in current understanding, namely the extent to which these definitions of rapport reflect the patient and family/whānau experience (English et al., 2022a). Although studies asked patients to rate aspects of health professionals’ rapport building, no reviewed studies explored the patient and families experiences of rapport. We concluded by identifying a need for future research to inform a more inclusive definition of rapport which is informed by the perspectives of patients and families.

One area of healthcare where the need to better understand patient and family/whānau understandings and experiences of rapport is palliative care. Indeed, creating rapport with patients and families has been identified as key to delivering high quality palliative care (Seipp et al., 2021). However, our scoping review identified that there were no studies which explicitly defined rapport in this context, even when arguing rapport was necessary to provide quality palliative care (Seccareccia et al., 2015).

When studies do not provide a definition, it becomes difficult to know exactly what is meant by the term “rapport” and leaves space for researchers and health professionals to make assumptions. Conceptualisation is the process that specifies precisely what is meant when a particular term is used (Martin et al., 2013). It tells the reader how the concept is defined in the context of the study, identifying the concept’s meaningful characteristics, and elucidating how the concept sits in relation to other concepts (Podsakoff et al., 2016). Within the context of rapport the lack of a clear conceptual definition hinders distinguishing it from related concepts such as trust, empathy, therapeutic alliance, and respect. If not defined conceptually these concepts can overlap and meanings become blurred (Martin et al., 2013) as has been the case in previous studies (for example, Dang et al, 2017). A conceptual definition also provides a common language between researchers, a building block for operationalisation of a concept (Allen, 2017) and can influence clinical understanding and policy development (Nagel et al., 2021).

It was within this context, that the study presented in this paper explored patient and family/whānau perceptions of rapport during interactions with health professionals when receiving palliative care. These findings were then used to develop a conceptual definition of rapport.

Methodology

This study has an interpretive perspective through a Symbolic Interactionist lens (Blumer, 1969). The Symbolic Interactionist philosophy is based on the sense people make of their social worlds through communication and social interaction, particularly through the exchange of meaning through symbols and language. An interpretive stance is appropriate for a study exploring rapport between patients, families, and health professionals.

The study design followed the Interpretive Description qualitative methodology for applied practice (Burdine et al., 2021; Thorne, 2016). Interpretive Description is an approach to generating knowledge about "complex experiential clinical phenomena that would be optimally relevant and useful" in healthcare (Thorne, 2016, pg. 29). This aligned with our research team's commitment to producing research that contributes to knowledge academically and has clinical application. From the previous literature review (English et al., 2022a) we determined a qualitative approach was necessary to address the research aim and develop a conceptual definition. The Theory of Human Relatedness (Hagerty et al., 1993; Hagerty and Patusky, 2003) underpins this study and informed the development of aspects of the interview schedule regarding comfort and involvement. While this current paper focuses solely on developing a conceptual definition of rapport, data were collected as part of a larger qualitative study of experiences of rapport building during telehealth in palliative care. The results from the patients, families, and health professional telehealth experiences are to be reported elsewhere.

Data were collected using a single in-person semi-structured interview with participants. Interviews were conducted by the first author, an experienced palliative care nurse who had previously conducted research interviews (WE). An interview schedule was developed from the literature (English et al., 2022a; Hagerty et al., 1993). Questions 7-9 from the schedule (Appendix 2.5) are most relevant to the analysis presented in this paper. These questions related to the language patients and family/whānau members used to describe rapport, and examples of what rapport with health professionals meant for them. The interviews were audio recorded after written consent obtained, and transcribed verbatim by WE, with field notes written after each interview. All participants were allocated a unique identifier to allow for anonymous linkage to specific quotes in text- e.g. for patients (Pt A, etc) or family/whānau members (FM B, etc). Ethics approval was granted by The Human and Disability Ethics committee (HDEC) New Zealand, ref: 20/CEN/165.

Setting/Participants

Participants were recruited from four hospices providing community services in Aotearoa, NZ. Patients over 18 years were eligible to participate if they were receiving palliative care in their homes and could converse in English. Adult family/whānau members were eligible if they were providing care and support for patients receiving palliative care at home and could converse in English. Non-clinical senior hospice staff selected patients and family/whānau members from the patient management systems and checked notes to ensure inclusion criteria were met. Some purposive selections were made on the basis of ethnicity to improve demographic representation. We referred to the Information Power model (Malterud et al., 2016), as recommended in Braun and Clarke (2022), to determine a preferred sample size of around thirty participants.

Potential participants were telephoned by hospice staff and provided with a description of the study to assess interest in participation and permission to be contacted by the researcher who was also described as an experienced palliative care nurse. Interested participants were later phoned by the interviewing researcher with additional study information and provided with an opportunity to ask questions. An interview appointment was made for a time and place of the participants choice, with an invitation for a person or family/whānau member to be present for support. Written consent was obtained from each participant before the interviewing commenced. Interviews were 30-45 minutes long. The interviews were conducted during November 2020 to May 2021 between nationwide Lockdowns (where in-person contact was prohibited due to outbreaks of COVID-19).

A total of eighteen patients (Pt) and eleven family/whānau members (FM) participated in interviews.

Table 6-1 Participants Characteristics

Characteristics	**Patients (n=18)**	**Family/whānau (n=11)**
Ethnicity	NZ European - 15 NZ Māori - 2 Other -1	NZ European - 10 NZ Māori - 1
Gender	Female - 9 Male - 9	Female - 8 Male - 3
Age	30-49 - 2 50-69 - 8 ≥ 70 - 8	30-49 - 4 50-69 - 5 ≥ 70 - 2
Diagnosis	Cancer - 18	(Of patient being cared for) Cancer – 11
Occupation	No longer working - 18	Full time caregivers - 8 working/caregivers - 3
Relationship to patient		Wife - 6 Husband - 3 Daughter - 2

Most patient participants were of European descent with two identifying as NZ Māori and one as Other. There were an equal number of men and women. Eight participants were over 50 years old and a further eight were over 70. All had a cancer diagnosis.

Family/whānau members were mainly of European descent with one identifying as NZ Māori. Most were female and under 70 years of age. All were close family/whānau members of the person being cared for either a wife, husband, or daughter. Eight were full-time caregivers, with three still working as well as involved in caregiving. All family/whānau members were caring for patients at home with a cancer diagnosis (Table 6-1).

Analysis

Reflexive Thematic Analysis (TA; Braun and Clarke, 2006; Braun and Clarke, 2022) was conducted using this participant group data which formed part of the larger study. Findings presented here drew from coding of one of the themes identified in that analysis "Rapport is a personal experience" (See Figure 9-1). This coding is related to the characteristics and attributes of rapport described by patient and family/whānau participants. As the intended output of this particular analysis was a conceptual definition of rapport rather than themes, an approach to data analysis other than Reflexive TA was needed (Braun and Clarke, 2022). We therefore, adapted the guidelines for developing a conceptual definition recommended by Podsakoff et al, (2016). Reflecting our approach and to avoid confusion, what might ordinarily be termed themes in the next section will be called topics.

Developing the conceptual definition

The process to develop a conceptual definition of rapport involved four stages adapted from Podsakoff et al, (2016) as outlined in Table 6- 2. All data related to the coding of attributes of rapport from the initial Reflexive TA were further analysed with the support of NVivo 12. This process implemented NVivo functions to develop a concept map with four topics headings of rapport- 1) the type of relating, 2) the essence of rapport as attributes, 3) the kind of communication needed; and 4) the effects of rapport. Topic headings were further analysed and refined to become dimensions of rapport and from these dimensions an initial conceptual definition was developed.

Table 6-2 Four stages to develop a conceptual definition

Stage 1. **Identify potential attributes of the concept by collecting representative data.**	Coding and data from patient/ family interviews included in the Theme "rapport is a personal experience" (See Figure 9-1).
Stage 2. **Analyse and organise the attributes by topic.**	Four topic headings identified.
Stage 3. **Develop a preliminary definition of the concept.**	Topic headings became dimensions of rapport and initial wording was developed.
Stage 4. **Refine the conceptual definition.**	Wording checked for dimensions and definition to create a clear and concise definition.

Adapted from Podsakoff et al., (2016)

Ensuring quality and rigour

To ensure the quality and rigour of the study, reflexive memos were written at each stage of the study (Thorne, 2016). These memos also provided an audit trail for thoughts and decisions made while navigating the analysis. Other measures included using a COREQ checklist (Tong et al., 2007), a reflexive journal kept by WE, and regular research team meetings to discuss the analysis. Considerable thought was given to the role of reflexivity in the research and analysis process and resulted in reflexive exemplars that assisted analysis.

Results

Most participants recognised the word rapport immediately and were able to put their own words to the concept and share their experiences of building rapport with health professionals. There was no single shared description of rapport identified from participants accounts, instead rapport was a personal experience for each participant. Most participants had experienced many interactions with health professionals over the duration of the patient's diagnosis and treatment of illness. All interactions discussed in the interviews occurred while the patients were receiving palliative care and included health professional contacts from general practice or hospital services such as oncology during this time.

Four dimensions of rapport were developed: 1) the type of relating, 2) the essence of rapport experienced, 3) key communication characteristics, and 4) the effect on interactions. These dimensions formed the basis of our conceptual definition for rapport

Four dimensions of rapport

Our interpretation of each dimension of rapport is outlined below and supported by participant quotations in text boxes to illustrate the key characteristics identified.

Dimension 1: Type of relating

Dimension 1 includes the participants perceived connections related to rapport and identifies those involved in the interactions.

Perceived connection

Rapport was a perceived connection between patient and/or family/whānau and health professionals. Most participants felt they did have a connection of some description with health professionals while receiving palliative care. Participants used phrases such as "getting on together" and having a relationship or connection with health professionals. While some participants felt a connection from the first meeting, other participants felt the connection developed over time. A small number of participants provided descriptions of feeling in-sync with the health professional by using language such as "clicking" or "being on the same page". Even though participants recognised rapport occurred within the context of two people, they experienced rapport personally and recognised there was no confirmation from the other person that they were experiencing the same thing at the same time. For example, when asked if she thought the health professional felt the same connection she did, one participant answered, “I am not sure how it was for them.” (FM F.)

Dimension 2: Essence of rapport experienced

Dimension 2 relates to the essential characteristics of rapport as experienced by the participants. The characteristics included participants experiencing an interaction that was relaxed, positive, friendly, with a sense of being accepted, and being cared about.

Relaxed, positive, friendly

Most participants perceived that rapport occurred in a relaxed context and described such interactions as warm, lovely, cheery, and positive and friendly (Text Box 1). Participants reported it was. Some participants were relieved when interactions were relaxed and less formal than they were expecting. For example, one patient discussed bracing himself for a formal interaction with doctors and was smiling while recalling how relaxed and engaged he felt instead. Other participants credited the health professionals they were interacting with for “making” them feel relaxed. Health professionals were perceived as responsible for setting a relaxed scene for rapport building.

Text Box 1: Participant quotations- Relaxed, positive, friendly
She can make you feel relaxed, and … I am comfortable talking on the phone with her. (Pt C)

They are just so cheery, and it makes me feel so good. (Pt F)
Amazingly relaxed. I thought it was going to be one of these business ones, stiff shirt jobs, but no it was very relaxed. (Pt R)
Because I think I'm also pleased to hear from them you know, they ring up and I go, "Hi, what are you up to, are you busy and you know, how's L doing?" and we chat for a while. (FM G)

Being Accepted

Rapport was more likely to develop when participants felt they were accepted by the health professional. Participants perceived acceptance as feeling included, believed, and not being judged by health professionals (Text Box 2). When participants felt accepted, they also felt safe to be honest and ask "silly" questions and talk about anything including topics perceived as embarrassing or shameful.

A hallmark of acceptance in this context of rapport was the sense of relating to each other as people regardless of labels such as patient, doctor, nurse, or wife while remaining respectful of professional and personal boundaries. This acceptance involved participants feeling seen by health professionals as people living their lives rather than as a disease or a dying patient. For caregivers it was being recognised as a person with their own needs. When participants felt accepted, they also showed interest in the health professionals as people.

Text Box 2: Participant quotations -Being accepted
Accepting you for who you are no matter what clothes you've got on or without, you know, you are accepted for who you are and the problem that you have at this point of time. (Pt M)

…they talk to you as a human. (Pt G)
And I think we need that. Carers need that. Everybody needs that. For somebody to say to them every now and then - Hey, how are ***you*** *doing? (FM A)*
More a sort of mutual understanding and a mutual acceptance and fairly free communication between us, yes. (Pt O)

They care

Participants referred to the characteristic of caring more often than empathy in this study. Whereas empathy is said to be a vital component of developing rapport from a health professional point of view, (Epstein and Street, 2007; Norfolk et al., 2007) the concept of caring was more personally meaningful for the participants in this study. Participants needed interactions with health professionals to be based on caring to develop rapport and make a meaningful connection. Health professionals demonstrated care in simple ways often with tone of voice, smiles, nods, knowing patients' names, their interests, and families, sharing a book, or having a laugh together during interactions. Many participants also associated feeling cared for with feeling safe to ask health professionals anything. Some participants were relieved by authentic caring tone and words, and health professionals not just pretending to care. One patient compared interactions with rapport and those that lacked rapport. For him, health professionals "actually" caring was a key difference in the interactions (Text Box 3).

Text Box 3: Participants quotations- They care
They do care. Oh yeah. It's that care, you can just tell. (FM A)
You can actually ask them sort of anything, and you don't feel as though you are stupid in asking them. Yeah. It just made me feel that they care. (Pt N)

They actually care and they talk to you. (Pt G)
I think it's mainly that they are very genuine. (The oncologist) she really cares. Possibly because she's been in the job for such a length of time, but also possibly because there is an underlying thing where her heart is really in it. (Pt H)

Dimension 3: Key communication characteristics

There were two main communication traits that participants reported as integral to building rapport, those of listening and being understood.

Feeling really listened to

Most participants linked rapport with feeling listened to by the health professionals. Participants felt reassured and more positive when they felt health professionals were listening to them. The listening was not idle, it was active and linked to participant problems being taken seriously. For some participants, listening was more obvious when they felt they had the attention and interest of the health professional they were speaking to, for others it was the ability to talk about anything. For one patient, he felt listened to when health professionals simply remembered and accommodated his deafness. This kind of thoughtful listening led to participants feeling comfortable to share deeper concerns (Text Box 4).

Text Box 4: Participant quotations – feeling really listened to
They listen and they are reassuring, so you do feel more positive. (FM J)
I felt listened to, I felt like any problems I had were being addressed. (Pt A)
J would listen - she's a great listener! I could talk to her about anything… and she would listen and she's great. (FM A)
I guess I always feel I am being listened to. It is because you know that you have their full attention, they are listening to you, and it is important. (FM F)

Being understood

Most participants perceived feeling understood as a key part of developing rapport with health professionals. Understanding involved the health professional listening with the intention to understand and verbally acknowledging what had been said in a way participants were satisfied with. It was important for participants to understand the health professional as well. Understanding each other was a prerequisite to moving onto meaningful discussion or planning (Text Box 5).

Text Box 5: Participant quotations – being understood
A certain understanding of each other is part of rapport and working together. (Pt O)
Yeah, I need the right people who understand the problem. (FM C)
If we get a feeling, we both understand each other really well, the treatment can be changed. (Pt B)
Understanding. Sensitivity. Concern. That's probably it. Put it together and you've got a good person looking after you. (Pt M)

Dimension 4: The effect on the interaction

Dimension four describes the effect rapport had on participants' interactions with health professionals. Participants felt rapport increased the confidence they had in themselves and in their health provider and seemed to have a bolstering effect for participants. Having rapport with health professionals fostered trust and in-depth sharing.

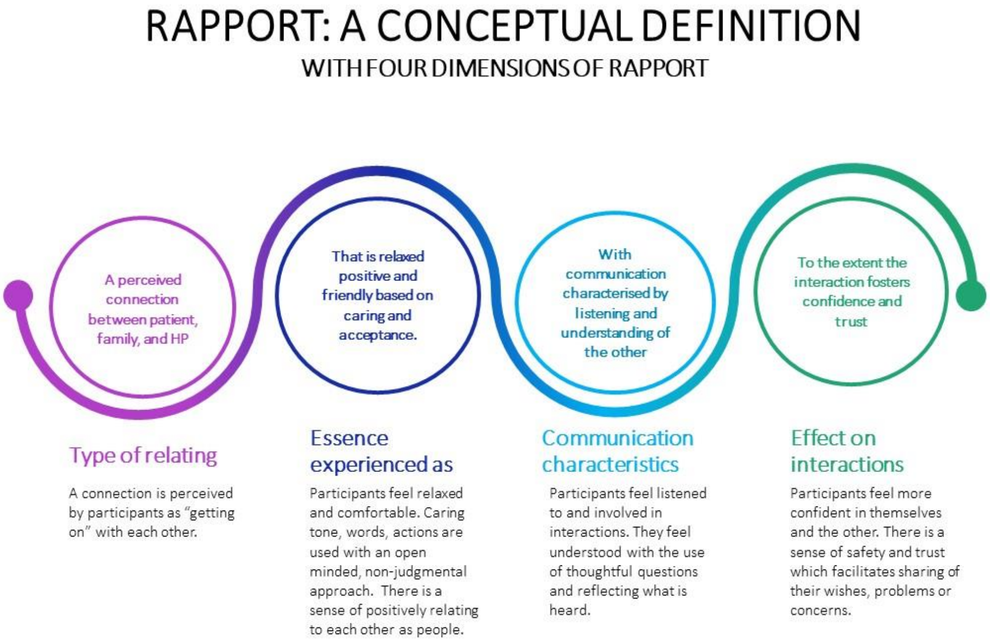
Text Box 6: Participant quotations- the effect on the interaction
Yeah, you sort of get your confidence back when you are talking to them. (Pt F)

Well I think it is quite important. You can't have the same confidence if you don't have [rapport]. (Pt O)
It brings in the trust element. That's when you start to feel you can really open up and tell them anything and everything. (FM D)
So I felt they trusted my judgement, which helped a lot. You didn't feel silly for ringing anybody or that you were putting people out really. (FM C)

Conceptual definition of Rapport

Based on these four dimensions of rapport we constructed a conceptual definition for rapport that reflected patient and family/whānau perspectives. Where possible the language of the conceptual definition used the words of the participants in the interviews: connection, relaxed, positive, friendly, caring, acceptance, listening, understanding, confidence, and trust. We also recognised that the definition needed to be clear, concise, and relatable to a broad audience (Podsakoff et al., 2016). The definition is as follows:

Rapport is a perceived connection between patient, family/whānau, and health professional, which is relaxed, positive and friendly, based on caring and acceptance, with communication that is characterised by listening to and understanding of the other, to the extent the interaction fosters confidence and trust (Figure 6-1).



A connection is perceived by participants as "getting on" with each other.

Participants feel relaxed and comfortable. Caring tone, words, actions are used with an open minded, non-judgmental approach. There is a sense of positively relating to each other as people.

Participants feel listened to and involved in interactions. They feel understood with the use of thoughtful questions and reflecting what is heard.

Participants feel more confident in themselves and the other. There is a sense of safety and trust which facilitates sharing of their wishes, problems or concerns.

Figure 6-1 Conceptual Definition of Rapport

Discussion

This study is the first of its kind to develop a conceptual definition of rapport informed by patient and family/whānau perspectives. Our analysis drew on interviews with patients and family/whānau members receiving palliative care and identified four dimensions of rapport: the type of relating, the essence of rapport experienced, key communication characteristics, and the effect on interactions. These dimensions formed the basis of a conceptual definition of rapport which differs from previous definitions in three ways. Firstly, this definition identifies the key communication skills required for rapport building, secondly, it is grounded in patient and family/whānau perceptions and thirdly, it includes the effects that rapport has on interactions. Our definition serves a different function to that of Tickle-Degnen and Rosenthal's (1990) which was developed to identify the nonverbal behaviours of rapport. It also extends beyond the scope of Epstein & Street's (2007) definition which listed characteristics and the type of relating that included a mutual commitment to the relationship.

A conceptual definition of rapport has importance for both research and clinical practice (Babbie, 2016; Guthrie and Beadle-Brown, 2006). In general, research is conducted to better understand a phenomenon and to build upon existing knowledge (Thorne, 2016). It is imperative that studies about rapport include a definition; a definition provides the reader with a clear understanding of the concept in the context of the study (Foppe van Mil and Henman, 2016). A further benefit of using a definition of rapport is to reassure researchers how the concept is being understood, for example, when conducting a meta-analysis across studies (Timulak, 2009). During the development of this conceptual definition of rapport we considered how rapport might be operationalised in future research, including the larger study this paper is part of. A definition needs to avoid terms that are too vague to operationalise in qualitative studies (Langham et al., 2016). An example of a term we avoided was the word relationship, opting instead to use the word connection (Dimension 1). We made this decision as the term connection was used more often by participants. Connection can also apply equally to one-off interactions as well as a relationship over time, which more realistically reflects the clinical context. Similarly we chose the word interaction (Dimension 4) to reinforce the notion that rapport is interactionally based and intentional, not just done once in an initial meeting (Price, 2017).

We wanted to develop a definition of rapport which health professionals could draw on in their clinical practice as until now rapport has not been conceptually defined for this context. Health professionals are expected to develop rapport with their patients, yet evidence of what constitutes rapport building in individual practices may be interpreted differently (Segaric and Hall, 2015). For some health professionals, rapport may be perceived similarly to our definition. However, other health professionals may perceive rapport as out of their control particularly when they do not “click” with the person (Kromme et al., 2016). Rapport may then be seen as optional, especially if the health professional is too busy or stressed, or think rapport is just a smile and seeming to be “nice” (Segaric et al., 2015; Stein-Parbury, 2018). Patients and family/whānau participants in this study perceived the health professional as responsible for creating a relaxed environment in which they could be listened to and understood by the health professional as a basis to developing rapport. These are rapport building skills that need active participation and mindfulness from the health professional, whether or not personalities have “clicked” and regardless of how others are behaving (Kromme et al., 2016; Alison and Alison, 2020).

A definition that conceptualises rapport can also be used to identify what constitutes a lack of rapport. According to the definition developed in this study, an interaction perceived to be without rapport is likely to be one where health professionals interact without acceptance, caring, listening, or understanding. In turn, this results in a lack of trust and confidence in the health professional or service. Indeed, some studies identified in the English et al, review (2022a) gave examples of health professional behaviours that lacked rapport (Segaric and Hall., 20215; Insua-Summerhays et al., 2018; Albahri et al., 2018). Interactions without rapport have been found to have the potential to lead to bias, judgement, and stigma (Gudzune et al., 2013; Fitzgerald and Hurst., 2017). Hill (2010) argues, it is not enough to be well meaning advocates of non-judgmental attitudes and patient-centred care. Health professionals need a better understanding of what actually happens in healthcare relationships and what the cost is for poor communication (Alison and Alison., 2020; Thorne at al., 2005). A conceptual definition grounded in patient and family/whānau perceptions may help further understandings of rapport, however more research is needed to investigate how interactions characterised by a lack of rapport impact on outcomes for patients, families, and health professionals.

A possible limitation of the study is that participants were patients and families receiving palliative care at home. The findings are situated in the community palliative care context and may not be generalisable to other care settings. Whilst there is little to suggest that the definition and findings are unique to this community setting, this would provide a fruitful area for future research in various contexts. Another limitation may be that despite recruitment efforts to be more ethnically inclusive, the sample of participants was limited to predominately European descent. The findings therefore, may not be transferable to other cultures. Furthermore, all participants had a cancer diagnosis or were caregiving for persons with cancer. Therefore, the findings may not be indicative of the views and experiences of people with a non-cancer diagnosis.

Rapport is important to patients and considered an essential part of the relationship with health professionals (Guthrie and Beadle-Brown, 2006; English et al., 2022a). For patients and the family/whānau members in this study, rapport was more than social chat and pleasantries, rapport was a unique and personal connection where they felt cared for, safe, and confident to share their concerns without fear of judgement from health professionals. However, due to the uniqueness of each person and interaction there are many opportunities for rapport to go well or go awry (Rolfe, 2006). The presupposition that health professionals develop rapport with patients and families, makes it an ideal experience to reflect upon (Price, 2017). To this end, we suggest it is important for health professionals to adopt a reflective practice on their rapport building experiences to develop their skill and expertise in this area (see table 6-3).

Conclusion

Health professionals are expected to develop rapport with patients and families as part of their clinical practice and yet, until now, rapport has not been conceptually defined for this context. By drawing on patient and family/whānau views and experiences, this study identified four dimensions of rapport which formed the basis of a new conceptual definition for rapport. This definition has three key differences from existing definitions: Firstly, it is grounded in patient and family/whānau perceptions; secondly, it identifies the key communication skills required for rapport building; and thirdly, it includes the effects that rapport has on clinical interactions. Our definition provides clarity and a common language regarding rapport to apply to research and clinical practice.

Implications for practice

Having a commonly used conceptual definition of rapport that is patient and family-centred may improve health professionals’ understanding and clinical expertise in rapport building. Although developed in a palliative care context the definition may be applied to any clinical area where developing rapport with patients and families is a crucial part of the therapeutic process.

The definition of rapport in this paper could provide a potential tool for health professionals to reflect on their own rapport building practice and consider the experiences of the other person in each interaction. By using questions derived from the four dimensions of rapport, health professionals can reflect on rapport in a flexible way. This could be done by reflecting on one dimension at a time or undertaking more comprehensive reflection of an entire interaction (See table 6-3).

Table 6-3 Reflection on rapport- “How is my rapport today?”

Dimension	**Examples of reflective questions**
Perceived connection between patient, family, and health professional	• Do the patients and families I interact with perceive a connection with me? How do I know? • Do I feel a connection with them? What does it feel like?

Relaxed friendly positive **Based on care and acceptance**	• Is the connection relaxed? Am I relaxed? • How am I demonstrating being positive and friendly? • How am I demonstrating caring? • How am I demonstrating inclusivity and acceptance? • How am I ensuring there is a sense of safety to speak about anything?
Communicating with listening and understanding	• How well am I listening? • Am I listening to understand this person or am I assessing and solving problems? • How am I indicating my understanding of what is being said?
Fostering confidence and trust	• Has this interaction fostered the person's confidence in themselves, or me, or the care provided? How do I know? • How well have we developed trust? What indicates this?

Chapter summary

This chapter has provided an overview of the development of a conceptual definition of rapport that is based on patient and family/whānau experiences. The definition supports the notion that rapport is important to patients and families and is the “bedrock” on which to base clinical interactions (Alison and Alison, 2020). This definition is robustly constructed to support clinical education and practice, and to inform future research related to rapport. The dimensions of rapport that make up the conceptual definition provide a framework for a reflective tool for health professionals.

The definition of rapport developed here, is used throughout the remainder of the study, and was used to support the analysis of the data in phases one, two and three. In the next chapter, I report the results from the patient and family/whānau data analysis (phase one) together with the health professional data analysis (phase two).

Chapter 7 Results: Phase one and two

Chapter introduction

Chapter 7 is the second chapter outlining findings from phase one and two. This chapter is presented in two parts. In Part 1, I present the findings from the analysis of patient and family interview data (phase one), while in Part 2 I present the findings from the analysis of the health professional focus group and interview data (phase two).

Part 1 includes the themes identified during the analysis of phase one data: 1) “The health professional’s vibe”, and 2) “Liminality as a relational context.” The first theme is explored in a paper that outlines patient and family member experiences of rapport during telehealth interactions. The paper is entitled: **“How are the vibes? Patient and family experiences of rapport during telehealth calls in palliative care”** (English et al., in press). I then present the second theme: “Liminality as a relational context” in an unpublished section of the study.

Part 2 includes a paper published in *Palliative Medicine*. The paper is entitled: **“Health professionals’ experiences of rapport during telehealth encounters in community palliative care: An interpretive description study”** (English et al., 2023b). The paper presents the themes of “Getting on together” and “Rapport is a soft skill” and explores some of the complexities health professionals identified when developing rapport during telehealth calls.

Part 1: Patient and family experiences of rapport during telehealth

Preamble to paper

The Beryl Institute defines patient experience as: “the sum of all interactions, shaped by an organisation’s culture, that influence patient perceptions, across the continuum of care” (The Beryl institute, 2023., Patient Experience, para. 3). Further to this, patient experience is recognised as more than satisfaction alone. Indeed, a recent conceptual analysis identified twenty attributes that conceptualise the patient experience (Avlijas et al., 2023). Of these the first four were:1) communication; 2) respect for patients; 3) information and education; and 4) patient-centered care, all of which have particular relevance to this current study (Avlijas et al., 2023).

There is a growing recognition of the need to conduct research that captures patients’ experiences of healthcare encounters to ensure the patient viewpoint influences practice and policy developments (Oben, 2020; Jonnagaddala, et al., 2021; Rand et al., 2019). Information about patient experience gives context to clinical evidence, informs a better understanding of patients’ needs, and can be used to evaluate quality of care (Avlijas et al., 2023; Larson et al., 2019; Rand et al., 2019). Indeed, it has been argued that patient experience should be considered key evidence in healthcare decision-making (Rand et al., 2019). In the case of this study, patient and family experiences of rapport during telehealth encounters are central to the findings and recommendations made.

The philosophy of palliative care recognises patient and family/whānau as the centre of care. Whānau is also integral to Māori experiences of health and healthcare (Moeke Maxwell et al., 2019). It is therefore important for palliative care research, and particularly that conducted in Aotearoa NZ, to include family/whānau experiences. This is especially pertinent when researching community palliative care given families are so often integral to providing patient care in the home (Bindley et al., 2018; Coyne et al., 2020). It is within this context that the paper presented here focused on patient and family experiences of rapport during telehealth. It has been accepted and in press with *Patient Experience*.

English, W., Robinson, J., and Gott., M. (in press, 2023c). "How are the vibes? Patient and family experiences of rapport during telehealth calls in palliative care".

How are the vibes? Patient and family experiences of rapport during telehealth calls in palliative care.

Introduction:

Rapport between health professionals, patients, and family members is considered essential to provide high quality palliative care (Engle et al., 2018; van Gurp et al., 2013). Interactions characterised as having rapport can alleviate patients' anxiety and distress, while enhancing patients' involvement in decision making and adherence to treatment. Such interactions can also lead to patients reporting more satisfaction with care (Dang et al., 2017; Ross, 2013). However, since the COVID-19 pandemic there have been changes in the delivery of community palliative care with a worldwide rise in the use of telehealth (Wosik et al., 2020). Organisations providing palliative care have been faced with a need to rapidly implement telehealth, often for the first time (Webb et al., 2021). As a result, patients and families are now having to develop rapport with health professionals utilising telehealth, rather than working with them directly in their homes.

Corresponding to this growth in the use of telehealth, is an increase in research exploring patient experiences with telehealth. Indeed, there is a steady flow of research reporting high levels of patient satisfaction with telehealth (Widberg et al., 2020; Imlach et al., 2020; Steindal et al., 2020). Some studies have suggested a general equivalence between levels of satisfaction with telehealth when compared to in-person visits (Agha et al., 2009; Kruse et al., 2017; Markey et al., 2019). Telehealth is also perceived as generally acceptable by health professionals and sometimes preferable for patients (Steindal et al., 2020; Chan et al., 2018; Eastman et al., 2021; Sutherland et al., 2020).

Beyond patient acceptance and satisfaction with telehealth, there seems to be little research into the effect telehealth has on developing rapport with an exception in tele-mental health (Goldstein ad Glueck, 2016). In our previous scoping review, there was a noticeable scarcity of research into patient and families experiences of rapport in palliative care generally (English et al., 2022a). Interestingly, it is the emergence of telehealth into the palliative care setting, during the COVID-19 pandemic, that has sparked new studies with a focus on rapport (Koppel et al., 2022; Calton et al., 2020). Whilst the evidence base is building, the effects that telehealth may have on the experiences of rapport for patients and family members in the palliative care setting have not yet been adequately investigated.

A fundamental aspect of palliative care is to include families and caregivers in discussions and care, thereby being family-centred as well as patient-centred (Kissane, 2017; Kokorelias et al., 2019). This reflects the tendency internationally for palliative care in the home to be highly reliant on family members as the main providers of end of life care (Gardiner et al., 2020, Robinson et al., 2017). Although some studies are emerging that include family satisfaction with telehealth, families need to be involved in palliative care research exploring the development of rapport in telehealth calls (Calton et al., 2020; Holland et al., 2020; Kissane, 2017; Wu et al., 2020; Zheng et al., 2015).

Even though rapport is perceived as essential in both palliative care and telehealth, key gaps in knowledge and understanding about how rapport is experienced by patients and families in telehealth remain. Thus, the aim of this study was to explore patient and family experiences of rapport with health professionals during telehealth interactions in the community palliative care setting.

Methodology

Given this study was based on clinical interactions and had an exploratory nature, we chose Symbolic Interactionism as the underlying philosophy (Blumer, 1969). Symbolic interactionism is based on the sense people make of their social worlds through communication and social interaction, particularly through the exchange of meaning through symbols and language (Blumer, 1969). We determined a qualitative interpretive approach was necessary to address the research aim, as such the study design followed the Interpretive Description methodology (Thorne et al., 2004; Thorne, 2016). Interpretive Description is an approach used to investigate complex experiential clinical phenomena and generate knowledge that is relevant and useful in healthcare settings (Thorne et al., 2004; Hunt, 2009; Kopchek, 2020). Underpinning this study is the theory of Human Relatedness (Hagerty et al., 1993), chosen as a theory based in an interpretivist and humanistic paradigm, it has informed the development of aspects of the interview schedule.

Data were collected using one in-person semi-structured interview per participant. Interviews were conducted by WE, a palliative care nurse with research interview experience. An interview schedule was developed from the literature (English et al., 2022a; Hagerty et al., 1993) which asked participants for their experiences with rapport building during telehealth encounters with health professionals. The interviews were audio recorded with written consent and transcribed verbatim by WE, with field notes written after each interview. All participants were given a unique identifier to allow for anonymous quotes in text e.g., for patients (Pt A) or family members (FM B). Ethics approval was granted by The Human and Disability Ethics committee (HDEC) New Zealand, ref: 20/CEN/165.

For this study we defined the key terms of telehealth and rapport.

Table 7-1 Definition of key terms

Telehealth is defined as personalised health care delivered via digital technology (i.e., telephone and video calls) to patients and their families at home.
We defined rapport as “a perceived connection between patient, family, and health professional, which is relaxed, positive and friendly, based on caring and acceptance, with communication that is characterised by listening to and understanding of the other, to the extent the interaction fosters confidence and trust” (English et al., 2023a).

Setting/Participants

Participants were patients and family members recruited from four hospices providing community services in the North and South Islands of Aotearoa, NZ. Patients were eligible to participate if they were over 18 years, receiving palliative care in their homes, had received telehealth calls and could converse in English. Adult family members were eligible if they were providing care and support for patients receiving palliative care at home, had received telehealth calls and could converse in English. Purposive sampling was used. Selection of potential participants was undertaken by senior hospice staff who selected patients and family members from their patient management systems and checked notes to ensure inclusion criteria was met. Additional purposive selections were made on the basis of ethnicity to improve demographic representation. A preferred sample size of around thirty participants was determined using Interpretive Description methodology (Thorne et al., 2004) and the Information Power model (Malterud et al., 2016).

Hospice staff telephoned potential participants providing a description of the study to assess interest in participation and permission to be contacted by the researcher. Interested participants were later phoned by the interviewing researcher with additional study information and provided with an opportunity to ask questions. An interview appointment was made for a time and place of the participant’s choice, with an invitation for a support person or family member to be present. Interviews were 30-45 minutes long and conducted during November 2020 -May 2021.

Analysis

Reflexive Thematic Analysis (TA; Braun and Clarke, 2022; Braun and Clarke, 2019) was used for data analysis as it is a qualitative interpretive approach interested in patterns of meaning across the data set, which suited our research aim. Our orientation to Reflexive TA was experiential and concerned with exploring the truth(s) of participants’ experiences, perspectives, and behaviours in the context they are situated (Braun and Clarke, 2022; Braun and Clarke, 2019). As part of this experiential orientation we considered our conceptual approach to language as active and symbolic (Braun and Clarke, 2022).

Transcriptions and field notes were loaded onto NVivo 12 software and analysed using reflexive TA (Braun and Clarke, 2022; Braun and Clarke, 2019). Folders were set up in NVivo to follow the 6 phases of the Reflexive TA: dataset familiarisation; data coding; initial theme generation; theme development and review; theme refining, defining, and naming; and writing up (Braun and Clarke, 2022). Coding was semantic and line by line initially with an inductive approach, although coding became more concerned with latent codes with each sweep of the data and when defining themes in later phases. Themes are defined in this study as patterns of shared meaning underpinned by a central organising concept (Braun and Clarke, 2006). The analysis and interpretation involved all authors.

Ensuring quality and rigour

In respect of quality and rigour in this study, we used a 15-point checklist (Braun and Clarke, 2022) and completed a COREQ checklist (Equator Network, n.d.). Other decisions to build quality into the study included a reflexive journal, regular meetings regarding analysis with research team members. In addition, WE wrote reflexive memos written at each stage of the analysis to provide an audit trail of decision making. Much consideration was given to reflexivity in the research process which led to a separate paper providing a practical example of reflexivity in research and clinical practice (English et al., 2022b).

Results

A total of 29 participants were recruited, 18 patients and 11 family members. There were five joint patient-family interviews conducted.

Most patient participants self-identified as of European descent with two identifying as NZ Māori and one as “Other”. There were an equal number of men and women, and all had a cancer diagnosis. Eight participants were over 50 years old and a further eight were over 70. Eight participants lived in urban settings, while ten lived rurally with low-remote urban accessibility. Low-remote urban accessibility is defined as living 25 minutes to 120 minutes from large urban areas (Stats NZ, 2020).

Family participants were mainly of European descent with one person identifying as NZ Māori. Most were female and under 70 years of age. All were close family members of the person being cared for either a wife, husband, or daughter. Eight participants were self-described as full-time caregivers, with three still working as well as involved in caregiving. Most lived in urban settings with three living rurally (See table 7-2)

Table 7-2 Patient and family member characteristics

Characteristics	Patients (n=18)	Family (n=11)

Ethnicity	NZ European - 15 NZ Māori - 2 Other -1	NZ European - 10 NZ Māori - 1
Gender	Female - 9 Male - 9	Female - 8 Male - 3
Age	30-49 - 2 50-69 - 8 ≥ 70 - 8	30-49 - 4 50-69 - 5 ≥ 70 - 2
Diagnosis	Cancer – 18 (Of patient being cared for) Cancer – 11	
Location	10 Rural* 8 Urban *25-120 minutes from city	3 Rural 8 Urban
Occupation	No longer working - 18	Full time caregiver- 8 working/caregiver - 3
Relationship to patient		Wife - 6 Husband - 3 Daughter - 2

Phone calls were the dominant means of telehealth communication. All participants received phone calls from health professionals, while seven also experienced video calling with health professionals (Table 7-3). Phone calls were from a variety of health professionals after referral to palliative care, including GPs, district nurses, oncology doctors and nurses, and hospice doctors, nurses, and multidisciplinary team members. Video calls involved oncology or hospice doctors and nurses. Two family members and six patients were offered (one patient declined) video calls. All video calls were assisted by a health professional setting up the call either in the person's home, or a clinical room. During these calls, the health professional remained with the participant while video-calling a doctor on another site. Nineteen participants indicated they would be likely to accept video calls if offered in the future from health professionals. Of the 9 participants likely to decline a video call, reasons given were: needing to know the person calling, unsure of video benefits, not wanting to be seen, anxiety, deafness, not interested in technology, too much technology, and a preference for phone or in-person contact (Table 7-3).

Table 7-3 Participants telehealth calls

Patient	**Phone calls**	**Video calls** **Accepted ✓** **Declined x** **Not offered- NA**	**✓ Likely to accept video calls if offered in future-** **x -Unlikely to accept video if offered- (with reasons given)**
A	✓	x	x - Needed to know the person calling
B	✓	NA	x - Unsure of video benefits
C	✓	NA	x - Not wanting to be seen
D	✓	NA	x - Anxiety and deafness
E	✓	✓ assisted in clinic	✓
F	✓	NA	x - Not interested in technology
G	✓	✓ assisted in clinic	✓
H	✓	NA	✓
I	✓	NA	✓
J	✓	NA	✓
K	✓	NA	✓
L	✓	NA	✓
M	✓	NA	✓
N	✓	NA	x - Too much technology
O	✓	NA	x – Too much technology

P	✓	✓ assisted at home	✓
Q	✓	✓ assisted in clinic	✓
R	✓	✓ assisted at home	✓
Family			
A	✓	NA	✓
B	✓	NA	x- Patient prefers phone or in-person contact
C	✓	NA	✓
D	✓	NA	Unsure
E	✓	✓ assisted in clinic	✓
F	✓	NA	✓
G	✓	NA	x – prefers phone or in-person contact
H	✓	NA	✓
I	✓	NA	✓
J	✓	NA	✓
K	✓	✓ assisted in clinic	✓
Totals:	29	7 accepted	19 Would accept video calls if offered
		1 declined	9 likely to decline
		21 not offered	1 unsure

Analysis from patient and family experiences of rapport in a palliative care telehealth context resulted in one major theme: “The health professional’s vibe” (Table 7-4).

Table 7-4 Theme: The health professional’s vibe

Sub themes:	
1. Relaxed comfortable encounters	**2. Difficult uncomfortable encounters**
Health professional behaviours aiding rapport building	Health professional behaviours detracting from rapport building
• Caring words and tone, • Time to talk, • Knowing who I am • A bit of a laugh	• Ticking the box • Being brushed off • Being spoken to rudely

The health professional’s vibe

Whether or not participants perceived rapport in telehealth calls was influenced by how they experienced the health professionals’ “vibe.” In this thematic context vibe is defined as “the mood of a place, situation, person etc. and the way that they make you feel” (Cambridge Dictionary, n.d.). The health professional vibe was more than a spontaneous “clicking” with each other (Kromme et al., 2016). Rather, the vibe included the therapeutic “presence” of the health professional, as an intentional, holistic being there for the other (Barrett, 2017; Geller, 2021). The participants’ experiences of the health professional’s vibe developed into two subthemes: Relaxed comfortable encounters aiding rapport building and, difficult uncomfortable encounters detracting from rapport building.

Relaxed comfortable encounters

Most participants spoke of rapport in terms of how the health professional addressed and interacted with them in a relaxed manner. Most participants felt rapport was experienced during telehealth encounters when there was a relaxed, comfortable vibe or atmosphere between them, and this was initiated and managed by the health professional. An example from one patient was the “lovely” health professional who led the interactions with a warm relaxed tone.

> *I mean like comfortable, trusting and listened to. She’s like always very lovely she’s got a great way of just making me feel really relaxed and her whole tone is lovely. Yeah, well just that she’s…y’know I feel very confident in her as a practitioner, y’know I wouldn’t want anyone else. (Pt A- phone call)*

Of the participants who had video calls, most had positive feedback about how they experienced rapport with the health professional in the calls and were impressed video calling was better than they expected in terms of rapport building. One patient delighted in the relaxed easy rapport building he experienced in a video call. He felt his views were heard and respected. He “loved” the immediacy of the video and even felt that the interaction had a healing aspect to it. Participants described four approaches from health professionals that aided rapport building during telehealth calls: 1) caring words and tone, 2) time to talk, 3) knowing who I am and, 4) bit of a laugh.

Caring words and tone

Participants experienced caring from a health professional as an indicator that a call would go well, and that rapport was possible. Caring was most obvious in the words and tone used by health professionals. For instance, a participant learned to build rapport like friends by believing the care offered by health professionals as genuine.

> *When (hospice) ring up, it’s always, they care, or they say they care, and I believe it. They make me feel good and make me… they are friends. (Pt I-phone call)*

Time to talk

The participants associated rapport building with health professionals taking time to talk with them in each call. Participants marvelled at the sense of not being hurried through a telehealth consultation. For many, it was the first time they felt a health professional had time to listen to them. Participants viewed health professionals taking the time to call as showing they cared.

> *Well, I certainly haven't had anybody that has been negative or rude or impatient or anything like that. They have always given me the impression that they have got plenty of time to talk. (Pt H- phone call)*

Know who I am

Rapport building was strengthened by health professionals expressing an interest in participants as individuals and showing interest in other aspects of the patient and families lives, apart from the illness and dying. For example, one patient laughed when describing the calls with one health professional "It's all about me!" Participants felt it was easier to build rapport with health professionals who had some idea of their health situation and story to date. Participants felt that when the health professional showed an interest in them and their family's daily lives, they were taking the next step in building rapport.

> *I don't know whether they discuss each client, I do not know, but you ring up and any of them can identify quickly with you and know what to say and do, which I find very helpful. (Pt M- after hours call)*

Bit of a laugh

Health professionals using a light tone and humour where appropriate created "feel good" moments considered important to participants when building rapport. Participants felt humour allowed them to touch on subjects around dying without being morbid. An observation from one family member was that laughing together was a good way to connect.

> *Laughter is really important too. Laughter, if you can sort of share a bit of a joke or have a bit of a laugh about something, that always makes you feel like you are connected too. (FM F-phone call)*

Difficult uncomfortable encounters

In addition to relaxed positive encounters, most participants also had difficult or uncomfortable telehealth encounters with very different "vibes" from health professionals. In each difficult call, participants identified it was the health professional's approach, rather than the medium they were communicating with, that created the discomfort and lack of rapport. For one participant rapport was not able to be developed when he felt there was an uncomfortable vibe of not believing what a health professional said. Participants could feel when health professionals showed a lack of interest in them as people during a call, which made building rapport unlikely.

> *Well, it's a hard one to answer because you pick up the vibes and when they are not giving you, you can feel they are not giving you a straight answer… (Pt I-phone call)*

We identified three health professional behaviours that detracted from rapport building during telehealth calls: Ticking the box, being brushed off, and being spoken to rudely.

Ticking the box

Some patients received calls from health professionals that were superficial, and it felt like the caller was just ticking a box. One patient experienced tick-the-box calls as annoying, as it showed a lack of knowing him as a person.

> *They can be a bit annoying. Just constantly phoning you know, "is there anything you need?" Like what? A new body? (Pt Q- phone call)*

For another patient a tick-the-box call was disrespectful and depersonalising.

> *Back on the shelf. And that's what it felt like, I was just a number, tick the box. It's going through the system, ticking their boxes, and having a quota filled type thing. [It seems] like they are doing their job but not really respecting the person at the other end of the line as the cancer patient. (Pt G- phone call)*

Being "brushed off"

Sometimes participants experienced difficulties developing rapport and felt "brushed off" by health professionals. The participant could hear the tone of frustration, tiredness, or busyness in the health professional's voice.

> *I didn't feel any rapport, and I certainly don't know what the circumstances were of the doctor at the other end, how busy he was, how involved he was, what else he had going on. And he was probably annoyed at having to answer the phone. But I felt no rapport at all. In fact, as I said, it was a brush off. Go to your G.P. even though she's shut. (Pt L- after hours phone call)*

In the following extract, a family member re-enacted a call she found daunting and lacking in rapport. The procedure being described was to administer a subcutaneous medication bolus to help her husband with acute symptom management in the middle of the night. She had not done the procedure before but did not feel able to say so to the nurse on the phone, as they sounded tired and reluctant to get more involved.

> *"You've got the portal there; you've got the medication?"*
>
> *Yes, I have.*

> *"Right, well just go onto it and do it and give me a ring if you have any problems." …But then I didn't give the info (to the nurse) and say I haven't done this before. She sounded tired. I just thought I'd let her go. Just I guess I was looking for perhaps a bit more of talking it through, but I should have said to her I haven't done this before, could you talk me through what I'm doing. I don't know whether she would have been the personality to talk me through it though, so I don't know. (FM F- after hours call).*

Spoken to rudely

Despite being aware patients were facing life limiting illness, two patients experienced rude telehealth calls from health professionals. The first patient felt labelled as a "difficult patient" during an initial telehealth phone call. This patient was a health professional herself and knew the impact of the "difficult" label. She was distressed by the implication she was "wasting resources" and felt unable to develop any rapport at all with the doctor or the nurse involved.

> *I had my first appointment with the oncologist there and that was by phone call. So, obviously that would not be normal practice, because it was during the lockdown… and I did not feel comfortable with her at all. She was, I actually found her quite rude, abrupt… And the nurse was just as rude as she (the doctor) was, probably ruder actually. I mean the (doctor) was probably rude in one phone call when she was like we have wasted all these resources on you, but she was professional in the other phone calls... it was kinda like I had become a difficult patient. That's the impression I had gotten, even though I hadn't even set foot in the hospital, y'know. (Pt A- phone calls)*

The second patient experienced a negative video call. The patient recalled being labelled as a liar in a video call from a hospital health professional known from prior in-person visits. The patient felt this call was disrespectful with no rapport, which left him feeling reluctant to speak up during the video call. He perceived the call to be of no benefit and was still angry during our interview months later.

> *They basically told me I that had to do it on Skype because of the snow and they couldn't get down, and she basically told me I was a liar that I refused everything that they had been offering. That ****** me right off, yeah. So, there is no help on that side of it…That's what p****d me off the most, that she basically called me a liar, that I was refusing treatment. (Pt G- video call)*

In both cases, patients perceived the calls went badly because the health professional jumped to conclusions that the patients disagreed with. However, they felt they could not challenge the health professional during the telehealth interaction. In contrast to these calls, both patients also gave examples of satisfying telehealth calls with other health professionals where rapport was developed. Overall, participants who had difficult telehealth calls said they were unlikely to complain. They described this choice as motivated by a desire to conserve their energy to be with their family.

Discussion

To the best of the authors' knowledge, this study is thought to be the first of its kind to explore patients and family experiences of rapport building during telehealth calls while receiving palliative care. Analysis of data related to patient and family experiences of rapport generated the major theme of "The health professionals vibe." All participants in this study experienced rapport during telehealth calls when the vibe of the health professionals was relaxed and caring, with interest and attention on them as people. Rapport with health professionals was important to participants as they felt it increased the likelihood of having their palliative care needs met. However, in addition to positive rapport building encounters with health professionals, this study provided evidence that patients and families also experienced some difficult and uncomfortable telehealth encounters that characterised a lack of rapport. Participants placed importance on the health professional’s communication style and intention over the modality of calling. The participants felt it was the health professionals’ responsibility to keep the relational interactions on track with rapport and positive connection. It was therefore, also the health professionals’ responsibility when calls went awry. A key finding from this study, therefore, is that rapport building during telehealth is dependent on how patients and families interpret the health professionals’ vibe and presence regardless of the modality used to communicate.

One explanation for the absence of rapport in telehealth experiences may be that health professionals lack awareness of the importance patients and families placed on “presence.” Participants experienced presence as the vibe of the health professional, that is, how the health professional came across and how they felt to the participants during the call. Presence in this context was more than a health professional being literally present in telehealth calls (Barrett, 2017). One definition of presence from psychotherapy is that therapeutic presence involves health professionals bringing their whole self to an encounter with patients and family, and being fully in the moment physically, emotionally, cognitively, relationally, and spiritually (Geller, 2021). Presence implies that the encounter is real and affects how participants experience enjoyment, and involvement (Hoffman, 2021; Lombard and Ditton, 1997). Presence over telehealth, also known as telepresence, has recently been defined as the realism experienced during a telehealth encounter that is created through connection, collaboration, trust, support, and the clinician’s skill at acting as the technology mediator (Groom et al., 2021). In this way, health professionals use their presence as the basis to build digital rapport with families and patients through active listening, empathic communication, and not appearing rushed (Gupta et al., 2021; Wood, 2021). Telehealth interactions with rapport can have a meaningful impact on a patient’s life, especially during times of isolation

(Hoffman, 2021). These findings correspond with the participants' positive experiences of rapport in this study.

Fatigue, burnout and coping with a pandemic-stressed healthcare system may also be reasons for some of the health professionals appearing uncaring, which detracted from rapport building (Botaitis and Southern, 2020; Fauville et al., 2021). Telehealth itself can be exhausting for health professionals, particularly video calls due to the frequency and intensity of the sensory work needed (Anh et al., 2022; Lupton and Maslen, 2017). The strain of constant telehealth use can result in fatigue and "technostress" for the providers (Anh et al., 2022; Fauville et al., 2021).

However, in this study there may be factors within the health professional's control that could address some of the issues with developing rapport in difficult calls. For example, health professionals can assess and follow up patients without having a tick-the-box approach. They can be aware of their tone of voice and the vocabulary used in telehealth calls and, they can listen and speak clearly and kindly. Ideally, health professionals need to assess their telehealth presence for caring and welcoming body language, voice, and facial expressions, even on the telephone, which says to the person, "I am here for you" (Gupta et al., 2021).

With ongoing uncertainty of pandemics and limited palliative care resources, telehealth will continue to be an important way to deliver palliative care into the future (Steindal et al., 2020). Understanding what aids and detracts from patients and family members building rapport with health professionals during telehealth can influence how telehealth is offered in palliative homecare. In this study, participants wanted flexible combinations of in-person visits, telephone, and video calls from their palliative care professionals, offered in a way that suited their lifestyles. Our findings echo the need for telehealth calls to prioritise patient choice and comfort and be more consistently patient-centred (Paige et al., 2022; Aung et al., 2022). Ideally, each telehealth call needs to be undertaken more purposefully with skill, compassion, and awareness of presence from health professionals to ensure rapport and personalised care is developed (Goldstein et al., 2021).

Video-calling was not offered to most participants in this study despite pandemic isolation and precautions. Some of the hesitation to offer and use video might be related to health professional concern and dissatisfaction with developing rapport via telehealth (Aung et al., 2022; Goldstein et al., 2021; Kristin Jonasdottir et al., 2022). Yet, there is mounting evidence video-calling can support rapport building by retaining the benefits of traditional face-to-face appointments through real-time visual cues (Orlando et al., 2019). Despite this, some health professionals may be reluctant to use video which indicates more research is needed into topics such as developing rapport and telepresence, and the benefits of telehealth to patient outcomes (Henry et al., 2018). Equally, more compelling education and commitment to training is needed for rapport building and telehealth interpersonal etiquette for health professionals (Gustin et al., 2020; Henry et al., 2022).

There are limitations to this study. Firstly, despite efforts to recruit a diverse population of participants, most were NZ European and therefore do not reflect diverse cultural approaches to telehealth. Secondly, all participants either had a diagnosis of cancer or were engaged in caring for cancer patients. Thirdly, some of the patients and family members were interviewed together, which may have influenced some of the opinions expressed, as opposed to being interviewed individually. The views expressed may therefore differ from persons with different diagnoses. Despite this, the findings may be generalisable and prove useful to not only hospices, oncology, community palliative care, but also to those interested in rapport building and telehealth communication with patients and their families in their homes.

Implications for Practice

This topic is important at a time when telehealth has been adopted widely and rapport building is essential to providing palliative telehealth care. From the patient and family perspectives, rapport can be achieved via telehealth and is dependent on health professional presence, skill, and care. Health professionals should have a relaxed and caring approach with excellent listening and understanding skills for rapport building via telehealth. However, as this study has shown patients and families can also experience an uncomfortable lack of rapport during telehealth calls with health professionals. One practical way to improve telehealth presence and rapport building might be to do a self "vibe check" before each interaction by checking facial expression, relaxing tension, and creating intentional presence for the other.

Conclusion

This study highlighted whether or not participants perceived rapport in telehealth calls was influenced by how they experienced the health professionals' "vibe." Rapport occurred in relaxed, comfortable encounters with health professionals who had an intentional presence and a caring approach. Participants relied on health professionals to initiate and manage rapport building and the vibe of each encounter.

However, there was also evidence that patients and families experienced some uncomfortable encounters without rapport which may have been attributable to the vibe of the health professional lacking presence. Therefore, a key finding of this study is the care, presence, and skill with which the health professional communicates in each call affects rapport more than the telehealth medium used. More compelling education is needed for health professionals regarding the development of rapport in telehealth along with further research into the impact of rapport on telehealth outcomes.

Preamble to the second theme

The second theme developed from the analysis of patient and family data was "Liminality as a relational context." The liminality theme has not yet been developed for publication.

Liminality as a relational context

On receiving a diagnosis of a life-limiting illness the person as-self becomes a person as-patient who inhabits a unique and liminal space sometimes described as "betwixt and between" (McKechnie et al., 2011; Vanderstichelen et al., 2020). In the theme "Liminality as a relational context" the liminal space is defined as a fluid, malleable space between two conceptually rigid and mutually exclusive thresholds (Vanderstichelen et al., 2020). The concept of liminality is used in palliative care to refer to the context of participants living in the between-ness of living and dying (McKechnie et al., 2011). Liminality in this theme also includes the relational aspects of developing rapport during telehealth calls, that may be affected by participants being in a liminal time and space.

In the context of living with terminal diagnoses individuals may transition from being a well member of society to that of a patient living with an uncertain future; they only exit the liminal space by crossing the threshold of death (McKechnie et al., 2011). Due to advances in treatments and longer prognosis for some conditions, a prolonged liminal state can see the person become slowly disconnected from their body, their social life, and their family (Lawton, 2000). Family members and caregivers potentially enter the liminal space alongside their loved one anywhere from diagnosis to dying, and then may re-enter a form of pre-liminal life on, or after, their relative's death (McKechnie et al., 2011).

A further threshold is crossed when a patient and their family enter into palliative care. This new threshold introduces them to a shift in philosophy and forms of care that differ from the life-prolonging treatment focused care (MacArtney et al., 2017, Bindley et al., 2018). There are new health professionals to meet and potentially new contexts for care delivery, such as being visited at home, and using telehealth. To make the matter more complex, some patients and families are juggling multiple contexts of healthcare simultaneously. With treatment options being offered later for some people, they are having visits and treatments with hospital specialities, general practice, and specialist palliative care teams at the same time (MacArtney et al., 2017). Patients and families are therefore likely to be dealing with the ambiguity of both living and dying and negotiating multiple healthcare contexts in this new space (MacArtney et al., 2017).

A liminal space in palliative care is likely to change the nuances of usual communication due to the effects of serious illness and physical, emotional, and existential distress (Lawton, 2000). In the context of this study, I found that patient participants receiving palliative care were often in a liminal space when the telehealth calls occurred. This liminality may have had particular requirements for developing rapport with health professionals. Rapport was perceived by the participants as an important part of interacting with health professionals and having their palliative care needs met in the liminal space.

The key theme identified was “Liminality as a relational context” with three sub-themes: 1) the relief of rapport in the unknown; 2) rapport can be empowering; and 3) becoming unavailable. Participant quotations are used to support the themes.

The relief of rapport in the unknown

There was a sense of relief from participants to be able to have in-depth conversations with health professionals about symptoms and concerns about dying. This type of conversation was perhaps not easily had with many other people. When there was rapport with a health professional, participants felt a reprieve from the sense of unknown-ness of their life and felt less alone. Rapport provided participants with relief in this liminality as it made difficult conversations more tolerable, provided a sense of connection for patients and family isolated at home and made it easier to share personal information.

Several participants commented on the volume, tone, and quality of health professionals' voice via telehealth that provided a stress relieving quality. For one participant the health professional's calm voice and words were clearly linked to rapport and the relief of having someone who could help him navigate through the unknown.

> *The talking is very calm and low level and non-stressful. To me that's rapport and I think part of that is ensuring there is a real sense of calm and a way through this. (Pt B- phone call)*

One participant had been a carer before becoming a patient and felt hospice staff understood the unique experiences of the individual in the liminal space. This person acknowledged that connection in the liminal space was somehow deeper than in other healthcare interactions.

> *You are an individual that they are genuinely interested in. Absolutely. They [hospice] do that very well. They get on with everybody. But it's deeper than that. (Pt M- phone calls)*

Several participants stressed the relief of "being believed" by health professionals which could lead to developing rapport in the liminal space. A family member felt she often had to convince health professionals to help at times through her husband's illness, which was exhausting and isolating. She was relieved when calling hospice staff on one occasion to be believed straight away.

> *They trusted what I said and were very happy to help. So I felt they trusted my judgment, which helped a lot. (FM C- phone call)*

For some participants there was a point where they felt comfortable to share more of themselves and how they were really feeling with health professionals on telehealth calls. For example, one patient shared the relief he felt when he had rapport with a health professional. He could then be honest about how he was feeling and have in-depth conversations about his goals for care.

> *Oh the ease of communication. The feeling of being at ease with somebody in order to be, you know, honest, I guess. (Pt Q- video call)*

Another example was a family member who described with emotion how relieved she felt when one nurse called and simply asked her how she was. She felt seen and recognised as an important person in her husband's care team, that he needed to safely stay at home. For her situation, being in a liminal space meant being invisible until seen by one health professional.

> *She [the nurse] was the one who asked me "How are* ***you****? (FM A- phone call)*

Most of the participants regarded the telehealth calls with health professionals as an important social connection, particularly when they felt like rapport had been developed. They discussed how this "human lifeline" in a liminal space was especially important during the "lockdown" periods of the pandemic when in-person home visits were not possible.

Rapport can be empowering

Participants related how they felt empowered when they experienced rapport with health professionals in telehealth interactions. Being in a liminal space with new health personnel and new ways of doing things was potentially disempowering for patients and families. To prevent this, participants recognised the importance of making connections that they felt were supportive. Participants noticed benefits of having rapport with a health professional, these included: becoming more assertive, feeling more confident in making plans and decisions, and being able to ask vulnerable questions. Ultimately, participants felt these telehealth interactions resulted in a sense of working together.

Participants responded positively to interactions with health professionals that were calm and provided a sense of hopefulness even when discussions were difficult. Imbued in the health professionals' approach was a sense of "let's sort something out"; which came with an awareness of preserving hope while being pragmatic. For example, one family member found that consistently having rapport on the phone with health professionals gave her confidence that her mum's issues would be "sorted out". This was helped by always receiving a call back from the nurse to report on conversations had, or actions to be taken, which built trust.

> *Because mum and I have a good rapport with the hospice nurses here, we feel confident that we can go to them with any issue or any symptom that mum is feeling and that they will listen and then sort it out and then come back to us. So when you hang up the phone, you have confidence that the issue is going to be sorted out. And they listen and they are reassuring, so you do feel more positive. (FM J- phone call)*

Participants valued feeling safe to ask questions as there was so much unknown in a liminal space, including symptoms, treatments, and prognosis as well as the stressors of work, finances, and managing family dynamics in the face of serious illness. Having a sense of safety to be able to ask any kind of question was therefore important and indicated to participants that rapport was being developed. An example was a patient who was pleased by the health professional encouraging her to ask questions and felt there was a freedom in being able to ask anything. However, it also implies that she may have felt "stupid" asking questions on previous occasions.

> *That you can actually ask them sort of anything, and you don't feel as though you are stupid in asking them. (Pt N- phone calls)*

Participants also valued being in partnership with health professionals while navigating the liminality of receiving palliative care. Partnership included the sense of working collaboratively with health professionals who had genuine concern for their well-being and understood the need for clear communication. For instance, one patient described partnership as having caring people overseeing his journey. He appreciated health professionals who made sure he felt included and informed, as this gave him a sense of reassurance and autonomy.

> *And so the phone call …I think they go well because there is a sense of oversight and care and concern and so on. So, to me those are the ones where you get a feeling of empathy and it's obvious that they don't want to leave me in a situation where I am unsure about where to go or what happens next. So I guess the best ones are reactions to that and have a feeling of inclusion and comfort and oversight really. Yeah. (Pt B – phone calls)*

Another participant isolated at home caring for her very ill husband, described having rapport with health professionals in regular phone calls as precious "like gold". She felt uplifted and supported by the rapport and caring in these calls and felt they helped her to navigate her way through the liminality of being a caregiver.

Becoming unavailable

Participants described feeling uncomfortable in telehealth interactions when there was a sense of being left in limbo with their care or uncertain about the health professional or the service being offered. One way the participants responded to this was to become unavailable, by disclosing less about themselves, or to not express their true feelings about the interaction. This came from interactions where participants felt misunderstood, not believed, or felt uncared for, such as when there was no follow up to visits or treatments from health professionals. This type of interaction resulted in patients and family members feeling unsure what to do next. This was the case for one patient who was unsettled by a lack of communication and follow-up from a health professional; he also felt unable to pursue the health professional for information due to a lack of connection.

> *I was unsure…there was a feeling that I was left a little bit in limbo about what were my options going forward (Pt B - phone call)*

"Becoming unavailable" in a liminal space also occurred when participants were mistrustful of what the health professional said to them. Patients felt sometimes their lived experiences of illness were discounted or challenged by health professionals. One patient said he would literally hand the phone to his wife when he felt any challenge to his health experiences. Due to previous difficult interactions, he wanted health professionals to respect his viewpoint as a way to develop trust and rapport.

> *Oh, you know what's wrong with your body, and when they are trying to tell you something different… I can't afford to get worked up… so I just hand the phone over to my wife. (Pt I – phone calls)*

Participants in a liminal space had limited energy for interactions they perceived were not genuinely supportive. Another patient developed the technique of deflecting what he felt were insincere approaches to him on telephone calls. When there was no sense of connection with the health professional he would try and “get rid of them.”

> *There is again a practical purpose there, but for just, “how are you feeling, how’s it going?”, well why should I tell you? I’m fine, everything is OK. So I just say, “no I’m cool”. I just try to basically get rid of them. (Pt Q- phone call)*

Some calls were derailed by misaligned expectations. There were sometimes differences between what participants expected of service and care, compared with what was actually available. These calls were often after-hours calls to hospice and made at a time when patients and families needed urgent advice and support. When these calls were unsatisfactory, they seemed to add to the patient and family’s sense of isolation and frustration in a liminal space.

> *I think misunderstanding possibly. They probably had their information to impart, and I had what I needed to hear and I’m not sure the two met. I was annoyed. That’s possibly too strong a word. But I had expected a different response and again, that’s my expectations. (Pt L- an after-hours phone call which resulted in Pt L being unsure whether to continue with the service).*

It was interesting to discover that patients and family members chose to withdraw and avoid discomfort during some calls which was preferable to engaging with some health professionals. Participants made this choice even when this meant they would possibly be left to navigate the unknown-ness of palliative care themselves. This example is from a patient who was so disturbed and upset by the calls from a health professional she left the service, without giving them a reason.

> *So yeah, I'd even rate it like a zero [out of 10], cause… In the end, I just terminated her services in the end because I just so upset. Yeah, I was really upset actually for quite a few days. (Pt A- phone calls)*

Discussion

For participants in this study, the liminal space became a space for potential relational connection with health professionals to help navigate a way through the unknown territory of living with dying. A key finding was that participants had telehealth calls where they experienced relief and felt more empowered when rapport was present. Telehealth calls without rapport, however, left participants in a type of limbo that caused distress and mistrust. Participants became more guarded in their interactions with health professionals when they felt there was no rapport developed. This type of interaction resulted in participants becoming "unavailable" by not disclosing personal information about themselves, cutting calls short, or avoiding expressing their true feelings in fear of service deteriorating further. At times, participants made these choices in preference to engaging with health professionals, even though it may result in less support within the unknown-ness of palliative care. A second key finding from this theme therefore was that being in interactions without rapport potentially places participants at risk of not receiving the best care available.

A reason for the difficult telehealth encounters may be as a result of some health professionals' lack of understanding of the crucial nature of developing rapport with persons in a liminal space (Bindley et al., 2018; McKechnie et al., 2011). For patients, there can be a "communicative alienation" or a feeling of difficulty communicating their experiences of illness and treatment while in the liminal space (Little et al., 2022). This can cause patients, family caregivers, and health professionals difficulties in communicating with and understanding one another (Bindley et al., 2018; Little et al., 2022). Participants in this study experienced a range of different telehealth encounters with health professionals at a time in their lives when they needed clear and caring communication. Some participants experienced relieving and empowering telehealth calls that promoted autonomy, while at the same time experiencing telehealth encounters in which they felt unsafe, preferring to withdraw from contact. For patients and families who have active contact with both hospice and hospital services, there seems to be considerable variation in callers and relational approaches. This may be adding to the burden of managing multiple healthcare realities at the same time (MacArtney et al., 2017). Conceptualising the experiences of telehealth calls in palliative care in terms of "liminality as a relational context" offers a lens for understanding the patients and families' challenges of relating with many different health professionals and different organisations (McKechnie et al., 2011).

The participants in this study wanted the health professional on the telehealth call to be involved with their care, with a sense of working together, which they found to be empowering. Telehealth can enhance the potential for communication between patients and health professionals and as such it can offer a mechanism to increase patient engagement and empowerment (Calvillo al., 2013; Mano and Morgan, 2022). From the participant's perspective in this study, being in a liminal space upset their sense of control over their own lives. Participants therefore valued interactions with health professionals who respected their need to be autonomous and feel in control, despite facing continual losses. Participants also seemed aware of the inherent "unequal" nature of power in the health professional-patient family relationships (Delgado, 2021). This was demonstrated in the ways participants responded to the heath professional's vibe. Participants had an "antenna" scanning the health professional's presence and the tone of the interaction which led them to decide whether it was safe to engage (English et al., in press, 2023c). The participants also appreciated the health professional’s ability to understand their altered state of relating and potential vulnerability resulting from being in the liminal space.

Empowerment is not something that simply occurs from within a person, nor can it be done by another, it requires intentional efforts from health professional to become involved as a partner (Richardson et al., 2010). The “Empowerment Track” is a reflective tool developed for the training of healthcare professionals in an attempt to avoid “oppression” and the objectifying of patients and families (Thesen, 2005). The basis of this tool is to reflect how well the health professional embodies acknowledgement of the other person, using critical reflection. In the tool, there are different steps up from acknowledgement to accepting diversity, showing positive regard, solidarity, and empowerment (Thesen, 2005). These steps have resonance with the definition of rapport developed in this study (English et al., 2022). When patient empowerment comes from having rapport with a health professional therefore, the empowerment is not “given” to the patient or family. Rather, it comes from them feeling safe and confident to explore their concerns and losses. In this way, rapport supports the development of partnerships to navigate the liminal space when receiving palliative care.

Conclusion Part 1

In Part 1, the findings highlight the importance of the “vibe” and presence of health professionals which can have an important effect on patients and families’ experiences of rapport. Participants felt comfortable and relaxed when they perceived the health professional had a positive and caring vibe that signalled the development of rapport. In contrast, participants experienced difficult and uncomfortable telehealth interactions with health professionals where rapport was unlikely to develop.

Part 1 also provided an overview of liminality in relation to experiences of rapport for patients and families receiving palliative care and its effect during telehealth encounters.

Participants in a liminal space felt relief and more confidence when rapport was developed. Conversely, when rapport was not developed participants were left in a sense of limbo which resulted in a tendency to avoid contact with a particular health professional or service. The patients and families were attuned to the vibe and presence of the health professional, as well as their understanding of what being in a liminal space might be like. Therefore, the degree to which the health professional understands both their own presence; and the liminal space concept when receiving palliative care, can have a significant bearing on the development of rapport.

[Part 1 ends]

Part 2: Health professional experiences of rapport during telehealth

Part 2 of this chapter presents the health professionals' perspective with a paper published in *Palliative Medicine* (English et al., 2023b). This paper contributes to the knowledge and understanding of the complexities that health professionals face and the skills needed when developing rapport during telehealth calls.

English, W., Robinson, J., & Gott, M. (2023). Health professionals' experiences of rapport during telehealth encounters in community palliative care: An interpretive description study. *Palliative Medicine*. 2023; 37(7):975-983

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Health professionals' experiences of rapport during telehealth encounters in community palliative care: An interpretive description study

Introduction:

The rapid introduction of telehealth into palliative care due to the COVID-19 pandemic has been disruptive to in-person interactions with patients. During times of heightened infection control precautions, in-person interactions have been restricted and replaced with telehealth calls (Frittgen and Haltaufderheide, 2021). In a relationship-based clinical area such as palliative care, rapport is crucial during difficult and complex conversations which are often of a sensitive and existential nature (Wallerstedt et al., 2019; Watts et al., 2021; Kirkpatrick et al., 2017). However, a recent review identified that there is little research concerning rapport from the viewpoint of health professionals (English et al., 2022a). With telehealth becoming more commonplace in palliative care, there is a growing need for research into how well health professionals are developing rapport via digital means.

Telehealth is now considered an acceptable mode of patient contact for community populations receiving palliative care and health professionals (Eastman et al., 2021, Ebneter et al., 2022; Keenan et al., 2021; Widberg et al., 2020). Furthermore, telehealth has the potential to improve access to palliative care and enable more equitable distribution of limited healthcare resources (Jess et al., 2019; Collier et al., 2016; Aung et al., 2022). However, palliative care professionals prefer in-person interactions (Eastman et al., 2021, Ebneter et al., 2022; Keenan et al., 2021), and have expressed concerns that the remoteness of telehealth represents a barrier to care delivery and rapport building (Sutherland et al., 2020; Webb et al., 2021). Along with these concerns, health professionals want education and evidence-based telehealth guidelines to ensure a compassionate, person-centred approach to care is not lost when using telehealth (Webb et al., 2021; Wu et al., 2021).

Although a spotlight has been on telehealth research in recent years, the topic of developing rapport during telehealth calls in community palliative care is under-investigated (Rosa et al., 2022). While all participants are equally important in interactions that occur in telehealth, in this instance our study will focus on the health professional perspective. As the effects of the COVID-19 pandemic and future service planning are considered, it is imperative to have a better understanding of how health professionals develop rapport during telehealth interactions (Goldstein et al.,2021). Access to such information would inform the ongoing effectiveness of telehealth and its integration into palliative care (Rosa et al., 2022). The aim of this study therefore is to gain an understanding about developing rapport during telehealth calls by exploring the experiences of health professionals in community palliative care.

Design

This study has a Symbolic Interactionist lens based on the sense people make of their social worlds through social interaction, particularly through the exchange of meaning through symbols and language (Blumer, 1969). We took a qualitative approach using the Interpretive Description methodology to generate knowledge for applied practice of complex experiential clinical phenomena (Thorne et al., 2004; Thorne, 2016; Hunt, 2009; Kopchek., 2020). The theory of Human Relatedness (Hagerty et al., 1993) underpins this study and informed the development of aspects of the interviews. For the purpose of clarity, we defined the key terms of telehealth and rapport as follows (Table 7-5).

Table 7-5 Key terms defined

Telehealth	The provision of personalised health care at a distance using telecommunication means which includes video-calling and telephone

Rapport	A perceived connection between patient, family, and health professional, which is relaxed, positive, and friendly, based on caring and acceptance, with communication that is characterised by listening to and understanding of the other, to the extent the interaction fosters confidence and trust (English et al., 2023a).

Population/setting

Participants were recruited from four hospices providing community services in the North and South Islands of Aotearoa, NZ. Participants were eligible if they were health professionals working in palliative care who had telehealth interactions with patients and families in their homes.

Table 7-6 Inclusion Exclusion Criteria

Inclusion criteria:	Palliative care health professionals from any discipline who have experience with telehealth methods of patient and family consultation.
Exclusion criteria:	Health professionals with no telehealth experience. Senior management excluded as their presence may be perceived to hinder the flow of discussion.

Sample/ recruitment

We referred to the Information Power model (Malterud et al., 2016) and Interpretive Description guidelines (Thorne, 2016) to determine a preferred sample size of approximately thirty participants. This was anticipated to be 24 health professional participants for four focus groups and six individual interviews. A senior staff member at each site emailed potential participants a description of the study and invitation to participate in focus groups, with consent forms attached. Potential participants self-selected, with the first 6-8 respondents at each site selected to attend the focus group, no further selection process was added. Individual interviews were offered for those unavailable at the focus groups times and an appointment was made for a time and place that suited the participant. Written consent was obtained from each participant prior to research activities.

Data Collection

Data were collected from palliative care professionals participating in focus groups or individual semi-structured interviews. A topic guide and interview schedule were developed from the literature (English et al., 2022a; Hagerty et al., 1993) asking participants for their experiences with rapport building during telehealth encounters. Duration of interviews and focus groups ranged between 45-60 minutes and were conducted in-person and audio recorded during November 2020 -May 2021. WE, a palliative care nurse with previous experience with research interviews, conducted the interviews and focus groups and transcribed them verbatim. Memos were made after each interview or focus group. All participants were allocated a unique identifier e.g. (HP 1) etc, which allowed for anonymous quotations in text.

Data analysis

Data analysis was undertaken using a Reflexive Thematic Analysis (TA; Braun and Clarke, 2019; Braun and Clarke, 2022) approach as this study was interested in patterns of meaning across the data set. Our orientation to Reflexive TA was experiential and as such we considered our conceptual approach to language as active and symbolic and concerned with exploring the truth(s) of participants' experiences, perspectives, and behaviours in their situated context (Braun and Clarke, 2006; Braun and Clarke, 2022).

After transcriptions and field notes were loaded onto NVivo 12 software, folders were set up in NVivo to reflect the phases of Reflexive TA (Braun and Clarke, 2019). Coding started as line by line across the data set using an inductive analysis. From these codes initial themes were developed, with several subsequent themes created, reviewed, and discarded, such as "making the call." In Reflexive TA, theme is defined as patterns of shared meaning underpinned by a central organising concept (Braun and Clarke, 2022). We developed two final themes to create insights that were relevant to addressing the research aim (Table 7-8).

Checklists were used to reflect on the quality and rigour of our study (Braun and Clarke, 2022; Tong et al., 2007). Reflexive memos were written at each stage of the analysis which provided an audit trail for decisions made. Other decisions to promote data rigour included a reflexive journal and regular research team meetings regarding analysis.

Ethical considerations

Consideration was given to WE being an interviewer at her place of work which was one of the four participating hospices. Provisions to ensure the safety and comfort of colleagues during the interview process included the need to disclose the dual roles of WE to participants at recruitment, and to allow participant withdrawal at any time, for any reason, until analysis began. A full Ethics proposal was granted approval by The Human and Disability Ethics committee (HDEC) New Zealand, ref: 20/CEN/165.

Results

There were 31 palliative health professional participants, 7 participated in individual semi-structured interviews and 24 participated in four focus groups. The participants included 20 nurses, 4 doctors, 3 social workers, 3 family support (counselling team) and 1 kaiāwhina (Māori liaison), (Table 7-7). Most participants had 2-plus years of specialist palliative care experience, ranging from a few months to over 30 years. All participants had phone telehealth experiences, and 8 participants had experience with video calls as well. The latter included 3 doctors, 3 social workers and 2 nurses (Table 7-7). The majority of telehealth contacts were telephone calls. Video calls were mainly used to contact remote patients and families, or used as assisted calls where the specialist is at one location and the video call was set up by a nurse at the person's home. The nature of the calls was a mixture of initial consultations and follow up calls.

Table 7-7 Participants and telehealth calls

Professional group	Number of participants	Telephone	Phone and Video calls
Registered Nurses	20	20	2
Doctor	4	4	3
Social Workers	3	3	3
Family support	3	3	0
Kaiāwhina - Māori health liaison	1	1	0
Totals	31	31	8

The two themes developed during analysis were: 1) Getting on together and 2) Rapport is a soft skill (Table 7-8). Participant quotations have been chosen to illustrate what was interesting and important about key analytic points (Braun and Clark, 2022).

Table 7-8 Key Themes and sub-themes

Themes	Sub-themes
Getting on together: How rapport was experienced by health professionals during telehealth calls.	1) How rapport shows up in telehealth 2) Calls that went well 3) "Well, that didn't go well."

Rapport is a soft skill: Health professionals doing what it takes to develop rapport during telehealth calls.	1) Reviewing body language 2) Listening beyond the words 3) Managing the environment 4) “Training would be good.”

Getting on together

Participants perceived rapport as “getting on” with each other in a way that was conducive to developing therapeutic interactions during telehealth calls. Developing rapport was central to the interactions with patients and families during telehealth calls. Most participants felt it was not possible to do their jobs or make successful calls without rapport. The telehealth calls were a mix of new consultations, follow ups, and fielding calls from patients or families. Some calls were in the context of established relationships over weeks or months, and some were one-off calls with no prior knowledge of the patient or family members concerned.

How rapport shows up in telehealth

Most participants could articulate their experiences of rapport but found it difficult to report how they knew rapport was developed. However, several participants identified the indicators of rapport as non-verbal cues such as tone of voice, flow of speech, and speed of speaking which changed when rapport was beginning to develop. For example:

> *I think it feels good, cause you have established a relationship and there is that flow of information and you just hear them relax a bit more. (HP 1- phone call)*

Other participants noticed a shift in the quality and content of the conversation and some participants spoke of feeling a sense of mutuality in the interactions. For instance, one participant describes reaching a point of being comfortable with each other.

> *And to me, it's that common ground but also making people comfortable because whether it's face to face or phone or video, if you are not comfortable with each other, then nothing is going to happen, nothing of importance. But if you don't have that rapport, you can't get them to open up to you. (HP B)*

For other participants there was no clear indication of mutual rapport developed but they perceived a connection personally and felt the interaction was positive. Several participants made the statement that it was easier to discern if rapport was established during in-person interactions rather than during phone calls due to the lack of visual cues on the phone.

Calls that went well

Most participants felt they had positive and effective experiences of developing rapport during telehealth calls most of the time. One participant described the rapport she had with one of her longer-term patients was better on the phone call than previous in-person visits.

> *I got lots of what I would call information that I hadn't had before, because he (patient) felt comfortable talking to me on the phone. ... I was thinking on the phone in that conversation, oh my god, that's the first time he has really mentioned that. (HP E-phone call)*

The eight participants who tried video calls all had positive reports about rapport building and were keen to carry on with video calling in their practice, with comments like "Completely converted!" and "Sometimes more comfortable than being in the room." One participant preferred video to phone calls.

> *I found I preferred a video chat to a telephone. To be able to see her and to make comment on the things that I would notice that were different, because for her that was really actually quite important. It did enhance our relationship. (HP 21- video call)*

Well, that didn't go well

However, as well as many positive telehealth calls, most participants also recounted calls that were complex and challenging with no rapport developed, all of which were phone calls. Despite the challenges with some patients and families via telehealth, participants felt they needed to persevere to form some sort of rapport and relationship.

> *On the phone, quite different because she couldn't see me, she could only hear me. It's like she didn't trust anything that I said. I was not comfortable at all, and I just kept thinking, I need to keep the engagement up, I need to keep her, you know, talking, confident, sharing, whatever, and it really was a struggle. (HP E- phone call)*

Participants had calls where they had to manage strong emotions like anger and frustration from patients and families. Sometimes rapport was abandoned to be able to safely end the call, for example:

> *Yeah, and I know when I'm working hard because I'm more calculated with my words and I think my speech slows down. It's because I am thinking about every word that I'm saying in case it can be mis-interpreted or used as ammunition back. So I'm thinking of someone that is angry on the phone. I'm very calculated, I can hear myself and I can see myself really slowing down and having pauses. And less personality from me. It's a challenge to think, can I turn this situation around. How quickly can I do it? If I can't do it, then, it's not alright but I have to think of a way to establish a relationship if it's not going well. (HP F- phone call)*

Three experienced participants had the distressing experience of being hung up on during a telehealth phone call. Rapport was not developed during these calls, as one participant described:

> *Yeah. Hung-up-on-me. It is hard when someone hangs up on you. It is hard because… I always like to finish off a phone call on as good a term as possible and usually there is some agreement or there's some plan…And then someone hangs up on you, it's just left in the air and you are thinking, well clearly, she is upset, she's not happy. Things haven't ended in a good space. (HP D- phone call).*

Rapport is a soft skill

Despite the challenging calls, most participants demonstrated their desire and ability to do what it takes to develop rapport during telehealth calls. Participants felt it was their responsibility to ensure rapport was developed as it was vitally important to have a safe connection and trust to begin working together. Due to the determined approach health professionals had towards developing rapport we interpreted that participants were developing and managing rapport as a soft skill during telehealth calls. The concept of soft skills is defined here as personal and interpersonal skills that contribute to productive and harmonious relations between health professionals and patients and families (Kechagias, 2011).

Reviewing body language

Participants were aware that their body language was different in telehealth. Participants felt more aware of their facial expressions, eye, head, and torso movements. Participants were sometimes unconscious at the time they were adjusting their body language to develop rapport.

> *It [video] feels very comfortable. I think probably initially when we first started doing it there is always a bedding in process and it takes a while to get used to it, but now it feels almost second nature. Almost the same as doing a face to face conversation really.*

> *You can't use the same body language, it's basically just your face on the screen so you know maybe, and I don't know whether I would do this purposefully, but maybe you have to use more facial expression rather than relying on your body language to kind of gain trust and build rapport. (HP A- video call)*

As well as awareness of their own facial movements during the video calls, participants were checking the facial expressions of patients or family on the video screen to assess for signs of rapport.

> *And I could see that because that's the joy of a video, you can see people's expression and when it was not a good connect. (HP E-video call)*

Listening beyond the words

The key communication skill identified by participants to develop and manage rapport was that of listening. Most participants said they actively listened, read between the lines, or were listening for what was not said. Listening to understand during a telehealth call enabled the health professional to interpret what was said beyond the spoken words. For one participant the way to develop rapport during challenging calls was to listen and to prompt the family member to talk until they had a sense of being heard.

> *So they sound, that same thing, that tone changes. They don't sound so irate. They probably feel more listened to and heard and it's just that someone is actually helping them. Yeah, someone is doing something to help. (HP B, phone call)*

Listening was a gateway to developing rapport and building trust with the person. Some participants understood listening to be personal, and sensitive to nuances in speech, tone, and silences during telehealth calls.

> *Because you are listening. You don't have a distraction; you are listening, and you can pick up the nuances and you can hone in. HP E.*

Managing environment and privacy

Participants were aware that telehealth required private space to develop rapport. However, most work environments were not set up for telehealth at all. There was often a lack of private space to use video or phones in busy clinical areas and shared offices. Health professionals often moved to try and find quiet rooms to make telehealth calls that would allow uninterrupted flow and concentration.

> *Often, if our office is busy or noisy it can be hard to concentrate. Like the environment that you have made the phone call in can actually affect it sometimes. You might want to end that phone call sooner because you can't quite hear or get a sense or concentrate. It doesn't happen often, but it can affect how you do your phone call. So sometimes I have to walk, I walk away and go into an office and make a phone call there and have a chat to them. (HP G Phone calls)*

Working from home during the pandemic also posed privacy issues with one participant going to the extent of closing her windows so the neighbours couldn't hear her client's conversations.

"Training would be good"

Several participants pointed out the lack of training in telehealth interpersonal relationship building, which they felt would have been beneficial for themselves and patients. Due to a lack of training and practice opportunities some participants voiced a hesitancy to offer video telehealth calls. One participant had a sense of "wasting time" trying to sort out technology for video calling without having tried it, and felt her own uncertainty was a risk to vital first impressions and creating rapport.

Discussion

This study is the first of its kind to explore palliative care professionals experiences of rapport during telehealth calls. Participants considered rapport to be as essential during telehealth interactions, as ii is in face-to face visits. Importantly participants felt they developed rapport most of the time, but they also identified times when rapport was not achieved despite their best efforts and expertise. Some participants found it difficult to articulate when or how rapport was experienced during a telehealth interaction. Video calls were positive with rapport developed, whereas the most distressing telehealth calls were phone calls. In spite of this, participants used the phone as the “go to” for telehealth. A key result of our analysis is that developing and managing rapport is a soft skill that is essential to in-person and telehealth interactions and yet overlooked in terms of training.

Health professionals are more likely to use technology when they are trained and supported in how to use telehealth in their practice (Jess et al., 2019; Kristin Jonasdottir et al., 2022; Wade et al., 2014). Unfortunately, due to the COVID pandemic, many health professionals were not provided with a training opportunity to develop skills to navigate rapport in the telehealth environment Geller, 2021; Kirby et al., 2021; Thomas et al., 2020). As in other studies, our findings suggest that there is a gap in professional preparation for telehealth (Henry et al., 2018). In this study, participants were not asked explicitly how much telehealth training they had, but most indicated telehealth was approached by trial and error, while recognising a need for interpersonal skills training. Some untrained participants in other studies were also tentative to try video calls as they felt video may interfere with vital first impressions and rapport, as the technology might fail, or waste valuable relationship building time (Aung et al., 2022; Kristin Jonasdottir et al., 2022).

The “home visit” context of community palliative care is mostly soft skills based. Telehealth on the other hand, is a mix of “hard” technical skills and “soft” communication skills, such as developing rapport remotely which requires focus, intention, and practice (Henry et al., 2018; Continisio et al., 2021). To adapt to telehealth, health professionals need to consider how they can transition their in-person rapport skills while maintaining technology and patient-centred care in telehealth (Paige et al., 2022). A recent Swedish study gave an example of merging hard and soft skills during telehealth calls, when some nurses and patients simultaneously placed their palms on their respective screens to create a sense of proximity. These nurses had participated in online telehealth training which boosted their theoretical knowledge confidence and competence (Carlsson et al., 2022).

The concept of soft skills is a powerful way to conceptualise rapport as it implies rapport can be practised and developed into mastery in contexts like telehealth (Alison and Alison, 2020). This applies equally to health professionals understanding telepresence without which rapport could not be realistically experienced (Geller, 2021; Groom et al., 2021; Barrett, 2017). Even with mastery though, rapport is not guaranteed, and requires attention in every interaction. Rapport as a soft skill mitigates the common belief that rapport just happens, or that rapport is personality dependent (Kirby et al., 2021; Kromme et al., 2016). Although more research is needed into rapport and telehealth, researchers have identified the qualities required for successful rapport building and developed a checklist for telehealth skills (Alison and Alison, 2020; Henry et al., 2022). Further research is also warranted to reflect the vital experiences that patients and families have of rapport in telehealth.

Limitations of the study

We noted few focus groups participants had video-call experiences, whereas most interview participants had video-call experiences, this indicated different responses to recruitment to the two options. Data from the interviews also provided richer examples of rapport experiences. Focus groups may have limited the freedom to describe the individuals experiences of rapport and were difficult to recruit and plan for during the pandemic. However, the interpretive design allowed for exploration of the themes to generate knowledge about rapport that can be applied in clinical practice.

Despite efforts to recruit a diverse population of participants, most participants were NZ European and therefore may not reflect different cultural approaches to telehealth. Although conducted in the context of palliative care, the results of this study may be generalisable and prove useful to those interested in telehealth and developing rapport with patients and families in their homes.

Implications

Developing rapport is a foundational soft skill for health professionals and is suitable for a regular reflective practice to learn from telehealth interactions (English et al., 2023a). To demonstrate the skills required to develop rapport during telehealth, examples are provided from recent telehealth studies that focused on interpersonal skills development (Table 7-9). The categories are drawn from the key components of the definition of rapport (English et al., 2023a) and the studies referenced (Banerjee et al., 2022; Webb et al., 2021; Schrager, 2020; Carlsson et al., 2022; Watts et al., 2020; Henry et al., 2022; Hilty et al., 2021).

Table 7-9 Developing rapport as a soft skill in telehealth calls

Category	Examples of actions or approaches to develop rapport	Reference

Preparation	-Check technology so that you can see and hear each other. -Check also for non-technological barriers such as the person’s level of hearing and their preferred mode of communication.	Banerjee et al., 2022 Webb et al., 2021
Presence/ Telepresence	-Give each call your full attention and focus on the patient and family. Trying to do something else at the same time is very obvious on the phone or video call. -Pay attention to nonverbal communication (self and other) -If on a video call, make appropriate eye contact by looking at the camera.	Schrager, 2020 Carlsson et al., 2022 Webb et al., 2021 Watts et al., 2020
Privacy	-Confirm your patient is in a setting where they feel comfortable discussing their private health information. -Determine how the information discussed in the call is made available to the patient	Banerjee et al., 2022 Watts et al., 2020
Clarity	-Speak slowly and clearly -Avoid medical jargon -Clarify unclear statements	Webb et al., 2021 Schrager, 2020
Relaxed Positive friendly	-Introduce yourself and your role, offering a warm welcome -Express positive views of telehealth -Smile and use a friendly tone of voice -Open posture, lean forward, relax and focus -Spend time to get to know the person as a person at the beginning of the call, use “local” references.	Henry et al., 2022 Webb et al., 2021 Watts et al., 2020
Acceptance	-Use culturally appropriate greetings and show respectful awareness and acknowledgement of family/whānau in the room. -Check if the patient would like a support person to be with them, or if they need an interpreter -Endorse and encourage patient and families to ask questions or take notes -State that you aim to work as partners and listen throughout for ways to work together.	Hilty et al., 2021 Watts et al., 2020 Banerjee et al., 2022 Henry et al., 2022

Caring	-Use caring words, sounds, and tone of voice -Check in on persons comfort and emotional wellbeing -Make a caring statement expressing that the patient’s emotional response to an event or an experience is appropriate and reasonable.	Webb et al., 2021 Banerjee et al., 2022
Listening	-Avoid interruptions- Pause after speaking and wait a few seconds before responding to a patient to reduce interruptions. On video use visual cues, such as nodding, or positive verbal utterances to show that you are listening -Listen actively and do not make assumptions about what you have heard. Ask “Have I heard you correctly?”	Henry et al. 2022 Banerjee et al., 2022
Understanding	-Seek clarification for what you have said, “I would like to hear from you, what do you understand from our discussion so far?” -Reflect your understanding of what the patient has said. “So I want to make sure I am understanding what you are saying…”	Schrager, 2020
Clarify next steps	-Go over main points of your discussion and encourage questions. -Establish what will happen after you hang up. If you have the capability, send an after-visit summary through a portal so the patient will have something in writing from the phone visit.	Banerjee et al. 2022 Schrager, 2020

Conclusion

Health professionals felt they developed rapport most of the time using telehealth, while also identifying times when rapport was not achieved despite their best efforts and expertise, particularly on the phone. Importantly, rapport is identified as a key soft skill that can be practiced, and mastery developed, although, rapport in each interaction is not guaranteed. There is some urgency for health professional training to improve integration of telehealth into palliative care. Studies that include patient and family perspectives on rapport in the palliative care and telehealth contexts would be a promising area for further research.

Chapter summary

In Chapter 7, I have presented the different experiences of rapport reported by patients, families, and health professionals while interacting in telehealth calls. The following chapter integrates the patient, family, and health professional findings into a theoretical framework. Included in the chapter is a paper entitled “**Applying experiences of rapport during telehealth calls to the Theory of Human Relatedness”** currently under review.

Chapter 8 Results: Applying the Theory of Human Relatedness

Chapter introduction

This chapter presents the results from phase three of the study. It includes a paper currently under review with *Communication in Healthcare: Strategies, Media, and Engagement in Global Health* entitled: **Applying experiences of rapport during telehealth calls to the Theory of Human Relatedness: A qualitative study.** This paper applies relevant data from patients, family members, and health professionals to the Theory of Human Relatedness (Hagerty et al., 1993). This work was undertaken to 1) determine the extent to which patient, family. and health professional data aligned with the key propositions of the Theory of Human Relatedness, in relation to developing rapport; and 2) provide a theoretical framework to integrate the findings from phase 1 and 2.

English et al., (under review). Applying experiences of rapport during telehealth calls to the Theory of Human Relatedness: A qualitative study.

Applying experiences of rapport during telehealth calls to the Theory of Human Relatedness: A qualitative study

Introduction

In the domain of health communication, interpersonal relationships are a defining context within which most health professionals practice, both at the individual and the wider public level (Berry, 2006; Schiavo, 2013). Health professionals develop rapport and trust, and thereby assess a patient’s needs and impart health information and education through interpersonal relationships (Epstein and Street, 2007; Parrott, 2004**).** There is growing evidence that patients have satisfaction, greater adherence to treatment and better health outcomes when dealing with healthcare professionals who have good interpersonal skills, including in rapport building (Epstein and Street, 2007, Norfolk et al., 2007; Hall et al., 2009; Ruben et al., 2018). Conversely, ineffective communication with healthcare professionals can lead to patients not engaging with the healthcare system, refusing to follow advice or adhere to treatment plans. Ineffective communication is also associated with patient and family dissatisfaction, complaints, and malpractice suits (Zolnierek and DiMatteo, 2009; Allison and Hardin, 2020; Skär and Söderberg, 2018; Thompson and Harrington, 2021).

Rapport is a key indicator of the quality of communication between patients, families, and health professionals and considered a “bedrock” for fostering collaboration, trust, person-centred care, and healing relationships (Epstein and Street, 2007; Norfolk et al., 2007, Alison and Alison, 2020). Patients and families rely on health professionals to initiate and manage rapport as developing rapport with health professionals is a one way to ensure their needs will be met. Health professionals develop rapport to gather information and provide care effectively (English et al., 2023b). There is a tendency for brief interactions with patients and families in the current time and resource poor healthcare environment (Hagerty and Patusky, 2003). This places more pressure on health professionals to form rapport with patients and families in a relatively short time. Added to this, is the global shift to developing rapport and relationships in the telehealth environment in response to the global pandemic (Calton et al., 2020; Eastman et al., 2021). Along with the rise in telehealth services is an associated lack of communication training for health professionals (Henry et al., 2022; Chua et al., 2020).

Although rapport is foundational to therapeutic interactions including telehealth, there is a paucity of theoretical frameworks pertaining to rapport in the health professional-patient relationship. However, there are a number of interaction-centred theories providing frameworks that inform health professional-patient relationships. These theories focus primarily on the interaction itself and the ways verbal and nonverbal behaviour are used to manage the communication process (Bylund et al., 2012). This group of theories includes Communication Accommodation theory (CAT; Giles and Soliz, 2014), Rapport Management as a politeness-based theory (Spencer Oatey, 2007), the Person-centred approach (Rogers, 1979) and the Human Relatedness theory (Hagerty et al., 1993). These theories can provide descriptions of what happens in healthcare communication interactions (Bylund et al., 2012).

This study uses the Theory of Human Relatedness which was constructed to provide a framework to better understand patients experiencing difficulties in relatedness (Hagerty et al., 1993). The theoretical framework as it is applied in the study is focused on the relationship between people that occurs via technology, to reflect the upsurge in telehealth usage and the need to develop rapport digitally. This study seeks to apply theory to the phenomenon of rapport that so far has not been well articulated theoretically in relation to telehealth.

The aim of this study therefore is to apply the Theory of Human Relatedness (Hagerty et al., 1993; Hagerty and Patusky, 2003) to determine the extent to which patient, family, and health professional data aligned with the key propositions of the theory in relation to developing rapport during palliative care telehealth interactions.

Design

The philosophical underpinning of this study is an interpretive paradigm with a Symbolic Interactionist perspective to study how people make sense of their social worlds through communication and social interactions (Blumer, 1969). This study uses the Interpretive Description methodology which aims to generate knowledge for applied clinical practice into complex experiential phenomena (Thorne, 2016). Interpretive Description accommodates the use of theory as an analytical tool to guide, construct and transform data (Thorne, 2016). In addition, the Theory of Human Relatedness was utilised to inform the interview questions and to provide a framework for data analysis and discussion.

Data Collection

As part of a larger telehealth study, data were collected from three groups of participants: 1) patients, 2) family members, who participated in individual or joint semi-structured interviews, and 3) palliative care professionals who participated in focus groups or individual semi-structured interviews. Interview schedules and a topic guide were developed using the literature (English et al., 2022a; Hagerty and Patusky, 2003), asking participants for their experiences with rapport. All interviews, focus groups and field notes were completed by Author 1, a nurse with previous experience with research interviews. The interviews and focus groups were audio recorded and transcribed verbatim by Author 1. Each participant group was distinguished by patient (Pt), family member (FM) and health professional (HP), after which each individual participant was assigned a unique identifier such as Pt A, FM A, or HP 1, when quoted in-text. Where possible a quotation is provided from each participant group. A full ethics proposal was granted in September 2020, by The Health and Disability Ethics Committee (HDEC) NZ, ref: 20/CEN/165.

Setting/Participants

Participants were patients, family members, and palliative care professionals recruited from four hospices providing community services in NZ. Patients were eligible to participate if they were over 18 years, receiving palliative care in their homes, had received telehealth calls and could converse in English. Adult family members were eligible if they provided support for patients receiving palliative care at home, had received telehealth calls and could converse in English. Health professionals were eligible to participate if they were working in palliative care and had telehealth interactions with patients and families in their homes. We referred to the Interpretive Description guidelines (Thorne, 2016) to determine a preferred sample size of approximately 15 patients, 15 family members, and 30 health professional participants.

Recruitment

Senior hospice staff undertook selection of potential participants by selecting individuals from their patient management systems and checking notes to ensure inclusion criteria were met. Hospice staff telephoned eligible patient and family member participants providing a description of the study to assess interest in participation and permission to be contacted by the researcher. Interested participants were phoned by the interviewing researcher with additional study information and provided with an opportunity to ask questions. An interview appointment was made for a time and place of the participant’s choice, with an invitation for a support person or family member to be present.

Eligible health professional participants were emailed a description of the study to invite participation in focus groups. The first 6-8 respondents at each site were selected to attend the focus group held in their workplace. Individual interviews were offered for those who preferred an interview, an appointment was made for a time and place that suited the participant. Written consent was obtained from each participant prior to the interview or focus group. Duration of interviews and focus groups ranged between 45-70 minutes and conducted in-person during November 2020 -May 2021.

Analysis

Data analysis was undertaken using key components of the Theory of Human Relatedness (Hagerty et al., 1993) as a coding framework: Comfort, involvement, belonging, mutuality, reciprocity, and synchrony. Author 1 transcribed interview recordings and the transcriptions and relevant field notes were uploaded to NVivo to facilitate the analysis.

Reflexive memos provided an audit trail for decisions made while navigating the analysis. Other decisions to promote data rigour included, regular meetings regarding analysis with research team members and completion of a COREQ checklist (Tong et al., 2007).

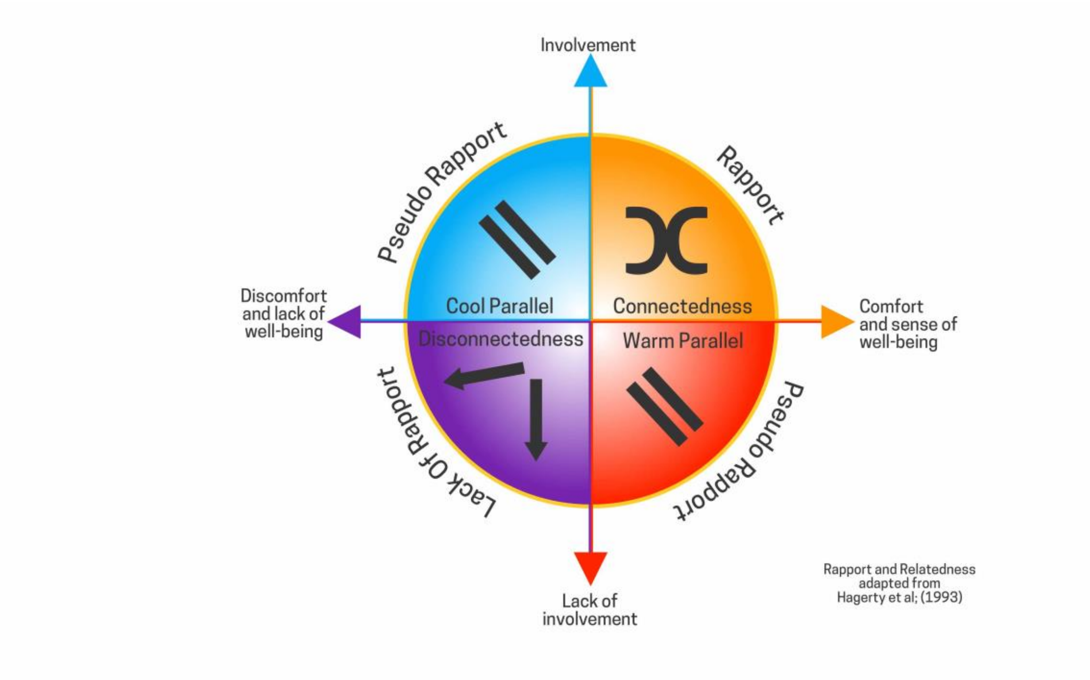
Results

Sixty participants were recruited across the four centres: 31 Health professionals, 18 patients and 11 family members. Of the health professional participants, 7 participated in individual semi-structured interviews and 24 participated in four focus groups. The health professional participants included 20 nurses, 4 doctors, 3 social workers, 3 family support (counselling team) and 1 Māori liaison. Most participants had 2-plus years of specialist palliative care experience, ranging from a few months to over 30 years. All participants had phone telehealth experiences, and 8 participants also had experience with video calls.

Most patient participants self-identified as of European descent with two identifying as NZ Māori and one as “Other.” There were an equal number of men and women, and all had a cancer diagnosis. Eight participants were over 50 years old and a further eight were over 70. Family participants were mainly of European descent with one person identifying as NZ Māori. Most were female and under 70 years of age.

Results are presented using the framework of the theory of Human relatedness with adaptions made based on the study findings. In relation to developing rapport there were four kinds of relatedness identified between patient, families and health professionals which were: 1) Connectedness- getting on together, 2) Disconnectedness- looking at each other across the abyss, and two types of pseudo-rapport- 3) Warm parallel and 4) Cool parallel. (Figure 8-1).

The quadrant of connectedness, depicted by a symbol of two lines intersecting, corresponded with the participants experiences characterised as having rapport (Figure 8-1). The quadrant of disconnectedness corresponded to the participants experiences characterised as having an absence of rapport, depicted as arrows moving away from each other (Figure 8-1). The quadrants labelled as parallelism and enmeshment were re-labelled as pseudo-rapport. De Paulo and Bell first described pseudo-rapport as interactions where participants feign warmth, positivity, and genuineness, or as interactions yet to achieve rapport (DePaulo and Bell, 1990). We identified two types of pseudo-rapport: 1) Warm parallel with interactions that were comfortable but not involved, (previously parallelism) and 2) Cool parallel with interactions that were involved but uncomfortable, (previously enmeshment). The adapted model depicted (Figure 8-1) shows the pseudo-rapport symbols as two parallel lines indicating the health professional and the patient or family member are not connecting but alongside one another in various states of comfort and involvement. These parallel interactions may be satisfactory for some interactions, but do not typify interactions with rapport as defined by (English et al., 2023a) which is the definition used here.



Rapport and Relatedness adapted from Hagerty et al; (1993)

Figure 8-1 States of Rapport and Relatedness Model

Connectedness: Getting on together

Rapport only occurred in the connectedness quadrant. Associated with the connectedness quadrant were participants’ experiences of the social competencies: a sense of belonging, reciprocity, mutuality, and synchrony (Hagerty and Patusky, 2003) which also only occurred in the connectedness quadrant.

All three participants groups’ experiences of rapport in telehealth interactions, were characterised by interactions that were positive, comfortable, involved, and person-centred. Patient experiences of rapport and connectedness during telehealth interactions included being seen as an individual, feeling cared for and supported by the health professional. Participants perceived interactions were based on respectful engagement, mutual understanding, and mutual acceptance (Table 8-1).

Family member experiences of rapport and connectedness included feeling comfortable with the health professional when they were interested in them as people, with a communication style that was easy, positive, and effective. The interactions had qualities of shared understanding and mutual attention with each other which promoted a safe space for honesty and “straight” talking.

Health professional experiences were more centred on the necessity of rapport in telehealth interactions to create workflow and trust by being open, approachable, with attentive listening. Health professionals experienced a sense of congruence, mutual comfort and understanding in their interactions that facilitated sharing and collaborating (Table 8-1).

Table 8-1 Participants quotations for connectedness and rapport

Component of relatedness model	Patient	Family	Health professional
Involvement	I felt pretty much 100 percent involved. Pt Q She (doctor) is just, from my point of view, involved with her patients. To me it's everything. Pt L	She (nurse) is interested in the same things, reading and gardening, that I am, so we have a great rapport. FM G	If you have a solid engagement with a person then you will engage with them, the work will flow, you will be able to do your intervention planning and whatever because there's that trust there. HP E
Comfort	I mean like comfortable, trusting and listened to. Pt A	I think she (CNS) is probably the best person I've ever spoken to on the phone because she gets something done. She pulled everybody together. She was very, very, easy to talk to. I felt very comfortable about it. FM C	And to me, it's more like that common ground but also making people comfortable because whether its face to face or phone or video, if you are not comfortable with each other nothing is going to happen, nothing of importance. HP B
Sense of belonging	I know they are there; you know what I mean. I know they are there, and I know they are doing their best to help me. Pt F	That's when you start to feel you can really open up and tell them anything and everything. FM F I am absolutely included.	Being open and listening really. Being approachable on the phone. HP 9

		All the time. FM I	
Reciprocity	They are talking or engaging with you. You can talk and you will get answers, and its back and forwards like a tennis match. Pt G	She’s straight up (CNS). Because you don’t want things sugar-coated when you get to this point in the journey - you want to know what your options are. FM B	Communication is always two ways. We give a lot of information but if the patient is not getting heard if they are not taking it in, the information, or can’t understand what I’m talking about…well…? HP 8
Mutuality	More a sort of mutual understanding and a mutual acceptance and fairly free communication between us…is part of rapport and working together. Pt O	It is because you know that you have their full attention, they are listening to you, and it is important. FM F	It’s probably about finding that common ground or having something that you can relate back to them. So rapport is when you and the person you are talking to reach that point where you feel comfortable with each other, when you can share information. HP G
Synchrony	She’s got a great way of just making me feel really relaxed and her whole tone is lovely. Pt A.	And I know she cares; I know from her voice. FM A	Having a mirror near the phone so that the staff could see themselves when they talked on the phone, and I thought, that’s really good, because actually if you have a crabby face, do you know, it’s probably coming across in your voice. HP 11

Disconnectedness: looking at each other across the abyss

The Disconnectedness quadrant corresponded with all three participants groups' experiences of interactions with a lack of rapport. These interactions were characterised by discomfort, lack of involvement, and absence of the social competencies, which we labelled: not belonging, non-reciprocity, non-mutuality, and asynchrony.

Most patient participants recalled experiences of disconnectedness in a telehealth interaction with health professionals, mostly during telephone calls. These experiences were related to health professionals using jargon, not listening, being rude or abrupt. Some patients felt labelled as difficult or complex and there were examples of misaligned expectations between patients and services provided (Table 8-2). This type of interaction left patients feeling unimportant, depersonalised, and not wanting to engage further with that health professional or service.

Similarly, most family members recalled an experience of disconnectedness related to uncaring, negative interactions with a health professional during telehealth interactions. Some family members described frustration with unclear communication and struggling with a sense of not feeling "seen" or heard at times on the phone. These experiences left family members feeling confused, adrift, or angry (Table 8-2).

Health professionals also described experiences of disconnectedness in telehealth interactions. Their experiences were related to dealing with strong emotions from patients and families, or sometimes not having time to deal with distressed calls. Some health professionals described feeling upset when they were not in-sync with patients and families which increased the risk of communication being misinterpreted. For other health professionals, they felt a sense of mutual discomfort or one-sidedness during some interactions. This resulted in health professionals adjusting their responses to include limiting self-disclosure and modifying their speech, tone, and body language to salvage the possibility of rapport developing in future calls (Table 8-2).

Table 8-2 Participant quotations for Disconnectedness and lack of rapport

Component of relatedness model	Patient	Family	Health Professional
Lack of Involvement	But there was very little involvement from that provider about the next steps. What are my options? If you have listened to me talking, what are my options? Pt B	I didn’t feel involved at all. I felt that the attitude was that you are lucky to be getting something, so you just better take it. FM C	If you’re not on the same page or wavelength, it’s really hard because it’s a barrier to actually going forward. If you can’t get good rapport, people can misinterpret things or hear things differently. HP G
Discomfort	Every time I spoke to the nurse it was always very like rude. It was kinda like I had become a “difficult patient.” I actually found her quite rude, abrupt. Pt A	I just felt she was very negative. I felt quite angry. I didn’t say that to her, but I felt that. FM C	…I came off that one feeling really uncomfortable, that it wasn’t a good connection, that I had more work to do with that patient. HP E Hung up on me, yeah. HP D
Not belonging	I’m not a person, I’m just a manilla folder. You know NHI number or whatever Pt G	Ah, - impersonal. Mm. I just think I’m another number. Oh, he’s probably thinking about the next shot on the golf tee.FM A	Sometimes I go into situations where the family is extremely rude and abusive towards you. They have very poor manners and that’s really hard to get a rapport going. HP G
Non-reciprocal	I didn’t really get that feel it was “how are you going?” and certainly it wasn’t listening to my observations and feedback and there was no real response to that feedback. I was left a bit in limbo about what my	They (HP) are always more engaging if you are sitting there with your partner and you are talking to someone, because you are right there and you are definitely more involved. On the	Sometimes, what they (patients or families) are picking up is actually what we are reflecting: please get to the point, we’re busy, and we hope it’s not too complex, you know. HP 11

	options were going forward. Pt B	other end of a phone, they don’t necessarily know you (family) are there. FM D	
Non-mutual	I think misunderstanding possibly. They probably had their information to impart, and I had what I needed to hear and I’m not sure the two met. Pt L	Yeah, because it’s crystal-ball- gazing when you’re on the end of a phone and somebody’s ringing you as a health professional and doesn’t give you clear instruction or...is not really direct in what they’re saying, it’s open to misinterpretation. FM B	Or mutual discomfort: …if I feel the conversation is not going well, I would sense or feel that the patient or family is feeling the same. HP F
Asynchrony	…she was not very likeable. Like when I listened to her voice, sort of thing. Pt A	I guess whether you’ve got the rapport with that health professional, which you don’t tend to have over the phone, you know - it’s just a voice as opposed to being able to see somebody’s body language.FM B	I know when I’m working hard because I’m more calculated with my words and I think my speech slows down. I can see myself really slowing down and having pauses. HP F

Warm parallel: comfortable but lacking involvement

One type of pseudo-rapport occurred during warm parallel interactions. These were characterised by comfort but also a lack of involvement, preventing rapport in the interaction. The chat during these interactions seemed friendly, but participants felt a lack of involvement from the other person that left them with limited trust in the interactions being effective.

Pseudo-rapport occurred when patient participants had hearing difficulties or understanding was impaired during the interactions. Health professionals wanted to make the best of the relationships, trying to understand the other person's viewpoint even though rapport may not have been developed (Table 8-3).

Table 8-3 Warm parallel interactions

Participant Group	Participant quotations
Patients	She's lovely but I cannot understand her accent- on the phone it's absolutely hopeless! Pt C Because the phone is turned up as loud as it can go and it's still not loud enough. So half the time it's guess work on my part as to what the other person is saying. Pt D (hearing impaired)
Family members	Some people you immediately connect, others, it takes a while to talk to a person. Three or four times before you really connect and maybe that's the problem with (place name). I think the connection will come in time. FM I
Health professionals	It's more difficult to build rapport over a screen than it would be in person, but I think generally the video calls were a success. I don't know what the patients and family's perspective were, but they seemed comfortable. HP 6

Cool parallel: involved but uncomfortable

A second type of pseudo-rapport occurred in cool parallel interactions characterised as involved but uncomfortable.

Some patient and family participants felt interactions were "professional" but not necessarily caring or person-centred. Interactions with health professionals that were "cold" or verging on rude, left them doubting themselves, their choices, and the value of the relationship. One family member stressed the importance of the health professional making sure rapport was created before diving into complex results and decisions on the phone. Other patients and family members expressed their reluctance to complain or change providers with whom they felt uncomfortable.

Most health professionals could recall interactions where developing rapport was one-sided, with no mutual connection made. This made for uncomfortable interactions where a task could be completed but there was little relational focus. Health professionals gave examples of challenging calls such as having to use an interpreter and not communicating directly with the patient. Another example was persevering with developing rapport in spite of friction in the interactions (Table 8-4).

Table 8-4 Cool parallel interactions

Participant Group	**Participant quotations:**
Patients	Like she was quite, like cold, in a way but very professional, very, but there was nothing warm. Pt A They are just, not rude, but they are, they just don’t seem to be able to convey a message politely. Pt J
Family members	Not that he was rude. I mean he just called the facts how it was and strongly suggested palliative care only for mum, so yeah. FM J Some people can be really abrupt. FM E
Health professionals	Usually they are the ones where you need an interpreter which is usually a family member., I usually end up building more of a rapport with the person who can speak English than the patient. You can get a bit of rapport with the patient, but if it’s on the phone, you are talking to the person who speaks the best English. HP B You know, whether it’s a confrontational one or you know, we know that patient or family are going to be slightly rubby, and (we) make the best of what we’ve got really. HP F

Discussion

The adapted model of the Human Relatedness theory (Hagerty et al., 1993) presented in this paper offers an expanded view of rapport during telehealth interactions, as it includes states other than the mere presence or absence of rapport. There were two key findings, firstly there were strong links with the state of relatedness model and all participant groups' experiences of rapport and lack of rapport. Secondly, the key difference between the theoretical framework and our findings were related to the participants' experiences of pseudo-rapport. These experiences of pseudo-rapport occurred between the presence and absence of rapport and existed in what could be considered "the grey zone" of clinical relating. Many of the interactions described in the data collected for this study may well fit into the pseudo-rapport quadrants.

There is synergy with our findings about rapport and another interaction-centred theory. Without specifically being about rapport, Halldorsdottir's relationship theory, has a *life-giving/biogenic* mode that covers similar territory to the connectedness quadrant (Halldorsdottir, 2008). A life-giving relationship was person-centred and provided a sense of hope, encouragement, reassurance, security, confidence and an improved sense of well-being and healing (Halldorsdottir, 2008).

The pseudo-rapport quadrants share a lack of concern or interest in the quality of relations with three modes of Halldorsdottir's model: a *life-sustaining/bioactive* mode that does not develop a life-giving connection; a *life-neutral/biopassive* mode that does not affect life in the other; and the *life-restraining/biostatic* mode that causes discouragement and uneasiness in the other (Halldorsdottir, 2008). The unease associated with the life-restraining mode is similar to that caused by medical "gaslighting" where the health professional denies the lived experiences of symptoms of the patient (Fraser, 2021). In this study, a few patients participants described feeling disbelieved by health professionals with resulting unease in the interactions. However, it is not known as yet if these states of pseudo-rapport may in fact be perceived as satisfactory in some clinical situations.

Disconnected interactions are similar to interactions described as *life-destroying/biocidic* (Halldorsdottir, 2008) and were unfortunately common across the participant groups in this study. These interactions were unacceptable and damaging for patients and families, and undesirable and challenging for the health professional participants. If these disconnected stances are taken by health professionals, they must be seen as unethical. Life-destroying dynamics place the patient and family in a position of vulnerability and call into question the ethics of responsibility and care for each other, which are foundational to the treatment of human beings in healthcare (Delgado, 2021).

Communication in the interpersonal encounter is complex and contextual, with no agreed gold standard for effective health professional–patient communication (Street, 2013). One of the challenges of creating effective relationships is the intrinsically asymmetrical nature between the health professional and patient, where expertise and power are unevenly distributed (Ruben, 2016). To achieve more equitable relations health professionals need to adhere to the principles of personalised care while being relational and developing rapport (Farrington et al.,2023). A recent study suggests approaching rapport as a soft skill when developing rapport in telehealth (English et al., 2023b).

Telehealth also presents challenges for measuring health outcomes. Research is needed to show the relationship between developing rapport and patient health outcomes when using telehealth. This future research may benefit from considering patient outcomes derived from an indirect pathway (Street et al., 2009). An example of the indirect pathway between rapport and health outcomes might be how the quality of advice and support received from a telehealth call may affect a person's decision to try a new treatment. In particular, if that treatment helps them be at home autonomously for longer and aligns with their goals of care. This study indicates the interactions most likely to be effective in this type of call are those where the participants perceive rapport to be present.

Theory alone does not guarantee rapport in clinical practice. However, this theory has characterised interactions with pseudo-rapport or interactions without rapport that pose a risk to patients and families. Based on the participant experiences in this study we would argue that rapport is fundamental to safe person-centred care. As such rapport should be the preferred default for all interactions with patients and families. In health communication, the learning process is lifelong (Schiavo, 2013) and this study highlights the need for health professionals to keep reflecting on and practicing rapport consciously. For health professionals, developing rapport via telehealth requires awareness, and a life-giving approach that may take more communication training, practice, and honest debriefing with each other when interactions are uncomfortable.

Limitations and strengths

A possible limitation of this study was a lack of interview questions that asked participants specifically about the model's social competencies. This may have impacted the results for the competencies and particularly for the competency of synchrony.

As there were a majority of European participants and patients with cancer diagnoses, our results may not reflect the views of people with different cultural or illness experiences.

A key strength of this study is applying peoples' real experiences of rapport to a relatedness theory. By drawing theory and practice together, new knowledge generated makes theory more clinically relevant. Despite the study being limited to the palliative care setting we believe these results may be generalisable to other settings where rapport is essential.

Implications for practice:

The challenge for health professionals is to evaluate if rapport has in fact been developed in their interactions. Health professionals can assess the status of a relationship with a patient using the relatedness grid (Figure 8-1) and ask reflexive questions about rapport. By asking questions that check the components of the Relatedness model (Hagerty and Patusky, 2003; Table 8-5), health professionals could gain insights into their own practice of developing rapport.

Table 8-5 Reflexive Rapport Questions

Components of relatedness model	**Examples of reflexive questions:**
Level of comfort	How comfortable am I? How comfortable is the other person in the interaction? How can I tell?
Level of involvement	How involved am I? How involved is the other person? How can I tell?
Sense of belonging	Does the other person feel a sense of belonging with me? Our organisation? Do they have a sense of belonging with anyone?
Reciprocity	Is there a sense of give and take in the interaction?

	Is the exchange equitable or is there a power imbalance affecting the interaction?
Mutuality	Is there a sense of sharedness and acceptance of each other? Or is there separateness due to judgement, or resistance to engage?
Synchrony	Is there a sense of shared movements and congruence between us? Or is there a sense of imbalance that feels uncomfortable?

Conclusion

Although there was a strong relationship to the theoretical model and participant experiences of telehealth interactions with rapport, it was evident that participants also had experiences of pseudo-rapport, and absence of rapport. Pseudo-rapport occurred in a grey-zone of clinical interactions that resulted in uncertainty, and a lack of trust in the effectiveness of the interactions for participants. The adaptions to the Theory of Human Relatedness provide a model that connects theory to clinical experience in relation to rapport, while suggesting a tool for reflecting on the state of rapport in clinical interactions. We urge further research into all interaction types identified in the Theory of Human Relatedness including pseudo-rapport and its effects on patients, families, and health professionals.

Chapter summary

The aim of this chapter was to present the findings from phase 3 in relation to developing rapport using the Theory of Human Relatedness. The results endorsed many aspects of the model, while also suggesting the need for modifications to reflect the participants experiences and build on the knowledge about rapport. The chief modification to the Theory of Human Relatedness was in regard to identifying two types of pseudo-rapport in clinical interactions between patient, family, and health professionals. A second aim of the chapter was to outline the integration of findings from phase one and two using the Theory of Human Relatedness. The adapted Theory of Human Relatedness proved capable of accommodating the participants' different experiences of rapport and relatedness during telehealth calls and was a useful theoretical framework to integrate the findings from this study.

The next chapter is the final chapter of this thesis and provides an overview of all elements of the study. In addition to the overview, I will also identify implications for practice and policy and make recommendations for education and future research before finishing with some concluding thoughts.

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Chapter 9 Discussion

I know what rapport is…

It is the giving of yourself to the other

It is knowing they may accept or reject you

And both may be difficult.

Knowing this you go ahead anyway

And be present and open and there for the other

It is not for the faint-hearted

But it can be life-giving.

A.C., Nurse, scholar, and patient, 2017.

The quote above is from an experienced nurse and scholar who knew she was dying when I was nursing her in hospice. We had many conversations about life-long learning, how nurses generate knowledge and the privilege of nursing. She asked me about my study which was at that time a master's degree focused on rapport experiences in hospice. AC looked at me from her bed and took my hand and said, "I know what rapport is" She offered the words above to use in my thesis and presentations. She was encouraging, saying that it was a good topic because not everyone understands how challenging, yet at the same time, how transformative, rapport can be. AC had experiences of rapport from both sides of the health professional-patient dyad. She had an integrated viewpoint and her words resonated powerfully as I wrote this chapter.

Chapter introduction

In this concluding chapter I present an interpretively woven and cohesive integration of the key findings of this study. The aim of the integrated discussion chapter is to bring all elements of the study together to highlight its originality and contribution to evidence, while at the same time provide an understanding of the study findings in their entirety (Lewis et al., 2021; Smith, 2015).

This chapter consists of several sections. Firstly, I revisit the research question, aims and objectives, present the integrated key findings and highlight how the research questions have been addressed. Secondly, I discuss the meaning and potential significance of the results in broader contexts. Thirdly, I make recommendations for education, practice, and future research and reflect on the theoretical, practical, and methodological strengths and limitations of the study. Lastly, I make concluding remarks and end with a short postamble.

Research Aim

The aim of this study was to explore patient, family/whānau, and palliative care professional’s perspectives of rapport in telehealth encounters. My intention was to generate new knowledge and theoretical insights to improve the development of rapport during telehealth interactions in palliative care.

Research Questions

1. What are patients and families/whānau experiences of rapport with palliative care health professionals in telehealth encounters?
2. How do palliative care health professionals experience and manage rapport in telehealth encounters?

Research Objectives

- To conduct approximately 20-30 semi-structured interviews with community hospice patients and their families to explore their experiences of rapport during telehealth encounters.
- To conduct 4-6 focus groups with hospice healthcare professionals to explore their views of rapport within the context of telehealth.
- To apply study findings to the Theory of Human Relatedness (Hagerty et al., 1993) to improve understanding of rapport during telehealth in palliative care.

Integrated Findings

To demonstrate how I have linked the findings I have used a visual framework which indicates the connections between key elements of the results as outlined in Chapters 6,7 and 8 (Figure 9-1). I integrate the findings in four ways: 1) I report on the research outcomes, 2) I identify the significance of the key findings, 3) I outline the three central themes of the study and explore their connections and, 4) I extend the scope of the States of Rapport and Relatedness model by exploring my definition of rapport in different theoretical contexts.

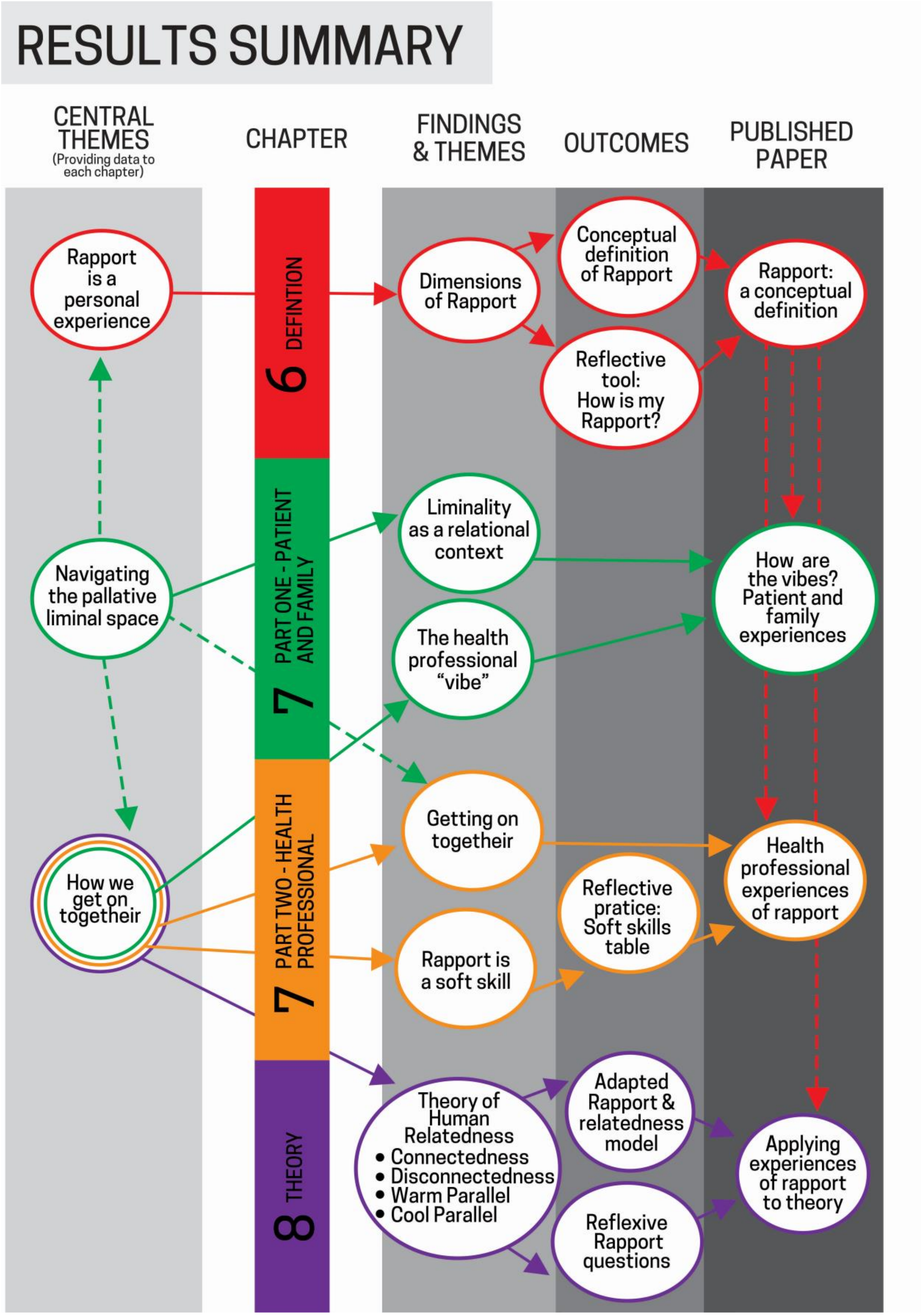


Figure 9-1 Results Summary

Research Outcomes

As shown in figure 9-1 the key research outcomes in this study are:

- The development of a conceptual definition of rapport (Chapter 6)
- A reflective tool for assessing “How is my rapport today?” (Chapter 6)
- A summary guide to developing rapport as a soft skill in telehealth calls (Chapter 7)
- A reflective tool “Reflexive rapport questions” for health professionals to evaluate if rapport has been developed in clinical interactions (Chapter 8)
- An adapted theoretical model of States of Rapport and Relatedness (Chapter 8)
- Four publications from the research results contribute new knowledge to the existing evidence base and are either published or under review in international journals.
- Two further publications in Chapters 2 and 3, contibute to the exisiting evidence base as literature reviews and an example of reflexivity.

Collectively, these outcomes contribute to a more nuanced understanding of rapport both as a concept and within the context of telehealth calls in the palliative care setting. One way this has been achieved is to address research gaps identified in this study. Five key research gaps were identified from both the literature reviews conducted for this study (Chapter 3). The table below outlines how the research findings and outcomes go some way to addressing the gaps (Table 9-1).

Table 9-1 Addressing the research gaps

Research gaps identified (Chapter 3)	How the findings and outcomes of the study contribute to addressing the gaps
Rapport was poorly defined conceptually	This study developed a conceptual definition of rapport based on patient and family experiences for use in research and clinical practice (Chapter 6)
A gap exists between the theoretical understanding of rapport and the reported findings from patient, family/ whānau and health professional participants in the reviewed studies. This included interactions without rapport.	Findings corroborated this gap between theory and the lived realities of participants in this study (Chapter 7). A theoretical model was adapted to reflect possible rapport variables within clinical interactions including a lack of rapport and pseudo-rapport. (See Adapted model of rapport and relatedness in Chapter 8 and "Expanding the States of Rapport and Relatedness model" section later in this chapter).
Limited evidence of patient and family/whānau experiences of rapport and little emphasis on the effects of rapport (or lack of rapport) on patient outcomes.	An example of a key finding from the patient and family/whānau experiences indicates the "vibe", presence, and skill of the health professionals affects rapport developing. The knowledge generated provides a basis for further studies determining the effects of rapport (or lack of rapport) on patient health outcomes.
Limited evidence was situated in the palliative care setting (Seccareccia et al., 2015).	This study contributes 4 publications to the literature of experiences of rapport based in the palliative care setting (see Chapter 6, Chapter 7 part 1 and 2, and Chapter 8).
Health professionals identified a lack of specific training and research in rapport building and interpersonal skills for telehealth.	The findings from this study (Chapters 7 and 8) corroborate a lack of training in rapport for health professionals. A key recommendation based on these findings is the need for telehealth training and education for health professionals that includes rapport and interpersonal skills (see Recommendations-Education and Training). The research outcomes from this study (listed directly above this table) have

	potential to be further developed to meet telehealth training needs.

Significance of key findings

The conceptual definition of rapport (Chapter 6) developed from this research has three significant features. Firstly, the conceptual definition of rapport is the first to be grounded in patient and family/whānau experiences of rapport and as such provides a new perspective on the concept of rapport. Secondly, the conceptual definition of rapport provides a clear understanding of the concept being studied and enables potential comparison across studies. For example, in this study I used the conceptual definition of rapport to describe how rapport is operationalised (Chapter 7 and 8). This provides a coherent approach to rapport and facilitates making connections and comparisons across and between the findings throughout the study. Thirdly, the conceptual definition was used to develop a reflective tool for health professionals (Chapter 6). The aim of the tool is to assist and improve practice by recognising the key dimensions of rapport during interactions with patients and families.

The experiences of rapport from the patient and family/whānau viewpoints provided insights into the previously unresearched dynamics of developing rapport between patients, families, and health professionals in telehealth (Chapter 7). For example, patients and families regard the health professional’s “vibe” as a significant indicator of rapport developing in telehealth. Indeed, the modality of the communication mattered less to them than the “vibe” of the health professional in the interaction. This indicates a power dynamic weighted towards the health professional to provide the kind of environment and approach for rapport to develop or not. Health professionals may have assumed they were responsible for the “vibe” of each interaction, but these findings now make this explicit (Chapter 7). Findings from this part of the study raise concerns about how often participants experience difficult encounters due to a poor “vibe” and subsequent lack of rapport with health professionals.

The important concept of liminality in palliative care communication was introduced and informed by the findings (Chapter 7). Patients and families/whānau under the care of community palliative care services identified how they experienced rapport during telehealth interactions with health professionals. They described this as akin to being thrown a lifeline in the unknown-ness of living with life limiting illness. In contrast, interactions without rapport created a greater sense of being in limbo for participants. A significant finding therefore was patients and family/whānau members need for health professionals to present a relaxed, positive, caring “vibe” and to understand the importance of rapport when someone may be in a liminal space (Chapter 7).

Findings from this study have provided insights into the complexity of developing rapport for palliative care professionals (Chapter 7). Of significance, health professionals regarded the development of rapport as fundamental to doing their job well and identified rapport to be as vitally important in telehealth calls as it is during in-person interactions. Health professionals also found some telehealth interactions to be difficult, uncomfortable, and upsetting, with poor rapport developed despite their best efforts. Participants identified a lack of training for communication skills during telehealth calls which may affect confidence using video conferencing with patients and families. Another significant feature of this study is the reconceptualising of rapport as a soft skill. This could encourage health professionals to learn, practice and acquire mastery in developing rapport rather than considering it as a spontaneous naturally occurring phenomena.

The application of real-life experiences of rapport from the perspectives of patients, families/whānau, and health professionals were used to adapt an existing theoretical model to elucidate the states of rapport in clinical interactions (Chapter 8). Using the Theory of Human Relatedness (Hagerty et al., 1993), the adapted model depicts the various states of rapport across the four quadrants of Connectedness, Disconnectedness, Warm parallel and Cool parallel. The latter two quadrants reflect participants’ experiences of pseudo-rapport. The identification of pseudo-rapport reflects the “grey-zone “of clinical relating (Chapter 8) and has significance for expanding the concept of rapport which is often considered as a duality, such as rapport is either achieved in an interaction or it is not. Importantly, this study has identified that pseudo-rapport and lack of rapport place patients and families at risk of receiving poor care and may affect patient outcomes.

Central themes:

As part of integrating the findings, this section outlines the overall analytical thematic structure for the study describing central themes and their relationship to the themes and outcomes (Figure 9-1). Three central themes were developed across the dataset using Reflexive Thematic Analysis (TA; Braun and Clarke, 2022). Each central theme had its own unique character and met Braun and Clarke’s definition of an “overarching” theme as an organisational device that can “add interpretive depth and clarity” to the thematic structure (Braun and Clarke, 2022, pg.88). In this study, I used the term central theme rather than overarching theme. I have labelled the theme structure as central theme, theme, and sub-theme. I define these terms based on Braun and Clarke (2022) as:

- **Central theme** -A central theme is an organisational device that holds additional contextual information that is not necessarily discussed in the analytic narrative.
- **Theme** is the key analytic unit in Reflexive TA and informs the analytic narrative. It is a shared pattern of meaning with a central concept.

- **Subtheme** sits under a theme. It focuses on one particular aspect of the theme and brings analytic emphasis to that aspect of the theme.

The central themes are shown in the first column (Figure 9-1) as they did not always fit neatly into one chapter or publication. For example, “How we get on together” is the central theme providing themes for three chapters (Figure 9-1). Central themes and their themes are outlined in figure 9-1 and, themes and sub-themes were described in detail throughout Chapter 7. The three central themes are: “Rapport is a personal experience”, “How we get on together” and “Navigating the palliative liminal space” (Figure 9-1).

Rapport is a personal experience

This central theme was developed from the experiences of the three participant groups and highlights how rapport was experienced as a personal and unique response to the interaction. These responses consisted of unique combinations of feelings, thoughts and observations described by each person. There was little, if any, checking with the other to see if what they were experiencing was shared. Yet, the positive feelings generated individually were perceived as rapport. This theme was the chief source of data for the four dimensions of rapport and the conceptual definition of rapport (Chapter 6), (see figure 9-1).

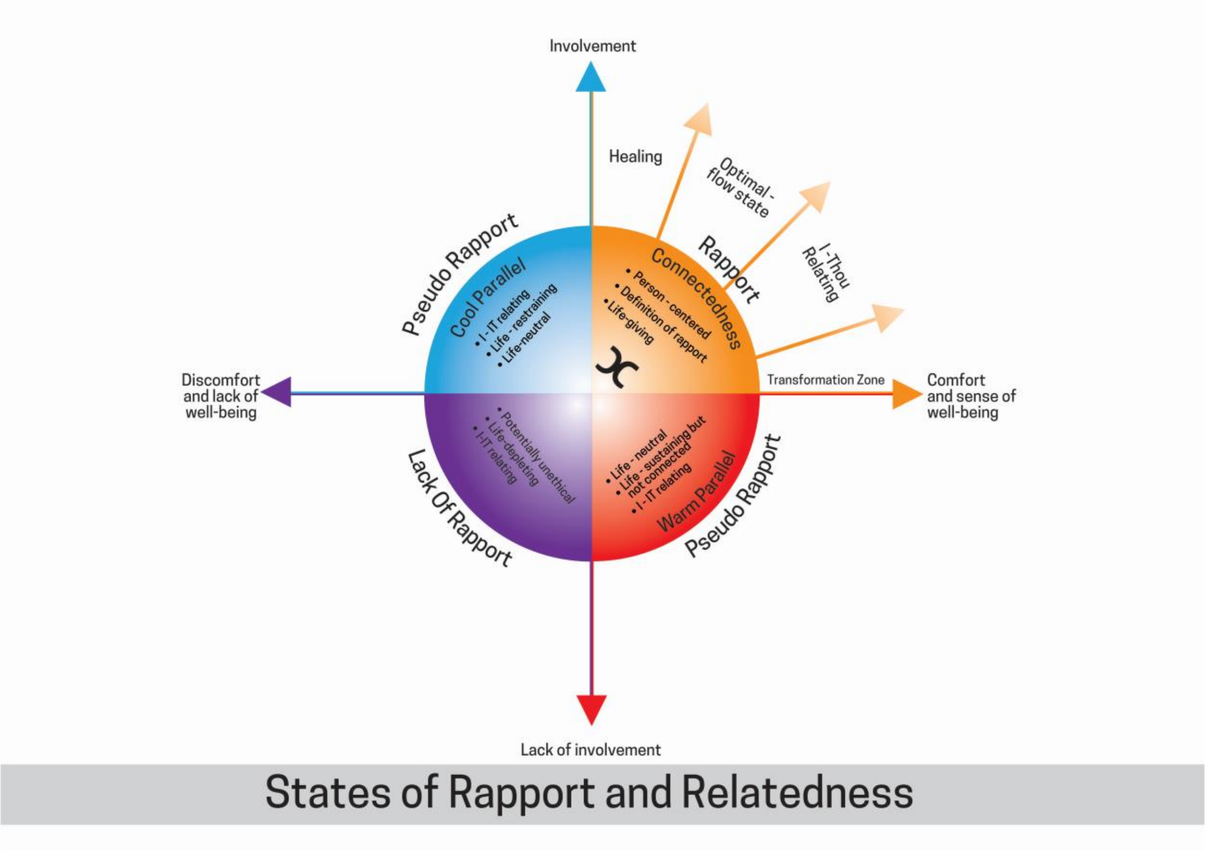
How we get on together

The second central theme describes the crux of the “betweenness” of rapport as experienced by the three participant groups (Chapter 7 and 8). So, although rapport is experienced in unique individual ways, it is also a dyadic dialogue-based experience between people. The “How we get on together” central theme provided three themes “The health professionals vibe”, “Rapport is a soft skill”, and “Getting on together” from Chapter 7 (See figure 9-1). “The health professionals’ vibe” identifies relaxed comfortable interactions, and difficult uncomfortable interactions. “Rapport is a soft skill” identifies rapport as a learnable skill to improve interactions. “Getting on together” describes how rapport was experienced by health professionals during telehealth calls. In addition, the adapted States of Rapport and Relatedness model (Chapter 8) draws on this central theme to situate the participants’ experiences of rapport within the various quadrants of the model (Figure 9-1).

Navigating the palliative liminal space.

The third theme describes the unique context that people with a life limiting illness have when interacting with health professionals (Chapter 7). The liminal space in this context is a conceptualisation of crossing a threshold from the life before knowledge of a terminal illness until death (McKechnie et al., 2011). The green dotted lines (Figure 9-1) indicate the contextual influence this central theme has on the thematic structure of this study. The theme “Liminality as a relational context” (Chapter 7) was developed from this central theme as part of the analysis of patient and family/whānau experiences (see Chapter 7), (Figure 9-1). The threshold into liminality is often crossed at the time of diagnosis and again upon referral to specialist palliative care (MacArtney et al., 2017). The findings of this study indicate that with liminality comes the need for a particular awareness by health professionals to support rapport with patients and families/whānau. The theme of liminality provides an important concept in the palliative care context and offers insights into telehealth interactions from the patient and family/whānau perspective.

Figure 9-2 Expanded States of Rapport and Relatedness Model



Expanding the States of Rapport and Relatedness model

The next section explores and extends the scope of the findings from the States of Rapport and Relatedness model’s four quadrants: connectedness, disconnectedness, warm parallel and cool parallel. I present here an expanded model of the States of Rapport and Relatedness (Figure 9-2) from the one outlined in Chapter 8, particularly in relation to the connectedness quadrant.

Expanding Connectedness

This section explores the relationship between the work of key theorists (Tickle-Degnen and Rosenthal, 1990; Tickle-Degnen, 2006; Buber, 1970; Rogers, 1979) and the conceptual definition of rapport (English et al., 2023a), (Chapter 6). The aim is to expand the ideas presented in Chapter 8, including the relationship between Halldorsdottir’s theory of nurse-patient relationship and the quadrants of the States of Rapport and Relatedness model (Chapter 8). A key finding from this study is that rapport only occurs in the connectedness quadrant of the States of Rapport and Relatedness model. The interactions in this quadrant are characterised as having involvement and comfort that includes having a sense of well-being and being life-giving (Chapter 8). The conceptual definition of rapport (Chapter 6) resonates with these characteristics and can be situated within the connectedness quadrant (Figure 2). Beyond the comfortable and involved interaction though lies potential for an optimal experience (Tickle-Degnen, 2006).

The landmark work of Tickle-Degnen and Rosenthal on the non-verbal nature of rapport (1990) has informed both the scoping review (Chapter 3) and the conceptual definition of rapport (Chapter 6) developed in this study. Their “nonverbal correlates” of rapport namely, positivity, mutual attention, and coordination, are noted to be similar to the social competencies of the Theory of Human Relatedness- a sense of belonging, mutuality, reciprocity, and synchrony (Chapter 8). It is interesting that after this influential work, Tickle-Degnen (2006) revisited the conceptualisation of rapport and proposed a model that viewed rapport as an optimal experience, based on Csikszentmihalyi’s optimal “flow” experiences in 1975 (Csikszentmihalyi, 2014). While in flow, a person’s anxieties often diminish and a feeling of ease results. Tickle-Degnen argues for rapport to be viewed as an optimal experience, with at least one study done subsequently that supports this assertion (Nelson et al., 2016). The idea of rapport as a flow state may translate well to research in telehealth, as research in related fields has explored the relationship between flow state and telepresence in social media (Pelet et al., 2017) and online learning (Shin, 2006).

It is difficult to say if any participant in this study experienced a flow state during telehealth interactions. However, while it was not specifically asked about in the interviews, there were signs of such interactions. For example, when patient participants were delighted with the genuine connections offered by health professionals and family/whānau members said that having rapport was “like gold”. Health professionals also described their sense of fulfilment when they believed interactions developed rapport (Chapter 7). It was clear that patient and family/whānau participants wanted rapport rooted in caring and acceptance in their healthcare interactions, as per the conceptual definition of rapport (Chapter 6). They perceived health professionals’ “vibes” and presence and wanted in effect, to have flow experiences with health professionals (Chapter 7). However, although health professionals indicated rapport was vital to their work in palliative care, reconceptualising rapport as an optimal flow state may need to be supported with time and training in practice. Tickle-Degnen’s repositioning of rapport holds an exciting possibility for patients, families/whānau and health professionals to be able to experience an optimal flow state of rapport during telehealth calls, where growth, transformation and even healing may occur (Wright, 2015).

Next, I turn to the seminal works of existential philosopher Martin Buber (1923, translated into English 1970) and psychotherapist Carl Rogers (1979) to explore their work in relation to the conceptual definition of rapport and connectedness quadrant. I have chosen the works of Buber and Rogers for the following reasons. Firstly, both the I-Thou philosophy of Buber and the Person-centered theory of Rogers are relational dialogue-based approaches. Secondly, both remain influential in relationship literature, with Buber’s work referenced in palliative care (Österlind and Henoch, 2021), healing relationships (Scott et al., 2009), and educational technology (Wegerif and Major, 2019). Rogers’ influence is widespread with recent examples from psychotherapy and police interviewing (Alison and Alison, 2020), social pedagogy (Murphy and Joseph, 2019) and sports coaching (Rowley and Lester, 2016).
The interactions of Buber and Rogers share approaches to relating with the conceptual definition of rapport (English et al., 2023a).

Buber is very specific about the need to have an “I-Thou intention” and to be present in an I-Thou encounter, he created the term “Presentness” and described it as:

> *Real Presentness cannot be identified with the I, for the I does not exist in itself, but only in relation to a Thou or an It. Presentness exists, moreover, not in the I, but between the I and the Thou …* (Friedman, 2003, p. 113).

According to Buber, “Presentness” is more than the individual presence of the I and the Thou; it is a presence of intensity, wholeness and betweenness that typifies an I-Thou encounter (Friedman, 2003). Similarly, Rogers makes explicit the requirement for the health professional to be the most authentic they can be in the encounter, as this creates a congruence that the client can feel and relax within (Rogers, 1979). These qualities are similar to the definition of rapport developed in this study. Central to the definition is the need for the health professional to be in an authentic state of relating- relaxed, positive, friendly, caring and accepting towards the other (English et al., 2023a; Chapter 6). The notion of presence was also the basis for a key finding from patient and family/whānau data, namely that the “vibe” and holistic presence of the health professional are integral to rapport being developed (Chapter 7).

For Buber, another key skill needed for an I-Thou interaction is “inclusion”, which he defined as the ability to see the side of the other person in a relational event while remaining able to see one’s own side (Buber, 1970). Buber is clear that inclusion is more than mere empathy and that the simultaneous perceiving of the perspectives of self and other is key to having a potentially mutual healing encounter (Friedman, 2003). Along with presence, one way to achieve inclusion is through listening. Indeed, the person-centred approach and the definition of rapport both emphasise the importance of a particular kind of listening (Chapter 6). From

Rogers' theory the key skill a health professional needs to be person-centred is the art of active empathetic listening. In his own words:

> *This kind of sensitive, active listening is exceedingly rare in our lives. We think we listen, but very rarely do we listen with real understanding, true empathy. Yet listening, of this very special kind, is one of the most potent forces for change that I know (Rogers 1979, p. 2).*

This type of listening aligns with that described in the conceptual definition of rapport (Chapter 6). It is also the type of amplified listening health professional participants used, with an intention to understand the other person (Chapter 7). Patients and family/whānau members perceived being listened to in this way as health professionals caring for them (Chapter 6).

Rogers describes the effects of person-centred encounters as mutually beneficial for the client and the therapist (Rogers, 1979). Buber's I-Thou encounters are also mutually beneficial, providing potential for existential healing for both persons by being involved in dialogue (Buber, 1970). Rapport is also associated with positivity and mutuality (Tickle-Degnen and Rosenthal., 1990). The conceptual definition of rapport (Chapter 6) identified the effect of rapport on interactions which included the formation of potentially mutually beneficial trust and confidence.

The similarities between the I-Thou encounters, person-centred approach and the conceptual definition of rapport are strong. The interactions are all based on unconditional acceptance and a reflexive awareness of the other. The health professional is fully present with the person listening in a deep way that demonstrates care and regard for the patient as a unique being, and these interactions are mutually beneficial. I argue therefore, that rapport as defined in this study (English et al., 2023a) is fundamental to an I-Thou encounter (Buber,1970), a person-centred interaction (Rogers, 1979), and a flow state interaction (Tickle-Degnen, 2006). In addition, these ways of relating fit into the connectedness quadrant of the States of Rapport and Relatedness model, along with Halldorsdottir's life giving (Chapter 8) interactions (Figure 9-2). Developing rapport in this way provides the basis for interactions to become more than transactional; they may become transformational and healing.

Connectedness Quadrant

I have extended the connectedness quadrant to accommodate the transformational and healing interactions described above (Figure 9-2). When initially considering how to depict rapport in the state of relatedness model in chapter 6, I decided to show this by shape and colour. The connectedness quadrant of the States of Rapport and Relatedness model is a quarter circle, graduated in colour from light in the centre indicating a lower level of comfort and involvement, to darker on the outer edge of the quadrant indicating higher levels of comfort and involvement (Figure 9-2). This helps depict how an interaction perceived to have higher levels of rapport and stronger bonds of connection would be situated further from the centre. However, the curve of the circle has the effect of implying there is a knowable end to what is experienced as rapport, which may not be the case. The expansive potential of rapport is therefore depicted by the arrows moving further away from the centre beyond the coloured area, labelled as the "transformational zone." (Figure 9-2).

Disconnectedness

In contrast to the interactions with rapport in the connectedness quadrant are the interactions in the disconnectedness quadrant. These interactions without rapport are characterised by discomfort and a lack of involvement from both participants, ultimately resulting in a lack of well-being. To depict the interactions in this quadrant the colour is graduated from lighter in the centre where there are some levels of feeling uninvolved and uncomfortable, to the darker shading on the outer ring of the quadrant which indicates higher degrees of disconnection (Figure 9-2)

A disconnected type of interaction with no rapport was not a random or infrequent occurrence in this study (Chapter 7 and 8). Disconnected interactions occurred for both patient/family and health professional participants in this study and were experienced as disempowering and unacceptable by the former, and undesirable and challenging by the latter (Chapter 8). Similar to findings in this study (Chapter 7), interactions with an absence of rapport can be characterised as objectifying (Buber, 1970) and depersonalising non-healing encounters (Mount 1993). A study looked at "interactional suffering" for people with palliative care needs in hospital (Beng et al., 2014). Suffering was defined as a state of severe distress associated with actual or perceived threat to the intactness or integrity of a person. This suffering occurred as a result of a negative interaction with health professionals (Beng et al., 2014). These interactions left many patients feeling "devastated" after the interaction had occurred. This was similar to two patient participants in this study who described feeling deeply negatively affected by telehealth interactions months after they had occurred.

A negative, objectifying interaction characterised by a lack of rapport would therefore fit into the disconnectedness quadrant of the States of Rapport and Relatedness model (Figure 9-2). Beng and colleagues go so far as to say that a disconnected interaction is unethical in healthcare and violates the principle of "above all, do no harm" (Beng et al., 2014). This is strong language. However, this study also shows that disconnected interactions are incrementally life-depleting (Halldorsdottir, 2008) and make developing rapport very unlikely (Chapter 7 and 8). One possible explanation for the poor quality of some interactions in palliative care may be related to an "attention deficit" culture (Beng et al., 2014) where health professionals are too busy to be attentive to the non-physical aspect of the person's care. This type of disconnected interaction was also reported in the literature reviews (Chapter 3), with patients describing separation, isolation, and dissatisfaction with care (Dang., et al., 2017; Elliot., et al., 2016; Segaric et al., 2007; Insua-Summerhays et al., 2018). As well as resulting in difficult interactions for patients and families, this state of fractured attention and poor-quality relationships may also contribute to health professional burnout (Scott et al., 2009). In essence, these are negative harmful interactions where the health professional cannot do their job satisfactorily and the person does not have their healthcare needs met. The discomfort and dissatisfaction in these interactions is therefore likely to be mutual.

Pseudo-rapport

A key finding of this study is that there are interactions without rapport that sit in a "grey-zone" of relating. These interactions may not be as damaging as disconnectedness, but do not qualify as rapport as defined in this study (English et al., 2023a) instead are identified as a pseudo-rapport (Chapter 8). Pseudo-rapport interactions are when the involvement is poor, but some comfort is present and might be characterised as "Ok, I suppose". There can be a vagueness to the interactions with participants not quite sure where they stand with the other, whereas interactions with rapport and connectedness or even no rapport and disconnectedness, are clearly characterised. The effect of this type of interaction is mostly unknown and unlabelled in the literature which makes it difficult to research and understand from a clinical perspective. This study provides labels and examples of pseudo-rapport-warm and cool parallel, that could facilitate further research.

Warm parallel

Pseudo-rapport interactions that are warm parallel are shown in the red quadrant. The light shading in the centre shows some level of comfort but also some sense of a lack of involvement which makes developing rapport difficult. The darker the red, the more comfort and lack of involvement there may be (Figure 9-2). This creates a dissonance; participants are experiencing both friendliness and lack of interest at the same time which keeps the interaction superficial. There is also potential for patients and family/whānau to develop mistrust in the effectiveness of the health professional and the service offered. Findings from this study showed that interactions which reflected “warm parallel” characteristics were limited in trust and unlikely to be considered effective by participants (Chapter 8). The interactions seemed friendly, but there was a lack of involvement from the other person that left them unwilling to share or expect much from the interaction. Halldorsdottir (2008) describes this as life-sustaining but not connected, while Buber states this type of interaction, despite the warmest ‘personal’ feeling, is actually an I-it encounter (Freidman, 2003).

It is difficult to find supporting studies of interactions in the “grey-zone.” One example is a study that investigated nurses who seemed to refuse patient involvement in palliative care (Glasdam et al., 2020). The authors used the concept of thoughtlessness to analyse case studies of people with palliative care needs. The study’s main finding attributed the thoughtlessness of some nurses to an assumption that patient input was going to be time-consuming and distract from clinical tasks. In other words, it was quicker to avoid patient involvement in interactions. This was not helped by nurses having a generally “unreflective strategy” towards patient care (Glasdam et al., 2020). As well as raising concerns about the difficulty to develop rapport in this type of interaction, the concept of thoughtlessness fits with interactions in the warm parallel quadrant. This thoughtlessness may also be similar to rapport-neglect (Spencer-Oatey, 2007).

Cool parallel

Interactions that are cool parallel are shown in the blue quadrant. This quadrant shows interactions which have both a level of involvement and a level of discomfort. The lighter shading near the centre shows lower levels of involvement and some discomfort which increases to more involvement and more discomfort indicated by the darker shading (Figure 9-2).

Findings from this study indicate it is the feeling of discomfort that makes developing rapport difficult and prevents connection. An example of this type of interaction would be a “tick the box” approach used by some health professionals during telehealth interactions (Chapter 7 and 8). As there was involvement, the tick-the-box tasks could be completed, but they were experienced without relational satisfaction, which echoes life-restraining (Halldorsdottir, 2008) and I-it interactions where the other is objectified (Buber, 1970). Similarly, there were reports of patients and family/whānau members who were stressed, anxious, or angry on the phone which created discomfort for the health professional trying to be involved (Chapter 7). In a study that explored “uncomfortable moments”, participants who experienced “unease” in the interactions with health professionals were unlikely to develop rapport (Kovarsky et al., 2011). The study described an example of unease which was caused by using sexually explicit humour, but the authors indicated unease may be caused by other verbal and nonverbal asynchrony (Kovarsky et al., 2011).

The next section provides an exemplar based on one of the interviews from this study with two different telehealth calls. At this final stage of the study, it is now possible to apply some of the learnings related to the States of Rapport and Relatedness model to each of these telehealth situations.

Exemplar of two calls

Text Box: Exemplar of two calls

Call number 1

The young woman has recently been told that she has advanced metastatic breast cancer. She is married with two children and has a busy full life. The setting is during a nation-wide lockdown period of the COVID-19 pandemic. She is at home; her phone is ringing, and she answers it. The call is from her new doctor. Due to lockdown restrictions, they have been unable to meet in-person, so they are using the phone for a consultation. As the conversation progresses, the woman realises the call is not going well, there are misunderstandings, awkward pauses, defensiveness, and even perceived rudeness. The woman has a growing sense of unease and wants to withdraw from the call. She feels unable to speak up for herself. She is upset after the call and feels reluctant to engage with this health professional again. There is no rapport between them and yet she needs this doctor to help her.

Call number 2

The same young woman is at home a few weeks later. Her phone is ringing, and it is a different specialist calling to check in with how she is feeling and how that last medication change is going. There is smiling, chatting, and nodding even when the talk becomes more about symptoms and medication. She is engaged, animated and even laughs at times. They have rapport. After a time they make a plan for follow up. The call ends with “Thank you so much for calling, it was so lovely talking with you. I feel somehow better.”

These are examples of telehealth encounters based on real calls from health professionals to a patient participant in this study. At the time of the interview, I found it interesting that this young woman could describe two such very different telehealth experiences. Both of these calls were on the telephone, both with the same patient in her own home. The calls were made by two different health professionals. The key difference between the callers was in their approach, care and skill making the call to her.

In the first telehealth call, the woman reported a high level of discomfort and a feeling of a lack of involvement from the health professional which detracted from her well-being. These are indicators of the disconnectedness quadrant. Further the interaction typified the I-it encounter (Buber, 1970) where she felt objectified as there was no regard for her as a person. The encounter also fits the description of a biocidic or life-depleting interaction (Halldorsdottir, 2008) as the woman was still upset and feeling the impact of this call months later. This was not a healing encounter, nor was it an optimal “flow” experience, nor was it person-centred (Figure 9-2). The social competencies of the Human Relatedness theory (Hagerty et al., 1993) were all negative (Chapter 8). There was no sense of belonging, instead there was withdrawal as she felt she was an unwanted complex problem for the doctor. In addition, there was a lack of mutuality, with misunderstandings, negative reciprocity, and a strong sense of asynchrony with awkward pauses.

In the second call, the woman reported a high level of comfort between herself and the new doctor and a high level of involvement from the doctor which contributed to her well-being. These characteristics fit the connectedness quadrant (Figure 9-2). From the woman’s description and evident pleasure relating the account to me, it would indicate this was both an I-Thou and a life-giving/biogenic encounter (Buber, 1970; Halldorsdottir, 2008). It was also likely to be an optimal “flow” experience that was person-centred and healing (Rogers, 1979). The social competencies (Hagerty et al., 1993) were all present (Chapter 8). There was a clear sense of belonging in terms of being pleased this doctor was on her “team.” There was mutuality in their ease together and reciprocity as she felt cared for and “knew” she was not placing demands on the doctor’s time; they were “in sync” or synchronous in their dialogue that enabled planning and the interaction was interspersed with laughter. The woman also told me she looked forward to the calls from this health professional.

When describing the calls to me later during our interview, I asked her what made the difference between the first call and the second. The woman laughed and said, “That’s easy, the second call was all about me”.

Recommendations for practice, policy, and research.

This study explored the experiences of patients, family/whānau, and health professionals during telehealth interactions in palliative care. The findings highlight important considerations for practice, policy, and directions for future research.

Practice

Key recommendations for practice are:

- **For health professionals to recognise rapport as essential to patient family/whānau telehealth interactions**
- **For health professionals to develop a reflexive practice related to rapport in telehealth.**

Health professionals can be reassured from the findings in this study (Chapter 7) and other recent studies that rapport can be established during telehealth calls (Koppel et al., 2022, Bandini et al., 2022, Chou et al., 2021; Steindal et al., 2023). There are three key findings from this study that I considered together in relation to recommendations for developing rapport in clinical practice:

1. The conceptual definition of rapport (Chapter 6)
2. Rapport only occurs in the connectedness quadrant of the States of rapport and relatedness model (Figure 9-2)
3. The modality of communication was less important to patients and families than the presence and skill of the health professional to connect with them (Chapter 7).

By bringing these findings together it becomes clear that rapport is the preferred state of relatedness for patients, family/whānau and health professionals. Health professionals have a belief that face-to face is the gold standard of patient communication, particularly in palliative care (Bradford et al., 2014). However, the findings of this study dispute this. Patients and family/whānau wanted rapport to occur with health professionals during telehealth calls. A key recommendation for practice, therefore, is for health professionals to recognise rapport as essential to patient family/whānau telehealth interactions. Indeed, ultimately, I would argue that rapport, as defined in this study, be reconceptualised as the gold standard of clinical communication. It may well be useful to develop a concept analysis, or similar, to further operationalise rapport as part of this recommendation.

The second recommendation is for health professionals to develop a reflexive practice related to rapport**.** Cunliffe defines reflexivity as "Questioning what we, and others, might be taking for granted—what is being said and not said—and examining the impact this has or might have." (Cunliffe, 2016, p. 741). This definition easily accommodates the concept of rapport as a subject for reflexive practice. When considering the study as a whole, I identified a strong theme of reflective practice as an important way to improve practice in relation to rapport (Chapter 2, 6,7, and 8). Reflexive practice can be taught and practiced (Smith, 2011), thus giving a wider perspective of each health professional's daily interactions and states of relatedness (Chapter 8). This study has also developed reflective tools to support health professionals in Chapters 6, 7, and 8 (see figure 9-1). These reflective tools were created for health professionals with the intention of improving their understanding of rapport and what happens during interactions with patients and families/whānau regarding rapport (See also Future directions for research).

Education and Training

Key recommendations for education and training are:

- **To proactively develop a health professional workforce that is skilled and competent in the interpersonal skills required to develop rapport using telehealth.**
- **To develop soft skills training for telehealth in palliative care so that healthcare professionals can master rapport in their interactions with patients and families/whānau.**

Telehealth was rolled out in an unprecedented way in response to the COVID-19 pandemic and a large proportion of the workforce had not been trained in how to deliver care via telehealth (Thomas et al., 2020, Webb et al., 2021). This was also a finding in this study, health professionals wanted training to feel more confident providing video calls, in particular (Chapter 7). The hesitancy some health professionals have towards telehealth may be related to assumptions they hold (Chapter 3).as well as a lack of interpersonal training (Chapter 7). Another finding from this study, indicates that most health professionals did not use video calls and correspondingly most patients and families were not offered video telehealth services (Chapter 7). Health professionals' lack of training and confidence in telehealth may therefore be affecting the preferences for family/whānau members to try video calling resulting in a potentially unmet communication need.

There is also evidence that health professionals remain uncertain about how best to provide telehealth care. For example, in a recent survey of nearly 3000 international nurses and doctors, over half felt telehealth would negatively impact their ability to demonstrate empathy; guidance was also requested in learning "web-side" telehealth skills (Goodchild et al., 2022). Another study found telehealth etiquette is not intuitive and needs to be taught (Gustin et al., 2020). There is also a strong call for telehealth communication training and education for health professionals in some recent telehealth studies (Banbury et al., 2023; Carlsson et al., 2022; Jess et al., 2019).

Clinician acceptance is recognised as a key factor in developing a sustainable telehealth service (Wade et al., 2014). A key recommendation for training and education, therefore, is for organisations to proactively develop a health professional workforce that is skilled and competent in the interpersonal skills needed in telehealth, as telehealth becomes part of business as usual (Thomas et al., 2020). To achieve this, up to date telehealth interpersonal competencies and trainings are required to ensure the current and emerging workforce develop the necessary interpersonal skills (Thomas et al., 2020; Rutledge and Gustin, 2021). As part of building a competent telehealth trained workforce, there are calls to add virtual rapport-building to the list of critical skills needed in new nursing and medical training curricula (Newcombe et al., 2021; Rutledge and Gustin, 2021; Schwartz and DeMasi, 2021). Cultural considerations must also be included in telehealth training and may require more research. For example, the work from this study may be useful in specific topics for Māori, such as understanding how/if telehealth fits with the need for kanohi ki te kanohi (face to face) meeting and manaakitanga (care of others and cultural and social responsibility). Such research would benefit telehealth planning and training in NZ.

This study also recommends that rapport be taught and practiced as a soft skill. The soft skills concept was identified as a way to hone the skills health professionals need to become confident and, indeed, expert at developing rapport while using telehealth (Chapter 7). The teaching of soft skills in healthcare have mostly been trial and error, or "acquired" with work experiences (Continisio et al., 2021; Goldman and Wong, 2020). This seems a rather ad hoc approach to learning how to develop rapport, especially surprising when rapport is an essential communication concept linked to patient-centred and compassionate care (Kerr et al., 2022). For soft skills, the concepts being taught preferably needs to be well defined conceptually and operationally (Kechagias, 2011). The conceptual definition of rapport developed in this study will be useful in this context. Further suggestions for developing a telehealth training methodology include using online modules, interactions with standardised patients, in-person, and videoconference with tutor and pre- and post-training surveys (Gustin et al., 2020; Continisio., 2021; Kechagias, 2011).

Education and training tools are emerging in telehealth, and studies with health professionals trained in telehealth communication show improvements in health professionals' confidence and skill, and increased patient satisfaction (Aung et al., 2022; Banerjee et al., 2022; Carlsson et al., 2022; Elliot et al., 2020; Gustin et al., 2020; Tan et al., 2021; Watts et al., 2021; Webb et al., 2021), However, there appears to be substantial scope to develop telehealth training resources in interpersonal soft skills that include rapport for palliative care. A key recommendation from this study, therefore, is the development of soft skills training and support for healthcare professionals to develop rapport masterfully in their interactions with patients and families/whānau.

Policy and organisational support

Key recommendations for policy and organisational support are:

- **For health care organisations to plan and support a hybrid approach that includes in-person and telehealth options tailored to patient and family/whānau preferences in palliative care.**
- **For governments and health care organisations to develop policy that advocates for inclusive and equitable implementation of telehealth in palliative care.**

Lessons from the COVID-19 pandemic suggest there are policy implications for health care organisations to consider regarding telehealth and organisation preparedness for future health crises. Although not directly linked to the findings of this study, organisational policies have a key role in the success of telehealth implementation.

There are growing recommendations for telehealth to be used in conjunction with in-person home or clinic visits as a hybrid service to provide flexibility and improve accessibility (Aldana et al., 2023; Rariy et al., 2021; Eastman et al., 2021 McGinnis et al., 2023). It is important therefore, that planning, policy, and guidelines accommodate the preferences of patients, family/whānau, and health professionals and ensure that appropriate options are offered and supported (Steindal et al., 2023; van Gurp et al., 2015). For instance, in this study, one of the patients and family/whānau findings indicated that most participants were not offered a video call by health professionals. For telehealth to deliver high-quality care, it would seem useful for health professionals to have a positive approach towards telehealth and explicitly ask patients and families about their preferred mode of communication. Organisations, therefore, need to provide support and telehealth training for health professionals, and to provide the flexibility and infrastructure to meet end-user preferences (Rosa et al., 2022).

Several studies have identified that telehealth has the potential to improve or worsen inequity of care, related to access to technology in underserved populations (Bakitas et al., 2021; Kjeldsted et al., 2021; Hilty et al., 2021; Goodchild et al., 2022). Governments and organisational policymaking therefore, need to consider how to provide access to telehealth to achieve optimal and equitable health outcomes for all patients (Aung et al., 2022; Bandini et al., 2022). This also requires a trained engaged health professional team who offer telehealth and in-person options to patients and whānau and are supported organisationally to provide these services.

In NZ, Te Whatu Ora (Health New Zealand) provides policy guidance for telehealth and refers to The NZ Telehealth forum and resource centre (Telehealth.org.nz, 2023) for organisations seeking guidance and resources to set up improve or use a telehealth service in NZ. The Telehealth forum and resource centre site has examples of telehealth policy documents, guidelines and includes position statements from New Zealand Nursing Organisation (NZNO.org, 2016) and the Medical Council of New Zealand (MCNZ.org.nz, 2020). An abstract of this study and links to the published papers will be available soon on the NZ Telehealth resource centre as part of their research resource.

Future directions of research

Key recommendations for future directions of research are:

- **Exploration of the effects of rapport and pseudo-rapport on patient outcomes.**
- **Developing and evaluating rapport and interpersonal skills training for telehealth.**
- **Exploring relationship with reflexive practice to improve rapport in telehealth.**

Telehealth has developed over the course of the COVID-19 pandemic with a constant flow of research examining many aspects of telehealth care. In regard to this study, there were several future research opportunities identified in the results chapters, I have chosen three to discuss further below.

More research is needed to explore the relationship between the States of Rapport and Relatedness model (Figure 9-2) and patient outcomes. A recent study urges researchers to uncover pathways that link conversational elements with specific health outcomes (Tarbi et al., 2022). For example, this study has highlighted that patients and families experienced unsatisfactory disconnected interactions as well those identified as pseudo-rapport. There is little research occurring in this area of the "grey zone "of relatedness, yet it holds significant potential risks for patients and family/whānau receiving poor levels of care. I recommend research into this area to provide greater understanding of patient and families experiences of pseudo-rapport. The aim of such research would be to explore what pseudo-rapport is and how it happens in clinical interactions. By health professionals gaining understanding of pseudo-rapport, strategies can be developed to prevent it from happening with patients and families.

Linked to pseudo-rapport is the need to develop training for interpersonal skills in telehealth. Telehealth may be emphasising existing weaknesses in some health professionals' rapport building skills, that may also be present during in-person interactions. This study highlights the need to understand in much more depth what to teach and how to teach health professionals about communication, including interpersonal skills required to develop rapport in telehealth (Kerr et al., 2022). In addition, the definition of rapport from this study can be further developed to explicitly operationalise the variables of rapport in order to teach rapport as a soft skill to health professionals. This could then be included as a foundation for palliative care communication skills, while also be generalisable to both undergraduate and post graduate health professional training.

Another area of inquiry is linked to the recommendations for practice I have made related to reflexive practice. The benefits of reflexivity include increased accountability, trustworthiness, clarity, ethics, and personal growth (Probst, 2015). In the research setting, this includes benefits to the researcher and the quality of the research (Probst, 2015). Similarly in clinical practice, health professionals using reflexivity can encourage critical, flexible thinking and innovation. Through reflexivity, practitioners can become more comfortable with themselves and as a result more comfortable with the patients and families with which they interact (English et al., 2022b). This study has developed reflective tools to support health professionals to identify rapport in their practice and how it might improve (Chapter 6, 7 and 8). However, the reflective tools require evaluating in practice. A recommendation for further research in this area is to explore the connection between reflexive practice related to rapport and improved patient outcomes in telehealth.

Strengths and limitations

In this section, I consider the theoretical, practical, methodological strengths and limitations of the study. This is a qualitative study that sought to achieve a deep understanding of the participants' experiences of rapport. A strength of this study is that it addresses a gap in current knowledge about rapport as identified by a scoping and an integrative review of the literature (see Chapter 3). Robust attention was given to enhancing quality to the resulting knowledge claims, following quality principles suggested by Thorne, (2016, see Chapter 5). A further strength of the design is the way reflexivity has been embedded throughout the research process (Chapter 2). This ensures transparency, which is vital to the rigour of the study, by providing a trail of thinking and decision making.

Creating a cohesive thesis-with-publication presents challenges. However, the publications help to demonstrate the strengths of my research. The methodology and findings have been scrutinised by anonymous peer reviewers and found to be of sufficient interest and quality to publish for readers from medical, nursing, and health communication journals. Each publication included in this thesis also highlights the key strengths and limitations of the aspect of the study it reports upon.

The main strength of Interpretive Description as a methodology is the clearly stated aim to generate knowledge to inform clinical practice (Thorne et al., 2004; Thorne, 2016). This aligned with my desire to undertake a study to support health professionals to improve their practice of rapport. The Interpretive Description methodology is supported by a coherent logic and guidance for designing and conducting the research without being too prescriptive. Similarly, Reflexive TA (Braun and Clarke, 2019, 2022) provided robust guidance which enabled me to develop the themes that allowed for a deep and insightful analysis.

One of the limitations of the theoretical aspect of the study is the relatively small number of studies that have used the Theory of Human Relatedness. The studies I found in the literature all accepted the theory as presented. A strength of this study then is the more critical approach to the theory which resulted in adaptions to accommodate the rapport findings as well as validating other aspects of the theory.

In terms of recruiting there was a low number of participants identifying as Māori in the study. Māori are potentially underrepresented in hospice populations, in part this may be due to palliative care services being designed and resourced to suit the needs of the non-Māori majority (Jones et al., 2023). There is also a recognised stigma among Māori associated with palliative and hospice settings being places to die (Moeke-Maxwell et al., 2019; Jones et al., 2023). As there are proportionally fewer Māori patients and whānau receiving palliative care, it was challenging to select Māori as potential participants. To make a representative sample of Māori participants, the study may have benefitted from more time working with each hospice and kaiāwhina. However, this research supports the need for a specific Māori focused study that examines the experiences of Māori recipients of telehealth calls. There may well be synergies between rapport and important cultural values such as whanaungatanga (forming and maintaining relationships between kin and communities) and manaakitanga (care of others and cultural and social responsibility).

A limitation noted during data collection was that focus groups were not as effective as interviews for gathering experiential data about rapport. A possible reason for this may be that rapport is a topic that needed more time for health professionals to share personal experiences. Finding time to meet was difficult to arrange during a pandemic. Due to time constraints at each hospice, focus groups lasted 60 minutes when the range of time thought to be ideal is 60-90 minutes (Leung and Savithiri, 2009). Individual interviews on the other hand, provided rich data. The health professionals who volunteered for the individual interviews were very experienced and had a deep appreciation for the complexities of developing rapport in palliative care. Of significance, these health professionals were prepared to be vulnerable about interactions with poor connection.

There were practical limitations to conducting research across four hospice centres during the COVID pandemic. The interviews and focus groups were planned at a time of uncertainty and a heightened awareness of the vulnerability to infection for persons with life-limiting illness and their family/whānau. As a researcher, I was not considered an essential worker and was therefore dependent on the capacity of the hospice staff to assist with sampling and recruitment. However, I managed to conduct in-person participant interviews and focus groups in-between various national and regional "lock-downs" due to COVID-19. The restrictions to travelling into different regions after the initial interviews prevented me returning for any additional interviews that may have suited some participants timing better.

I include here a brief reflection on my doctoral experience and the process of "doctorateness." According to Yazdani and Shokooh (2018), a person demonstrates doctorateness by being an independent scholar who undergoes a developmental and transformative apprenticeship process, resulting in original conceptual contribution, and stewardship of the discipline. Overall, this is a fair description of what has evolved for me over the last few years. I remember completing an assessment of skills as an early doctoral enrolment activity and looked at the advanced scope of skills as a list to aspire to. As I relook at this list now, I see I have made headway in most areas with one main area of weakness being that of collaboration. This has been very difficult to achieve as a distance student during a pandemic. I have had excellent supervision from incredibly available, inspiring academics who shine as people. However, my involvement with other doctoral candidates, networking activities, and leadership opportunities have been very limited. This is an area I will now focus on developing in the post-doctoral research for which I have obtained grant funding.

Chapter summary

In this integrated discussion chapter I have provided research outcomes and evidence from this study that address the research aim, questions, and objectives of this study. I have highlighted the significant and original aspects of the study and its outcomes. In addition, I have analysed key theorists in relation to the conceptual definition of rapport developed in this study. I have argued that the flow, I-Thou, and person-centred types of relationship are only possible when rapport is developed between the patient, family/whānau and health professional. I have also made recommendations to support rapport and telehealth in practice, training, policy, and research.

Conclusion

In conclusion, this study has provided new knowledge that will assist health professionals to become more aware of their own practice in relation to developing rapport and ultimately improve communication and care of patients and family/whānau. This study found patients and families/whānau and health professionals preferred to have interactions with rapport during telehealth calls. Rapport was more important to patients and family/whānau than the modality of communication chosen in their interactions. The findings indicate that rapport needs the health professional's holistic presence and skill. Rapport also requires conscious reflection and practice for health professionals to become adept. This aptitude in developing rapport is likely to support improved patient and family/whānau outcomes in telehealth.

This study began by providing evidence in the literature reviews that rapport suffers from a taken-for-grantedness, which results in rapport not being critically examined by health professionals. Having such a crucial component of clinical communication taken-for-granted and with an assumed meaning, allows health professionals to presume, at best, that they are developing rapport. One of the most significant contributions of this study therefore, was the development of a conceptual definition of rapport. This definition was the basis for how rapport was operationalised and provided a common understanding of rapport for meaningful interpretation across the findings.

A key original finding of this study identified the pseudo-rapport and disconnected interactions experienced by patients, family/whānau and health professionals. The results in this study indicate that interactions with a lack of rapport or pseudo-rapport are unsatisfactory, upsetting and potentially harmful for health professionals as well as patients and families. It is therefore a matter of urgency that rapport be highlighted as a vital soft skill to be learned, practiced, and mastered.

It is my hope that the outcomes of this study, namely the conceptual definition of rapport, the reflective tools and adapted States of Rapport and Relatedness model, and the various published papers, may be useful resources for health professionals to apply to clinical practice. Together, these outcomes provide an interesting basis for developing an interpersonal skills resource, the establishing and assessing of which may become a likely focus of future research.

This study has highlighted the importance of rapport as an interpersonal soft skill that is valued by patients and their family/whānau. Rapport is also considered a necessary skill by health professionals to be able to effectively do the essence of their work. In particular, health professionals in palliative care have the opportunity to make a profound difference in people's health and healing experiences through their ability to develop rapport and connectedness via telehealth and in-person interactions. I close this study therefore reiterating the recommendation that interactions with rapport be reconceptualised as the gold standard of interpersonal communication.

Postamble

I have drawn on Joyce Travelbee's paper written in 1963 to inform the scoping review (Chapter 3) and her work as a nursing theorist is credited as an influence in the Theory of Human Relatedness (Chapter 4). From her writing, it seems that Travelbee had experiential wisdom about rapport. What was missing at the time of her writing, however, was evidence from patients, families, and health professionals' experiences of rapport. Together, the findings of this study provide a small piece of the evidence and knowledge puzzle to answer the question she posed: “What do we mean by rapport?” In drawing this thesis to a close, I turn again to reflect on Travelbee’s words that are a call to action and have influenced the work of this study.

> *Each one of us may reach a certain degree of skill in establishing rapport, but as every patient is different and we ourselves change, we can never sit back and fold our arms in satisfaction. We must continually question the value of our achievement, continue learning and actively seek to improve our ability, not only to relate to others and to establish rapport but to gain increased understanding of our human condition (Travelbee, 1963).*

Appendix 1: Appendices from publications

Appendix 1.1 Descriptive data of 34 selected studies for scoping review

Authors/ **date**	**Aim of study**	**Study type** **Methodology**	**Participants**	**Rapport definition**	**Findings related to rapport**
Adams et al., 2014	To explore how family members of Intensive Care Unit patients at high risk of dying, respond to nursing communication strategies.	Prospective qualitative descriptive design 42 interviews	32 family members.	No	Building rapport was one of 5 nursing approaches described by family members that helped family cope, have hope, prepare for impending death, and make decisions.
Albahri et al., 2018	to identify the perceived barriers to effective communication between patients and their family physicians from both viewpoints.	Quantitative Patient questionnaire and physician questionnaire	1122 adult patients 170 family physicians	No	Failure of rapport building ranked as the least risk to communication by family physicians. On the other hand, there were patients who claimed that they face issues pertaining to rapport building half of the time-always.
Beach et al., 2013.	to assess clinicians' self-reported mindfulness with the patient-centeredness of clinical encounters.	Quantitative Roter Interaction Analysis System coding (RIAS). Interpersonal process of care scale (IPS)	45 clinicians 437 patients	No	Mindfulness among clinicians was associated with more rapport building and communication about psychosocial issues between patient and clinician, and a more positive emotional atmosphere within the clinical encounter.
Beach et al., 2006	To explore the domain of physician-reported respect for individual patients	Quantitative RIAS coding.	215 patients physician encounters	No	Physicians did not offer significantly more or fewer rapport-building statements, nor were physicians more or less verbally dominant, based on the level of respect they reported having for the patient.
Belcher and Jones, 2009	to explore and describe graduate nurse perceptions and experiences of developing trust in the nurse–patient relationship.	Qualitative descriptive In-depth interviews	7 first year nurses	Yes	The results of this study indicate that before a graduate nurse can achieve a trusting relationship with a patient, they first have to develop a rapport with them. Trust is a natural consequence of rapport being established.

Céne et al., 2017	To describe the frequency, roles, and utility of family companion involvement in the care of patients with Heart Failure.	Quantitative RIAS coding plus surveys. A cross sectional study with survey	95 Patients 36 with companions and 6 cardiology providers.	No	There were 32% more positive rapport-building statements from patients and companions in accompanied visits than in unaccompanied patient visits. Providers engaged in more social rapport-building and trended towards more emotional rapport-building in accompanied visits.
Dean and Oetzel, **2014**	To explore emergency department (ED) physicians' perspectives of guidelines for effective communication.	Qualitative in-depth interviews and observation.	70 Physicians	No	Tension between efficiency and rapport. Efficiency chosen over rapport by physicians. Physicians perceived there was not enough time in ED to establish rapport.
Eksteen & Marsh, 2019.	To test validity and reliability of the Medical Interview Satisfaction Scale (MISS) and evaluate patient satisfaction with consultations.	Quantative MISS questionnaire	150 patient consultations with nurses /doctors	Yes	Patient were most satisfied with the rapport created in the therapeutic relationship and the understanding of their concerns, fears, and beliefs. High patient satisfaction may reflect low expectations rather than high quality of care.
Flickinger et al., 2016	To investigate whether respect for patients was associated with communication behaviors during HIV care visits.	Quantitative Audio-taped visits coded using RIAS	413 patients 45 Primary HIV care providers	No	When clinicians had higher reported respect for a patient, they engaged in more rapport-building, social chitchat, and positive talk. Correspondingly, patients of clinicians with higher respect for them engaged in more rapport-building.
Gehenne et al., 2020.	To test two competitive models of physician empathy (PE) in cancer care.	Quantitative. Consultation and relational empathy (CARE) questionnaire.	488 cancer pts	No	In the "establishing rapport process," patients need to feel comfortable with their physician to establish a trusting relationship and feel comfortable enough to disclose information about themselves.
Ghods et al., 2008.	To compare patient–physician communication patterns for African-American and white patients who have high levels of depressive symptoms.	Quantitative cross-sectional study. RIAS coding.	108 patients (46 white, 62 African American) 54 physicians	No	African-American patients experienced less depression and rapport-building communication with their physicians than white patients. The amount of physician talk about depression for African-American patients was one third of that for white patients.

Gilbert & Hayes, 2009.	To examine contributions of older patients' and NPs' characteristics and relationship components of their communication to patients' outcomes.	Quantitative. RIAS coding. Nonverbal checklist. Patient questionnaire	31 Nurse Practitioners (NP) 155 older patients	No	Poorer outcomes were associated with higher rates of lifestyle discussion and NPs' rapport building that patients may have perceived to be patronizing.
Gudzune et al., 2013.	To describe the relationship between patient body mass index (BMI) and physician communication behaviors during outpatient visits.	Quantitative Recorded visits coded using RIAS.	39 PCP 208 patients	No	Physicians engaged most in positive rapport building and least often in social rapport building, neither of which differed by patient BMI. However, physicians were significantly less likely to build emotional rapport with overweight and obese patients.
Henry et al., 2017	To investigate associations between ratings from recorded clinic visits and perceived patient-centeredness.	Quantitative Video recorded visits coded using RIAS	133pts 17 physicians	Yes	Patient-physician rapport was significantly positively associated with perceived patient-centeredness using audio, but not video thin slices. Inconsistent evidence was found of a positive association between patient-physician rapport and perceived patient-centeredness.
Hurley et al., 2018. **5x clinics** **Mali**	To define features of positive effective patient-provider communication (PPC) according to patient values	33 qualitative interviews and 7 focus groups	69 pts 17 providers	No	Participants highlighted "establishing rapport" as a foundational feature of effective patient-provider communication (PPC).
Insua-Summerhays et al., 2018.	To integrate staff and patient perspectives to determine what factors facilitate or impede therapeutic engagement during one-to-one observation.	Thematic analysis of qualitative interviews	31 psychiatric inpatient staff 28 patients	Yes	A key finding was that rapport-building via simple demonstrations of compassion and conversations about everyday things, was viewed as an essential prerequisite to encouraging patients to open up about their experiences of emotional distress.
Jonassaint et al., 2012	To evaluate the influence of patient depression on the quality of patient provider communication	Quantitative Audio-taped visits coded using RIAS. Post-visit questionnaires.	406 Patient-provider visits	No	Patients with severe depressive symptoms did more emotional rapport building but less social rapport building, and their providers did more data gathering/counselling. Providers reported lower levels of positive regard for patients reporting more depressive symptoms, whereas these patients felt less respected and

					less known as a person by their provider than none/mild depressive symptoms patients.
Kromme et al., 2016	To gain a better understanding of physician views of productive interactions with the chronically ill.	Qualitative Interviews and constructivist approach to grounded theory	20 internists	Yes	Achieving rapport with the patient (‘clicking,’ in the term of the participants) was found to be a key condition that catalysed collaboration goals in productive interactions model.
Lelorian et al., 2013	To examine the determinants of the accuracy with which physicians assess metastatic cancer patient distress, also referred to as their empathic accuracy (EA).	Quantitative. Physician questionnaire on self-empathetic attitudes; patient distress thermometer post-visit	28 physicians 201 patients	Yes	“Physician-perceived rapport with the patient” was one of 5 hypothesised determinants of EA. Despite only one question on rapport in questionnaire, results showed physicians with a high rapport on average demonstrated high EA on average.
Leonard and Kalman 2015	To explore the experience of being touched in people diagnosed with cancer and undergoing IV chemotherapy.	Phenomenological interviews	11 patients	No	The “building rapport” theme, evolved from touch during IV chemotherapy and how touch affects the relationship between provider and patient. The participant’s depth of comfort or discomfort with each touch was influenced by the degree that the provider was able to establish rapport that demonstrated a positive regard and full attention.
Martin et al., 2013.	To determine any associations between physician communication behaviors, visit process measures, and patient trust, particularly within racial groups.	Quantitative Audiotaped visits coded using RIAS	39 PCP 227 patients	No	Physicians uttered significantly fewer rapport-building statements during visits with Black patients compared with those with white patients.
O’Lynn and Krautscheid, 2011	To elicit the attitudes of laypersons on intimate touch provided by nurses in general and male nurses in particular	Qualitative Semi-structured interviews and 4 focus groups.	24 adult patients	No	Patients wanted rapport and interaction with their nurses. They want nurses to listen to their concerns and answer their questions and to use self-disclosure, and humour with discretion. All of these things increase their comfort with intimate touch.

Ogrin et al., 2020	To explore how diversity principles are considered by older people to improve participation in their healthcare and promote human interaction between the older person and their aged care provider.	Semi-structured interviews Thematic Analysis.	15 older adults	No	Building rapport, a human connection, was critical in engaging with health and aged care workers. It was highly valued as an approach by older people who considered rapport and trust as important for a positive care experience and for carers to understand what is important to the older person.
Paasche-Orlow and Roter, 2004	To compare the communication patterns of community based internal medicine IM) and Family Practice (FP) clinicians during interviews with patients.	Quantitative secondary data analysis. RIAS coding.	564 patient-physician visits. 30 (IM), and 29 (FP) clinicians.	No	Satisfaction was linked to measures of rapport and patient-centeredness for patients of FP physicians more than for patients of IM physicians. The correlations between patient satisfaction and rapport building communication were more than doubled for family physicians than internists in each case.
Raingruber et al., 2001.	To study nonverbal manifestations of rapport between nurse psychotherapists and clients	Interpretive Phenomenology .	8prs nurses and clients	No	Relational synchrony is associated with a sense of rapport between client and therapist. Emotional congruence between client and therapist illustrated feelings of rapport.
Ratanawongsa et al., 2008	To investigate the relationship between physician burnout and observed patient-physician communication outcomes in patient-physician encounters.	Quantitative. Longitudinal study, randomized controlled trial RIAS coding.	40 Physicians 235 patients	No	No differences were evident in the rapport-building behaviors of physicians relative to their burnout scores. However compared with patients of low-burnout physicians, patients of higher burnout physicians used nearly twice as many negative rapport-building statements. Patients of high-burnout physicians were also more likely to use reassurance/optimism statements, a type of emotional rapport-building behavior.
Seccareccia et al., 2015.	To identify elements of communication that are central to quality of care and satisfaction with care on palliative care units (PCUs).	Qualitative Interviews and focus groups	Patient, family-caregiver, and health care providers.	No	Patients stated that “good” rapport with staff provided a sense of belonging and made them feel the care was genuine.

Segaric and Hall, 2015	To explain how, in acute care hospital settings, nurses', patients', and family members' construct relationships during the planning and provision of care.	Qualitative Grounded theory	13 nurses, 17 patients, and 10 family members	No	There are three stages of Progressively Engaging: focusing on tasks, getting acquainted, and establishing rapport. With higher levels of engagement, participants experienced greater satisfaction and cooperation.
Shaw et al., 2012	To assess the validity of the Patient Practitioner Orientation Scale (PPOS) with pain pts.	Quantitative. PPOS questionnaire. Audiotape sessions with RIAS coding	14HP 89 pts observer	No	Providers with a more patient-centred orientation asked fewer biomedical questions, posed more lifestyle questions, gave more lifestyle advice, and did more rapport-building. Their patients shared more lifestyle information and made more attempts at rapport building and provider engagement. Patients spend more time make more rapport building utterances than the clinician in the consult.
Song et al., 2020	To identify key consumer expectations in clinical interactions in Australian general practice based on consumer and General practitioner (GP) perspectives.	Qualitative, phenomenology using thematic analysis of semi-structured interviews	18 pts 10 GPs and 3 GP reg	No	Participants described having a good rapport with the GP as a crucial aspect of the clinical relationship and a key component of consumer experience in general practice. GP participants believed that having a positive relationship with consumers was crucial to their own work. They perceived that this enabled a greater sense of trust from consumers that made them more willing to agree with the GP's recommendations.
Tracey, 2008	To examine health professionals' perceptions of the roles they play and their influence on the psychological recovery of their clients.	Qualitative semi-structured interviews and thematic analysis	18 HP 17 physical therapists, 1 athletic trainer)	No	Themes identified were centred on the roles of rapport builder, educator, and communicator. Rapport builder was highlighted as an integral component to establish initially before progress could be made toward being an educator and a communicator.
Umihara et al., 2016.	To explore key factors in enhancing patient satisfaction and the association between their satisfaction and their relationships	Quantitative cross-sectional questionnaire	576 patients who had received cancer treatment.	No	383 patients said they were satisfied and 193 dissatisfied with their care and communication. The patients in the satisfied group felt more than those in the dissatisfied group that their physicians' explanations of treatment were sufficient and were

	with their physicians.				satisfied with their rapport with their physicians.
Williams and Ogden, 2004	to explore the impact of matched and unmatched vocabulary on patient satisfaction with consultations.	Quantitative. RCT Medical Interview Satisfaction Scale (MISS)	62 pts	No	Patients in the matched vocabulary consultation group had significantly higher total satisfaction scores and higher ratings of rapport then the unmatched group. No difference in physicians in matched or unmatched group.
Zink et al., 2017.	to explore the incidence and impact of emergency department (ED) provider self-disclosure on patients' rating of provider communication skills.	Quantitative observational, cross-sectional, survey	520 adult patients or parents of patients	No	Patients responded that providers self-disclose to make patients comfortable/at ease and to build rapport. Provider self-disclosure in the ED is common and is associated with higher ratings of provider communication, rapport, and patient satisfaction.

Appendix 1.2 Descriptive data of 21 selected studies for Integrated Review

Author/year/title **setting**	Study type	Telehealth type Mode of visit	Participants	Rapport related findings
Agha et al., 2009. Patient Satisfaction with Physician–Patient Communication During Telemedicine Medical USA	Quantitative, Randomised controlled trial. Self-administered patient assessment.	Hosted Video. Nurse and patient at one site. Physician at another site. with electronic notes. No nurse at IP visit.	221-patients 9 physicians	Patients were equally satisfied with physician's ability to develop rapport, use shared decision making, and promote patient-centred communication during Telehealth and in-person consultations.
Beebe and Tian, 2004. Tips: Telephone Intervention— Problem Solving for Persons with Schizophrenia Mental health USA	Quantitative prospective experimental design Observer rated patient calls	Telephone	20 patients 1 doctorally prepared psychiatric clinical nurse specialist	To examine whether initial face-to-face meetings designed to establish rapport had an effect on the verbal responses of persons with schizophrenia in subsequent Telehealth calls. Experimental participants were twice as likely to make a feeling statement as those in the control group.
Burgess et al., 2016. A Comparison of Telephone Genetic Counseling and In-Person Genetic Counseling from the Genetic Counselor's Perspective Genetics	Mixed- Online survey	In-person (IP) vs telephone Genetic counselling (TGC)	88 genetic counsellors	The tasks identified as most different were: "establishing rapport through verbal and nonverbal interactions". A slight majority felt additional training was needed to perform psychosocial assessments more effectively.

USA				
Devadula et al., 2020. Tele-Rheumatology to Regional Hospital Outpatient Clinics: Patient Perspectives on a New Model of Care. Rheumatology Australia	Mixed methods. Surveys assessing patient perspectives. .	Hosted video. Nurse with patient at "spoke" site. Physician at hub.	48 patients 1 nurse and Physician	Developing a rapport between the patient and physician was examined. Participants viewed tele-rheumatology as relationally equivalent to in-person care after an initial adjustment period.
Elliot et al., 2020. Beyond Convenience: Patients' Perceptions of Physician Interactional Skills and Compassion via Telemedicine Urgent care USA	A qualitative analysis of patient visit feedback during a virtual urgent care visit.	Video Assessment of 5 star patient reviews, taken post video urgent care "virtual consult"	49967 5-star patient responses	More than 30% of the feedback comments coded were classified as Building Rapport. Highly satisfied patients who interacted with providers on this platform commented on skills that demonstrate patient-centred relationship building.
Flickinger et al., 2019. Secure Messaging Through PositiveLinks: Examination of Electronic Communication in a Clinic-Affiliated Smartphone App for	Qualitative analysis of 1474 text messages	1,474 messages analysed. Messaging functions were categorized as information exchange or rapport building.		Message function coding showed that 33.8% of messages contained rapport building. Positivelinks messaging offers an opportunity to strengthen patient–provider relationships through responsiveness and rapport building.

Patients Living with HIV. USA				
Frueh et al., 2007. Therapist Adherence and Competence with Manualized Cognitive-Behavioral Therapy for PTSD Delivered via Videoconferencing Technology. USA	Using secondary analyses of data from a randomized trial	Video Group therapy either by same room (SR) or telepsychiatry (TP). Audio taped sessions, coded by 2 raters.	38 patients	Therapist competence and adherence to cognitive-behavioral therapy is similar whether the treatment is delivered via Telehealth or in-person. Telehealth does not compromise therapists' ability to effectively structure sessions or build rapport with patients.
Grady and Singleton, 2011. Telepsychiatry “Coverage” to a Rural Inpatient Psychiatric Unit USA	Satisfaction survey Staff and Patients	As inpatients, video set up in a room with patient seen by covering telepsychiatrist. Nurses present for initial visits	9 in-patients 12 staff	Patients rated development of rapport and effectiveness of treatment higher than staff ratings.
Henry et al., 2017. Clinician behaviors in telehealth care delivery: a systematic review	Qualitative systematic literature review.	Synthesis of 45 articles in many settings including: home care, primary and specialist care, mental health		Rapport was one of 6 themes in the review. Positive outcomes with building rapport and fostering collaboration during telehealth care episodes were reported.
Innes et al., 2006. A profile of communication in primary care	Cross sectional study of telephone consultations	Telephone 43 telephone consults, audio recorded and	43 patients 8 PCPs	Domains from interaction with patient and PCP in a consultation included rapport, data gathering, patient education,

physician (PCP) telephone consultations: application of the Roter Interaction Analysis System (RIAS). UK	with PCPs coded using RIAS and compared to previous IP study.	transcribed. RIAS used to create 40 codes. Calls were shorter than IP.		counselling, partnership building, and doctor dominance and patient-centredness.
Martinez et al., 2017. Evaluation and Treatment of Mild Traumatic Brain Injury Through the Implementation of Clinical Video Telehealth: Provider Perspectives from the Veterans Health Administration (VHA). USA	Qualitative analysis. Semi-structured interviews and questionnaire	Video hosted Clinical video telehealth.	11 TB (traumatic brain) specialists and 14 telehealth clinic technicians	Rapport was one of the categories under “best practice” domain. Establishing rapport with patients was an important tactic for enhancing evaluation and treatment for Traumatic Brain Injury over video telehealth calls.
Mc Kinstry et al., 2010. The quality, safety and content of telephone and face-to-face consultations: a comparative study Scotland	Audio-recordings of telephone and face-to-face consultations using RIAS coding	Telephone PCPs recorded five consecutive telephone and five face-to-face consultations.	105 patient contacts 46 phone consults and 59 in-person. 19 doctors in nine practices	Telephone consultations were shorter presented fewer problems and included less data gathering, counselling/advice and rapport building than face-to-face consultations.
Parish et al., 2017. Managing Psychiatrist-Patient Relationships in the Digital Age: A summary Review of the Impact of	Thirty three relevant articles.	Review on the impact of technology on the clinical workflow and patient-provider		The use of technology clinically has evolved from making care more accessible and efficient to leveraging technology to improve care,

Technology-enabled Care on Clinical Processes and Rapport.		rapport in the mental health field		communication, and patient-provider rapport.
Pettinari and Jessopp, 2001. ‘Your ears become your eyes’: managing the absence of visibility in NHS Direct UK	Qualitative interviews- content analysis.	Telephone calls to RNs at Direct NHS call centre. Nurses interviewed x2 at start and 6 months later.	14 nurses	Nurses tailor interactions to a nonvisual environment in order to manage the more emotional aspects of telephone consultations, such as delivering information, advice, reassurance, and building trust and rapport.
Poulsen et al., 2015. Satisfaction with rural rheumatology telemedicine service. Rheumatology clinics rural northern Australia	A prospective, questionnaire-based exploratory study	Hosted video. To assess patient satisfaction with rheumatology telemedicine service.	107 patients	Themes of communication, confidentiality, physical examination, rapport, medication safety and access.
Simpson, and Reid, 2014. Therapeutic alliance in videoconferencing psychotherapy: A review Australia	Review of 23 articles that measured satisfaction, acceptability, or therapeutic rapport	Video call	Review mixed	Therapeutic alliance (TA) and rapport can be developed in psychotherapy by videoconference, with clients rating bond and presence at least equally as strongly as in-person settings across a range of diagnostic groups. Therapists also rated high levels of TA, but often not quite as high as that of their clients
Stevens et al, 1999. Pilot Study of Tele-video Psychiatric Assessments in an	Interviews then evaluated perceived	Patients randomly assigned to face-to-face or tele-video	40 patients	The patients gave high ratings to both satisfaction and ability to develop rapport for both the tele-video and face-to-face

Underserviced Community Canada	rapport and level of satisfaction with the interview	interviews for general psychiatric assessments.		interviews. The psychiatrists expressed significantly less satisfaction with the tele-video interviews, but their actual ratings were positive.
Wade et al., 2012. A qualitative study of ethical, medico-legal, and clinical governance matters in Australian telehealth services. Australia	Qualitative interviews		37 telehealth service providers	Results from interviews showed Patient-provider rapport occurred via video (n=7) Video communication better than in-person (n=4) Concern for loss of rapport via video (n=4).
Ward et al., 2013. Evaluation of a clinical service model for dysphagia assessment via telerehabilitation Speech pathology Australia	mixed methods study	Hosted video and distance simulated. Weekly clinic from online Speech pathologist to an allied health worker and second Speech pathologist at the patient end.	100 patients	Patient satisfaction was high, and clinicians felt that they developed good rapport, found the system easy to use, and were satisfied with the service in over 90% of the assessments conducted.
Warner et al., 2019. Patients' Experiences and Perspectives of Telehealth Coaching with a Dietitian to Improve Diet Quality in Chronic Kidney Disease: A	A qualitative Study Semi- structured interviews adults with chronic kidney disease	Telephone Phone, text and coaching for 12 weeks to chronic kidney disease patients in community.	21 patients	Five themes were identified and included: valuing relationships and building trust and rapport remotely.

Qualitative Interview Study. Australia				
Williamson et al., 2015. Patient experiences of nurse-led telephone follow-up following treatment for colorectal cancer. UK	Qualitative interviews	Telephone follow-up post treatment from hospital by specialist nurse to colorectal patients.	21 patients 1 nurse	Telehealth was well received by patients; it was perceived as highly convenient. Continuity of care was an important factor in building a trusting relationship and rapport between patient and nurse. All patients stated a preference for continuing with Telehealth.

Appendix 2: Study Documentation

Appendix 2.1 Information sheet and consent form-patient

THE UNIVERSITY OF AUCKLAND
NEW ZEALAND

The University of Auckland

School of Nursing

Building 505

85 Park Rd

Grafton, Auckland

Participant Information Sheet- Patient

Study Title:

Experiences of telehealth in hospice care at home.

Locality: NZ	Ethics committee ref: HDEC 20/CEN/165
Lead investigator: Wendy English RN	Contact phone number: 0211996599

You are invited to take part in a study on patients and families' experiences of telehealth in hospice care at home. Telehealth is telephone calls and video calls (like Skype or Zoom) made by a health professional to you at home.

Whether or not you take part is your choice. If you do not want to take part, you do not have to give a reason, and it will not affect the care you receive. If you do want to take part now, but change your mind later, you can pull out of the study at any time.

This Participant Information Sheet will help you decide if you would like to take part. It sets out why we are doing the study, what your participation would involve, what the benefits and risks to you might be, and what will happen after the study ends. We will go through this information with you and answer any questions you may have. You do not have to decide today whether you will participate in this study or not. Before you decide you may want to talk about the study with other people, such as family, whānau, friends, or healthcare providers.

If you agree to take part in this study, you will be asked to sign the Consent Form on the last page of this document. You will be given a copy of both the Participant Information Sheet and the Consent Form to keep.

This document is 6 pages long, including the Consent Form. Please make sure you have read all the pages. Thank you.

What is the purpose of the study?

The purpose of the study is to find out more about what is it like for patients and families talking with health professionals on telephone calls and video calls at home.

This study is funded by a University of Auckland Doctoral Scholarship and is planned to run between September 2020- September 2022.

Ethical approval for the study comes from Health and Disability Ethics Committee (HDEC) and research and site approval come from each hospice taking part.

What will my participation in the study involve?

You have been chosen to take part because you have received telehealth calls as part of the care provided from a hospice related service.

If you decided to take part you would be involved in one interview, which will be carried out by the researcher, Wendy English. Wendy is an experienced hospice nurse, and this study is part of her PhD research.

The interview will take place at a day, time, and place of your choice. It will most likely be an in-person interview, but provisions will be made for a video call under different COVID19 alert levels. This interview should take 30-60 minutes. During this interview you will be asked to reflect on what it is like for you talking with health professionals via video calls or phone calls. You are welcome to have whānau or a support person with you at the time of the interview. Sometimes a support person may wish to contribute to the interview, however your permission will be needed before that can happen.

The interview will be audio recorded with your permission.

What are the possible benefits and risks of this study?

There are no risks or side-effects likely from taking part in this study. Your well-being is important, and the researcher will ensure you are comfortable during the interview.

Taking part in the interview gives you the chance to share your views and experiences and to take part in valuable research. Your participation will also help the formation of guidelines for the use of telehealth in palliative care to improve care that other people receive in the future.

Who pays for the study?

You will be given a $30 petrol voucher in respect of your time taking part in the study,

There are no costs to you to participate.

What if something goes wrong?

Even though risk of harm to you is low, it is good to know what to do if something goes wrong. If you were injured in this study, you would be able to apply for compensation from ACC just as you would be if you were injured in an accident at work or at home. This does not mean that your claim will automatically be accepted. You will have to lodge a claim with ACC, which may take some time to assess. If your claim is accepted, you will receive funding to assist in your recovery.
If you have private health or life insurance, you may wish to check with your insurer that taking part in this study won't affect your cover.

What are my rights?

- Firstly, taking part in this study is your choice. You do not have to take part in the study. If you do agree to take part in the study, you are free to leave at any time without having to give a reason.
- Your decision to take part or not will not affect the treatment you receive from your health care provider in any way.
- You have the right to access information collected as part of the study which is about you. If you wish to receive a copy of the interview transcript (word for word) this will be sent to you once it is completed and there will be a 2 week period for you to review and makes changes to your interview transcript, should you want to. There is a place on the consent form to choose this option.
- If you wish to receive a summary of findings this will be sent to you at the end of the study. There is a place on the consent form to choose this option.
- You have a right to privacy and protection of your identity and information.

What happens after the study or if I change my mind?

- As part of protecting your identity, the researcher takes out all details that personally identify you from the information you provide. Your information will be given a study number instead of your name.
- It is important to note if you decide to withdraw from this study your information will be able to be withdrawn up to the point that the data is analysed.
- Care of your information involves the researcher storing all the study information in a locked cupboard and on a password protected computer. Only members of the research team will have access to them.
- Audio recordings will be destroyed after 12 months. At the end of the study the transcripts are kept for 10 years on a computer at University of Auckland and after this time will be deleted.
- The only data that the researcher will keep will be analysed data to support potential research in the future. This information will be stored on a password protected computer at the University of Auckland.
- For quality of research purposes an approved auditor may be appointed by the New Zealand Health and Disability Ethic Committees (HDEC), or their approved representative. An auditor may wish to review your relevant medical records for the sole purpose of checking the accuracy of the information recorded for the study.
- The study findings will be shared in conferences, journal articles and as part of Wendy English's PhD thesis. All written material will be de-identified, and your identity protected. This part of the project is likely to be completed in 2022

Who do I contact for more information or if I have concerns?

If you have any questions, concerns, or complaints about the study at any stage, you can contact:

Contact details of the research team:

Researcher:	
Wendy English MHSc, RN, Doctoral Candidate The School of Nursing The University of Auckland Research phone: 0211995699 Email: weng888@aucklanduni.ac.nz	
Supervisors contact details:	
Professor Merryn Gott, MA, PhD The School of Nursing The University of Auckland Email: m.gott@auckland.ac.nz	Dr Jackie Robinson, PhD, NP, RN The School of Nursing University of Auckland Email: j.robinson@auckland.ac.nz

If you want to talk to someone who is not involved with the study, you can contact an independent health and disability advocate on:

Phone:	0800 555 050
Fax:	0800 2 SUPPORT (0800 2787 7678)
Email:	advocacy@advocacy.org.nz
Website:	https://www.advocacy.org.nz/

For Maori health support please contact :

Name, position: to be confirmed at each location

Telephone number

Email

You can also contact the health and disability ethics committee (HDEC) that approved this study on:

Phone: 0800 4 ETHICS

Email: hdecs@health.govt.nz

THE UNIVERSITY OF AUCKLAND
NEW ZEALAND

The University of Auckland

School of Nursing

Level 2

Building 505

85 Park Road

Grafton, Auckland

Experiences of telehealth in hospice care at home.

For any further information or questions, please contact:

Wendy English; ph.0211995699

Consent Form

Please tick to indicate you consent to the following

I have read or have had read to me in my first language, and I understand the Participant Information Sheet.	☐
I have been given sufficient time to consider whether to participate or not in this study.	☐
I have had the opportunity to use a legal representative, whānau/ family support, or a friend to help me ask questions and understand the study.	☐
I am satisfied with the answers I have been given regarding the study and I have a copy of this consent form and information sheet.	☐
I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without this affecting my medical care.	☐

I consent to the research staff collecting and processing my information, including information about my health.	☐
If I decide to withdraw from the study, I agree that the information collected about me up to the point when I withdraw may continue to be processed.	☐
I agree to an approved auditor appointed by the New Zealand Health and Disability Ethic Committees, or any relevant regulatory authority or their approved representative reviewing my relevant medical records for the sole purpose of checking the accuracy of the information recorded for the study.	☐
I understand that my participation in this study is confidential and that no material, which could identify me personally, will be used in any reports on this study.	☐
I understand extracts of the interview may be used in publications and conference presentations, and that no material will be used that could identify me personally.	☐
I understand the compensation provisions in case of injury during the study.	☐
I know who to contact if I have any questions about the study in general.	☐
I understand my responsibilities as a study participant.	☐
I wish to receive a copy of the transcript of the interview	Yes ☐ No ☐
I wish to receive a summary of the results from the study.	Yes ☐ No ☐

Declaration by participant:

I hereby consent to take part in this study.

Participant's name:

Signature: Date:

Email/address if a copy of transcript or report required:

Declaration by member of research team:

I have given a verbal explanation of the research project to the participant and have answered the participant’s questions about it.

I believe that the participant understands the study and has given informed consent to participate.

Researcher’s name:

Signature: Date:

Appendix 2.2 Information sheet and consent form - family

Participant Information Sheet- Family

THE UNIVERSITY OF AUCKLAND
NEW ZEALAND
The University of Auckland
School of Nursing
Building 505
85 Park Rd
Grafton, Auckland

Study Title:

Experiences of telehealth in hospice care at home.

Locality: NZ	Ethics committee ref: HDEC 20/CEN/165
Lead investigator: Wendy English RN	Contact phone number: 0211996599

You are invited to take part in a study on patients and families' experiences of telehealth in hospice care at home. Telehealth is telephone calls and video calls (like Skype or Zoom) made by a health professional to you at home.

Whether or not you take part is your choice. If you do not want to take part, you do not have to give a reason, and it will not affect the care your family member receives. If you do want to take part now, but change your mind later, you can pull out of the study at any time.

This Participant Information Sheet will help you decide if you would like to take part. It sets out why we are doing the study, what your participation would involve, what the benefits and risks to you might be, and what will happen after the study ends. We will go through this information with you and answer any questions you may have. You do not have to decide today whether you will participate in this study or not. Before you decide you may want to talk about the study with other people, such as family, whānau, friends, or healthcare providers.

If you agree to take part in this study, you will be asked to sign the Consent Form on the last page of this document. You will be given a copy of both the Participant Information Sheet and the Consent Form to keep.

This document is 6 pages long, including the Consent Form. Please make sure you have read all the pages. Thank you.

What is the purpose of the study?

The purpose of the study is to find out more about what it is like for patients and families talking with health professionals on telephone calls and video calls at home.

This study is funded by the University of Auckland Doctoral Scholarship and is planned to run between September 2020- September 2022.

Ethical approval for the study comes from the Health and Disability Ethics Committee (HDEC) and from each hospice taking part.

What will my participation in the study involve?

You have been chosen to take part because you have taken part in a telehealth call as part of the care your family member received from a hospice service.
If you decided to take part in the study you would be involved in one interview, which will be carried out by the researcher, Wendy English. Wendy is an experienced hospice nurse, and this study is part of her PhD research.
The interview will take place at a day, time, and place of your choice. It will most likely be an in-person interview, but allowances will be made for a video call under different COVID19 alert levels. This interview should take 30-60 minutes. During this interview you will be asked to reflect on what it is like for you talking with health professionals via video calls or phone calls. The interview will be audio recorded with your permission.

What are the possible benefits and risks of this study?

There are no risks or side-effects likely from taking part in this study. Your well-being is important, and the researcher will ensure you are comfortable during the interview.
Taking part in the interview gives you the chance to share your views and experiences and to take part in valuable research. Your participation will also help the formation of guidelines for the use of telehealth in palliative care to improve care that other people receive in the future.
To reduce any potential conflict of interest if a patient is admitted to hospice after participating in an interview, the researcher (WE) will not be allocated as the nurse to care for your family member.

Who pays for the study?

You will be given a $30 petrol voucher in respect of your time taking part in the study,
There is no cost to you to participate.

What if something goes wrong?

Even though the risk of harm to you is low, it is good to know what to do if something goes wrong. If you were injured in this study, you would be able to apply for compensation from ACC just as you would be if you were injured in an accident at work or at home. This does not mean that your claim will automatically be accepted. You will have to lodge a claim with ACC, which may take some time to assess. If your claim is accepted, you will receive funding to assist in your recovery.
If you have private health or life insurance, you may wish to check with your insurer that taking part in this study won’t affect your cover.

What are my rights?

- Firstly, taking part in this study is your choice. You do not have to take part in the study. If you do agree to take part in the study, you are free to leave at any time without having to give a reason.
- Your decision to take part or not will not affect the treatment you receive from your health care provider.
- You have the right to access information collected as part of the study which is about you. If you wish to receive a copy of the interview transcript this will be sent to you once it is completed. If you wish to receive a summary of findings this will be sent to you at the end of the study. There is a place on the consent form to choose these options.
- You have a right to privacy and protection of your identity and information.

What happens after the study or if I change my mind?

- As part of protecting your identity, the researcher takes out all details that personally identify you from the information you provide. Your information will be given a study number instead of your name.
- It is important to note if you decide to withdraw from this study your information will be unable to be withdrawn after 31st December 2020.
- Care of your information involves the researcher storing all the study information in a locked cupboard and on a password protected computer. Only members of the research team will have access to them.
- Audio recordings will be destroyed after 12 months. At the end of the study the transcripts are kept for 10 years on a computer at the University of Auckland and after this time will be deleted.
- The only data that the researcher will keep will be analysed data to support potential research in the future.
- For quality of research purposes an approved auditor may be appointed by the New Zealand Health and Disability Ethic Committees, (or their approved representative). An auditor may wish to review your relevant medical records for the sole purpose of checking the accuracy of the information recorded for the study.
- The study findings will be shared in conferences, journal articles and as part of Wendy English’s PhD thesis. All written material will be de-identified, and your identity protected. This part of the project is likely to be completed in 2022.

Who do I contact for more information or if I have concerns?

If you have any questions, concerns, or complaints about the study at any stage, you can contact:

Contact details of the research team:

<table>
<tr><td colspan="2">Researcher:</td></tr>
<tr><td colspan="2">Wendy English MHSc, RN, Doctoral Candidate
The School of Nursing
The University of Auckland
Research phone: 0211995699
Email: weng888@aucklanduni.ac.nz</td></tr>
<tr><td colspan="2">‘Supervisors contact details:</td></tr>
<tr><td>Professor Merryn Gott, MA, PhD
The School of Nursing
The University of Auckland
Email: m.gott@auckland.ac.nz</td><td>Dr Jackie Robinson, PhD, NP, RN
The School of Nursing
University of Auckland
Email: j.robinson@auckland.ac.nz</td></tr>
</table>

If you want to talk to someone who is not involved with the study, you can contact an independent health and disability advocate on:

Phone: 0800 555 050
Fax: 0800 2 SUPPORT (0800 2787 7678)
Email: advocacy@advocacy.org.nz
Website: https://www.advocacy.org.nz/

For Maori health support please contact :

Name, position: to be confirmed at each location.
Telephone number
Email

You can also contact the health and disability ethics committee (HDEC) that approved this study on:

Phone: 0800 4 ETHICS
Email: hdecs@health.govt.nz

THE UNIVERSITY OF AUCKLAND
NEW ZEALAND

The University of Auckland
School of Nursing
Level 2
Building 505
85 Park Road
Grafton, Auckland

Experiences of telehealth in hospice care at home.

Consent Form

Please tick to indicate you consent to the following:

I have read or have had read to me in my first language, and I understand the Participant Information Sheet.		☐
I have been given sufficient time to consider whether to participate or not in this study.		☐
I have had the opportunity to use a legal representative, whānau/ family support, or a friend to help me ask questions and understand the study.		☐
I am satisfied with the answers I have been given regarding the study and I have a copy of this consent form and information sheet.		☐
I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without this affecting my medical care.		☐
I consent to the research staff collecting and processing my information, including information about my health.		☐
If I decide to withdraw from the study, I agree that the information collected about me up to the point when I withdraw may continue to be processed.	Yes ☐	No ☐
I understand that my participation in this study is confidential and that no material, which could identify me personally, will be used in any reports on this study.		☐
I understand extracts of the interview may be used in publications and conference presentations, and that no material will be used that could identify me personally.		☐
I understand the compensation provisions in case of injury during the study.		☐

I know who to contact if I have any questions about the study in general.		☐
I understand my responsibilities as a study participant.		☐
I wish to receive a copy of the transcript of the interview	Yes ☐	No ☐
I wish to receive a summary of the results from the study.	Yes ☐	No ☐

Declaration by participant:

I hereby consent to take part in this study.

Participant’s name: ____

Signature: ________________________ Date: ____________________

Email/address if a copy of transcript or report required: ______________

____

Declaration by member of research team:

I have given a verbal explanation of the research project to the participant and have answered the participant’s questions about it.

I believe that the participant understands the study and has given informed consent to participate.

Researcher’s name: ____

Signature: ________________________ Date: ____________________

Appendix 2.3 Information sheet and consent form health professional

THE UNIVERSITY OF AUCKLAND
NEW ZEALAND
The University of Auckland
School of Nursing
Building 505
85 Park Rd
Grafton, Auckland

Participant Information Sheet-

Health professional interview

Study Title:

Experiences of telehealth in hospice care at home.

Locality: NZ	Ethics committee ref: HDEC 20/CEN/165
Lead investigator: Wendy English RN	Contact phone number: 0211995699

You are invited to take part in a study on patients, families, and health professional experiences of telehealth in hospice care at home. Telehealth is telephone calls and video calls (like Skype or Zoom) made by a health professional to or from patients at home.

Whether or not you take part is your choice. If you do not want to take part, you do not have to give a reason. If you do want to take part now, but change your mind later, you can pull out of the study at any time.

This Participant Information Sheet will help you decide if you would like to take part. It sets out why we are doing the study, what your participation would involve, what the benefits and risks to you might be, and what will happen after the study ends. We will go through this information with you and answer any questions you may have.

If you agree to take part in this study, you will be asked to sign the Consent Form on the last page of this document. You will be given a copy of both the Participant Information Sheet and the Consent Form to keep.

Please make sure you have read all the pages including the Consent Form. Thank you.

What is the purpose of the study?

The purpose of the study is to find out more about what it is like for patients and families talking with health professionals on telephone calls and video calls at home.

This study is funded by the University of Auckland Doctoral Scholarship and is planned to run between September 2020- September 2022.

Ethical approval for the study comes from the Health and Disability Ethics Committee (HDEC) and from each hospice taking part.

What will my participation in the study involve?

If you decided to take part in the study you would be involved in one interview, which will be carried out by the researcher, Wendy English. Wendy is an experienced hospice nurse, and this study is part of her PhD research.

The interview will take place on a day, time, and place of your choice. It will most likely be an in-person interview, but allowances will be made for a video call under different COVID19 alert levels. This interview should take 30-60 minutes. During this interview you will be asked to reflect on what it is like for you talking with patients and family via video calls or phone calls. The interview will be audio recorded with your permission.

What are the possible benefits and risks of this study?

There are no risks or side-effects likely from taking part in this study.

Taking part in the interview gives you the chance to share your views and experiences and to take part in valuable research. Your participation will also help the formation of guidelines for the use of telehealth in palliative care to improve the care that people receive in the future.

Who pays for the study?

There is no cost to you to participate.

What if something goes wrong?

Even though the risk of harm to you is unlikely, it is good to know what to do if something goes wrong. If you were injured in this study, you would be able to apply for compensation from ACC just as you would be if you were injured in an accident at work or at home.

What are my rights?

- Firstly, taking part in this study is your choice. You do not have to take part in the study. If you do agree to take part in the study, you are free to leave at any time without having to give a reason.
- You have the right to access information collected as part of the study which is about you. If you wish to receive a copy of the interview transcript this will be sent to you once it is completed. If you wish to receive a summary of the findings this will be sent to you at the end of the study. There is a place on the consent form to choose these options.
- You have a right to privacy and protection of your identity and information.

What happens after the study or if I change my mind?

- As part of protecting your identity, the researcher takes out all details that personally identify you from the information you provide. Your information will be given a study number instead of your name.
- It is important to note if you decide to withdraw from this study your information will be unable to be withdrawn after September 2021.
- Care of your information involves the researcher storing all the study information in a locked cupboard and on a password protected computer. Only members of the research team will have access to them.
- Audio recordings will be destroyed after 12 months. At the end of the study the transcripts are kept for 10 years on a computer at the University of Auckland and after this time will be deleted.
- The only data that the researcher will keep will be analysed data to support potential research in the future.

- For quality of research purposes an approved auditor may be appointed by the New Zealand Health and Disability Ethic Committees, (or their approved representative). An auditor may wish to review your relevant medical records for the sole purpose of checking the accuracy of the information recorded for the study.
- The study findings will be shared in conferences, journal articles and as part of Wendy English's PhD thesis. All written material will be de-identified, and your identity protected. This part of the project is likely to be completed in 2022.

Who do I contact for more information or if I have concerns?

If you have any questions, concerns, or complaints about the study at any stage, you can contact:

Contact details of the research team:

Researcher:	
Wendy English MHSc, RN, Doctoral Candidate The School of Nursing The University of Auckland Research phone: 0211995699 Email: weng888@aucklanduni.ac.nz	
'Supervisors contact details:	
Professor Merryn Gott, MA, PhD The School of Nursing The University of Auckland Email: m.gott@auckland.ac.nz	Dr Jackie Robinson, PhD, NP, RN The School of Nursing University of Auckland Email: j.robinson@auckland.ac.nz

If you want to talk to someone who is not involved with the study, you can contact an independent health and disability advocate on:

Phone:	0800 555 050
Fax:	0800 2 SUPPORT (0800 2787 7678)
Email:	advocacy@advocacy.org.nz
Website:	https://www.advocacy.org.nz/

You can also contact the health and disability ethics committee (HDEC) that approved this study on:

Phone:	0800 4 ETHICS
Email:	hdecs@health.govt.nz

THE UNIVERSITY OF AUCKLAND
NEW ZEALAND

The University of Auckland
School of Nursing
Level 2
Building 505
85 Park Road
Grafton, Auckland

Experiences of telehealth in hospice care at home.

Consent Form

Please tick to indicate you consent to the following:

I have read or have had read to me in my first language, and I understand the Participant Information Sheet.	☐
I have been given sufficient time to consider whether to participate or not in this study.	☐
I am satisfied with the answers I have been given regarding the study and I have a copy of this consent form and information sheet.	☐
I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without this affecting my medical care.	☐
If I decide to withdraw from the study, I agree that the information collected about me up to the point when I withdraw may continue to be processed.	☐
I understand that my participation in this study is confidential and that no material, which could identify me personally, will be used in any reports on this study.	☐
I understand extracts of the interview may be used in publications and conference presentations, and that no material will be used that could identify me personally.	☐
I understand the compensation provisions in case of injury during the study.	☐
I know who to contact if I have any questions about the study in general.	☐
I understand my responsibilities as a study participant.	☐
I wish to receive a copy of the transcript of the interview	Yes ☐ No ☐

I wish to receive a summary of the results from the study. Yes ☐ No ☐

Declaration by participant:

I hereby consent to take part in this study.

Participant's name: ________________________________

Signature: __________________ Date: ____________

Email/address if a copy of transcript or report required: ____________

____

Declaration by member of research team:

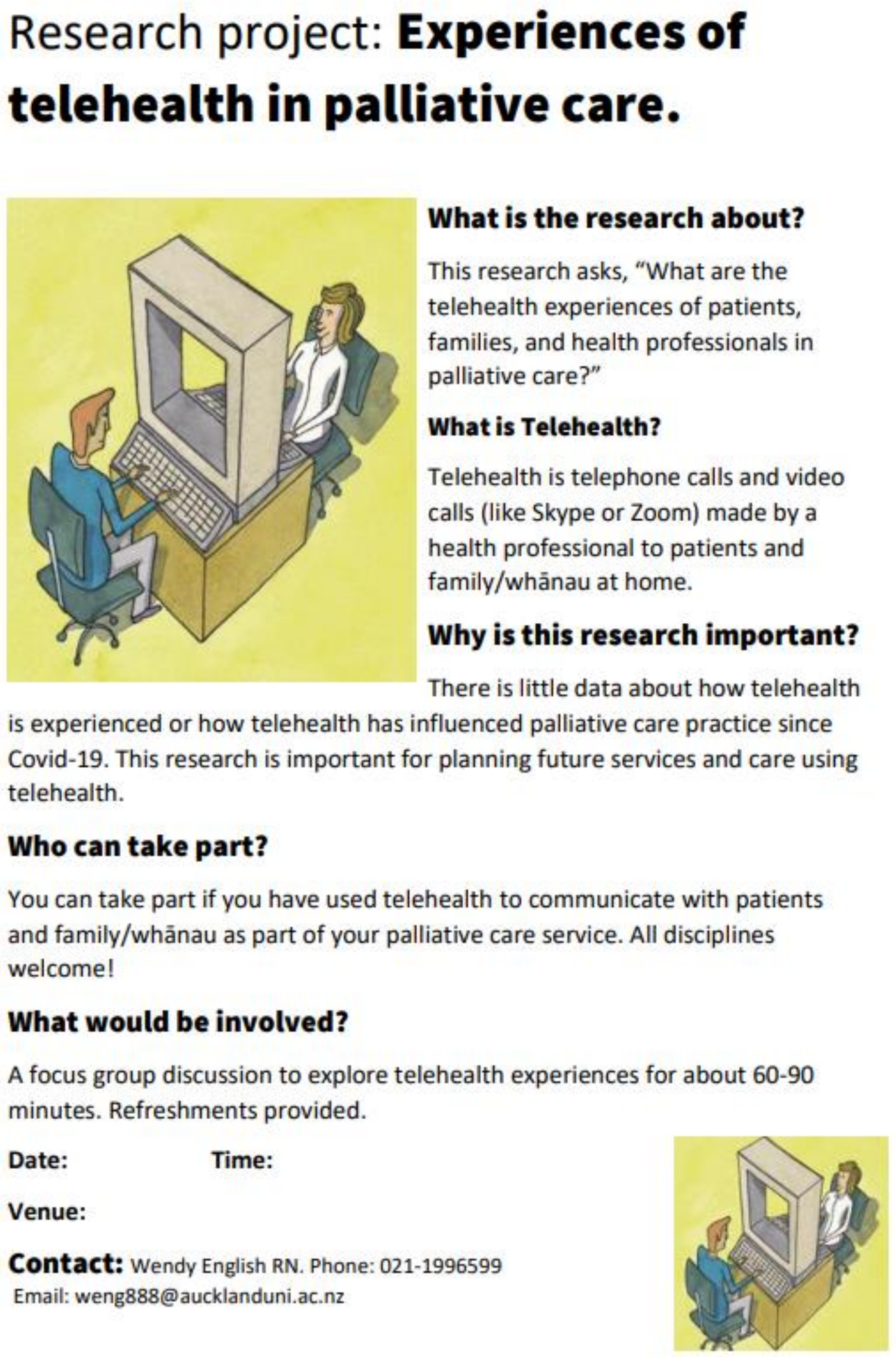
I have given a verbal explanation of the research project to the participant and have answered the participant's questions about it.

I believe that the participant understands the study and has given informed consent to participate.

Researcher's name: ________________________________

Signature: __________________ Date: ____________

Appendix 2.4 Poster



Research project: **Experiences of telehealth in palliative care.**

What is the research about?

This research asks, "What are the telehealth experiences of patients, families, and health professionals in palliative care?"

What is Telehealth?

Telehealth is telephone calls and video calls (like Skype or Zoom) made by a health professional to patients and family/whānau at home.

Why is this research important?

There is little data about how telehealth is experienced or how telehealth has influenced palliative care practice since Covid-19. This research is important for planning future services and care using telehealth.

Who can take part?

You can take part if you have used telehealth to communicate with patients and family/whānau as part of your palliative care service. All disciplines welcome!

What would be involved?

A focus group discussion to explore telehealth experiences for about 60-90 minutes. Refreshments provided.

Date: **Time:**

Venue:

Contact: Wendy English RN. Phone: 021-1996599
Email: weng888@aucklanduni.ac.nz

Appendix 2.5 Interview Schedule- Patient and family/whānau

Interview Schedule: Patient and family/whānau

This research study is interested in the experiences of what it is like for patients and families to receive video and telephone calls at home. The information will be helpful for health professionals to improve communication at a distance with patients and families/whānau at home.

I am going to ask you a series of questions about your experiences with phone or video calls at home.

1. How often do you have calls from health professionals?
2. What kind of calls are they? Phone or video?
3. What are the purpose of the calls? Follow up care? Assessment?
4. What type of health professionals is calling you?
5. Thinking of the calls you have received can you think of a time when it went really well? And what was it about that call that made it (reflect their words for good or positive) and what was that like for you?
(How did it begin? What the beginning like?)
(How did it end? What was the ending like?)

- What, if anything, is important to you about that call?
- How would you describe the call in terms of comfort for you?
- How would you describe the call in terms of involvement for you?

6. Again thinking of the calls you have received; can you think of a time when a call did not go so well. And what was it about that call that made it (reflect their words for "not go so well") and what was that like for you?
(How did it begin? What the beginning like?)
(How did it end? What was the ending like?)

- What, if anything, is important to you about that?
- How would you describe the call in terms of comfort for you?
- How would you describe the call in terms of involvement for you?

7. I am interested in the idea of rapport or how people get on together on these calls. What words would you use to talk about this idea of rapport?
8. How would you describe what it is like for you when you (their words for rapport e.g. "get on together") with the health professional?
9. What if anything was important about having (their words for have rapport) with health professionals?

10. What kinds of things might you say to (their words for create rapport) with the health professional?
- What kinds of things might you do?
- Do you think that worked? What is an example of that if you have one?

11. What, if anything, is different about how you (their words for create rapport) while on video/phone call?
- What is an example of that?

Note to Interviewer: Remember to ask questions that show interest: “I’m really interested in the way you are describing that. Can you give me a bit more detail about how that happened?” or “Was that surprising to you?” or “A few minutes ago, you mentioned X. Was this …?” or “Can you tell me more?”.

That is the end of the questions is there anything else you would like to say, or tell me?

Ngā mihi nui. Thank you so very much for your time.

Our interview is now finished, and the recording is now stopped.

Appendix 2.6 Interview Schedule – Health professionals

Health Professional Interview Schedule:

Thank you for you your time in participating in this interview

I am going to ask a few questions about your experiences with and thoughts about phone or video calls with patients and families at home.

But first tell me how long you have been practicing? and how long in palliative care?

1. How often would you make phone or video calls to patients and families as part of your average day? Week?
2. What kind of calls are these?
3. Do you initiate them or do Patient and families initiate them?
4. Do you make video calls? Did you during Lockdown periods? What was your experience of these?
5. Take a moment to think about some of the phone or video calls you have made generally:
    - Can you think of a time when a call with a patient or family member has gone really well? What is it about that call that went well? How was that for you?
    - How would you describe the call in terms of comfort for you? How comfortable were you?
    - How would you describe the call in terms of involvement for you? How involved were you?
    - What if anything is important about that for you?
    - Tell me more about that
6. Again thinking of the calls with patients and families can you think of a time(s) when the call did not go so well? What is it about the call that did not go well? How was that for you?
    - How would you describe the call in terms of comfort for you? How comfortable were you?
    - How would you describe the call in terms of involvement for you? How involved were you?
    - What if anything is important about that for you?
    - Tell me more about that?
7. I am interested in the idea of rapport and especially what you understand it to mean? How would you describe rapport? What other types of words would you use to describe rapport?
    - What if anything is important about rapport?
8. What kind of things might you say to (their words) create rapport with patients/whānau?
    - What kinds of things might you do?
    - Do you have an example(s) of that working?
9. How do you know when you have (created rapport) with the other person? What is an example of that?

    - How does that feel for you?

10. What about when rapport is not created? What is an example of that?
    - How does that feel for you?

    2.
11. How does the use of telephone or video affect how you create rapport with patients and whānau? What if anything is different about your rapport building?
12. If you have not used video calling for clients, what would you need to make you feel more likely to undertake a call this way?

3.

13. If you look to the future, how do you see telehealth calls fitting into palliative care?

4. Professionally?
5. Personally?
6. Patients?
7. Whānau?

14. Thank you. Before we finish do you have anything else you would like to say?

Ngā mihi nui. Thank you so much.

Appendix 2.7 Topic Guide – Focus Group

Focus group topic guide:

Kia ora, welcome and thank you for participating in this focus group.

Introduce moderator and ground rules:

Introduce topic: This focus group discussion is designed to assess your thoughts and feelings about telehealth in palliative care. It aims to explore both your experiences and some of the early feedback from the patient and family interviews about their experiences with telehealth calls. For this project telehealth is defined as telephone or video calls made between health professionals and patients or family/whānau receiving palliative care at home.

Recorder on - asking participants to introduce themselves. Name, profession, how long practicing, how long in palliative care?

Questions:

1. Take a couple of minutes to think about your experiences of phoning or video calling patients or family members at home. Is anyone happy to share their experience?
   (10 minutes).
   What went well?
   What did not go well?
2. Patient feedback (20 minutes). Detailed below.
3. As you look to the future how do you see telehealth fitting in with palliative care?
   (10 minutes)
   Professionally
   Your practice
   Patients
   Whānau

Summing up:

Of all the things discussed here what do you consider the most important?

Is this an adequate summary?

Do I have everything covered?

Thank you. Deep gratitude for the gifts you have given to our professions.
Ngā mihi nui
Tena kotou, tena koutou, tena koutou katoa.

Recorder off.

See next page-

Preliminary patient and whānau feedback from interviews

Theme 1: Not understanding the system

- Who's the best person to call and when?
- How do I find out… if I don't know that I don't know?

Soundbites:
I don't know who to call first, the DN the GP or the specialist team
I know I can ring hospice anytime
I wait till I really need to call the hospice
I need a case manager, one person to deal with
I have become a coordinator of services and don't know what I am doing
I bought the equipment and then found out we could borrow it

Theme 2: Speaking up and stepping up

- Patients and family members have to learn new communication skills to get needs met by health professionals
- Role change for partners
- Barriers can be not understanding accents, Hearing loss, Brain fog

Soundbites:
I don't want to waste your time when I ring
I should have said that I didn't understand and had never done it before (given sub cut pushes-Family member)
I make up half of it and feel anxious that I got it wrong (hearing loss, medication effects)
I was told I was "wasting resources"
I am not important
I knew the CNS had spoken to hospice about my husband, they knew my name when I rang

Rapport means	A lack of rapport means
Feeling heard	Feeling frustrated
Feeling seen	Feeling stupid
I am involved	I am not involved
I am comfortable and can say anything	I am not comfortable
I trust what is being said	There is no trust
I feel supported	I feel unsupported

Appendix 2.8 Ethics Approval

Health and Disability Ethics Committees
Ministry of Health
133 Molesworth Street
PO Box 5013
Wellington
6011

0800 4 ETHICS
hdecs@health.govt.nz

09 September 2020

Ms Wendy English
47a Hawford Rd

Opawa

Christchurch 8023

Dear Ms English

Re:	**Ethics ref:**	**20/CEN/165**
	Study title:	Experiences of building rapport in telehealth encounters from the perspectives of patient, family, and health professional in palliative care.

I am pleased to advise that this application has been *approved* by the Central Health and Disability Ethics Committee. This decision was made through the HDEC-Expedited Review pathway.

Conditions of HDEC approval

HDEC approval for this study is subject to the following conditions being met prior to the commencement of the study in New Zealand. It is your responsibility, and that of the study's sponsor, to ensure that these conditions are met. No further review by the Central Health and Disability Ethics Committee is required.

Standard conditions:

1. Before the study commences at *any* locality in New Zealand, all relevant regulatory approvals must be obtained.

2. Before the study commences at *each given* locality in New Zealand, it must be authorised by that locality in Online Forms. Locality authorisation confirms that the

locality is suitable for the safe and effective conduct of the study, and that local research governance issues have been addressed.

After HDEC review

Please refer to the *Standard Operating Procedures for Health and Disability Ethics Committees* (available on www.ethics.health.govt.nz) for HDEC requirements relating to amendments and other post-approval processes.

Your next progress report is due by 08 September 2021.

Participant access to ACC

The Central Health and Disability Ethics Committee is satisfied that your study is not a clinical trial that is to be conducted principally for the benefit of the manufacturer or distributor of the medicine or item being trialled. Participants injured as a result of treatment received as part of your study may therefore be eligible for publicly-funded compensation through the Accident Compensation Corporation (ACC).

Please don't hesitate to contact the HDEC secretariat for further information. We wish you all the best for your study.

Yours sincerely,

Mrs Helen Walker

Chairperson

Central Health and Disability Ethics Committee

Encl: appendix A: documents submitted appendix B: statement of compliance and list of members

Health and disability research

These screening questions will help determine whether HDEC review is required for your study. They are based on the rules contained in section three of the *Standard Operating Procedures for Health and Disability Ethics Committees*.

Don’t hesitate to contact us if you’d like help answering these questions, or any others in the HDEC form.

A. Health and disability research

Does your study aim to improve health outcomes, or outcomes for disabled people?

● Yes

○ No

Human reproductive research

B. Will your study involve the creation or use of a human gamete, a human embryo, or a hybrid embryo?

○ Yes

● No

Type of study

C. Is your study:

○ an intervention study?

In intervention studies, the investigator controls and studies the preventive, diagnostic or therapeutic intervention(s) provided to participants for the purpose of adding to knowledge of the health effects of the intervention(s).
Many intervention studies are clinical trials.

● an observational study?

In observational studies the researcher has no control over study variables, and merely observes outcomes.

Main Criteria

D. Will your study involve **human participants** recruited in their capacity as:

- consumers of health or disability support services, or relatives and/or caregivers of
- consumers of health or disability support services, or volunteers in clinical trials
- (including bioequivalence and bioavailability studies)?

● Yes

○ No

E. Does your study involve the use, collection or storage of **human tissue** (as defined by section 7 of the Human Tissue Act 2008)?

Examples of human tissue include:

- *all or any part of a body*
- *whole human organs or parts of them*
- *human stem cells or other human cells*
- *human blood*
- *human bone marrow*
- *human hair, nails, and skin*
- *human mucus, sputum, or urine.*

○ Yes

● No

G. Will your study involve the use or disclosure of **health information** (as defined by section 4(1) of the Health Information Privacy Code 1996)?

Health information is about identifiable individuals. It includes:

- *information about the health of an individual, including his or her medical history information*
- *about any disabilities that individual has, or has had*
- *information about any health services or disability services that are being provided, or have been provided, to that individual*
- *information in connection with the donation of any body part or any bodily substance of that individual information*
- *derived from the testing or examination of any body part, or any bodily substance of that individual information*
- *about the individual, which is collected before or in the course of, and incidental to, the provision of any health service or disability service to that individual.*

○ Yes

● No

Exemptions

I. *Exemption for low risk medical devices*

Does your study involve evaluating a low-risk (class I) medical device?

Low-risk (class I) medical devices are defined from page 77 of the Australian Therapeutic Goods Administration's Australian Regulatory Guidelines for Medical Devices.

○ yes

● no

J. *Exemption for audits and related activities*

i. Is your observational study an audit or related activity?

The term "audit and related activity" is defined in the Ethical Guidelines for Observational Studies.

○ yes ● no

K. ***Exemption for minimal risk observational studies***

Does your study involve more than minimal risk?

A study involves more than minimal risk if the probability and magnitude of possible harms resulting from participation in the study is greater than those encountered in everyday life.

A study always involves more than minimal risk if it involves one or more of the following:

one or more participants who will not have given informed consent to participate one or more

- *participants are vulnerable*
-
- *standard treatment being withheld from one or more participants the*
- *storage, preservation, or use of human tissue without consent the*
- *disclosure* of health information without authorisation.*

● yes

○ no

* See rule 11 of the Health Information Privacy Code 1996.

Kb. Please briefly explain your answer above.

[< 1200 characters]

Participants will be receiving palliative care in the home environment either as a patient or associated caregiver or family member. They are potentially vulnerable due to their physical and emotional state and awareness of their dying. However this group of participants will be capable of giving informed consent freely.

L. ***Exemption for some student research***

Is your study being done at or below Masters level? yes

○

● no

INCLUSIONS

HDEC REVIEW

O. Your study requires HDEC review

The question below will determine the review pathway appropriate to your study.

Does your study involve any of the following? (Select all that apply)

☐ a new medicine

☐ an approved medicine being used for a new indication or through a new mode of administration
☐ a medical device that is or would be classified as a class IIb, class III, or active implantable medical device by the Therapeutic Goods Administration (TGA).
☐ a new surgical intervention

☐ one or more participants who will not have given informed consent to participate
☐ one or more participants who are vulnerable (that is, who have a restricted ability to make independent decisions about their participation) ☐ standard treatment being withheld from one or more participants ☐ the storage, preservation, or use of human tissue without consent ☐ Future Unspecified Use of Tissue ☑ none

Exp.

Your study will be reviewed by the ***expedited review*** *pathway described at section 6 of the Standard Operating Procedures for Health and Disability Ethics Committees.*

a.1 Title and summary

a.1.1.

Short study title: Experiences of telehealth in hospice care at home.

a.1.2.

Formal study title: Experiences of building rapport in telehealth encounters from the perspectives of patient, family, and health professional in palliative care.

a.1.3. A protocol must be uploaded in the “Documents” tab before submission to an HDEC.

If this protocol has a unique identifier, please enter this below.

Protocol number (if applicable): none

a.1.4. Please provide the dates on which you plan to commence and conclude your study in New Zealand

Planned commencement date: 28/09/2020

Planned conclusion date: 30/09/2022

a.1.5. Please provide a brief, plain English summary of your study.

[< 2000 characters]

This is a qualitative study, designed to investigate participants experiences of telehealth in palliative care at home.
Why is this important?
Along with many others, palliative care professionals turned to telehealth during COVID-19 “lock-down” to bridge the gap of not being in the same room with their patients. Telehealth via video-call or phone call was suddenly the safest way to consult and maintain contact for everyone involved. This research asks, “What are the experiences of telehealth encounters for patients families and health professionals receiving palliative care at home?” There is no data yet about how this is experienced by patients families or health professionals or how telehealth has influenced patient outcomes. As we adjust into a world knowing more about our vulnerability to pandemics, this research on telehealth in palliative care is timely and could contribute to future palliative telehealth service options.
What is the purpose of the study?
To contribute to better understanding and practice of rapport building in palliative telehealth. The data from the two phases of the project will be used to form guidelines for rapport building in telehealth.
Who are we recruiting?

- Patients, family members who have had telehealth interactions with palliative care professionals at home.
- Palliative care professionals from all disciplines who are users of or are interested in telehealth methods to explore rapport and telehealth in focus groups. Participation involves:
- The first phase will interview patients and families about their experiences of telehealth encounters.
- The second phase is focus groups with palliative care professionals discussing topics from the patient family interviews.

a.1.6. Please provide a brief summary of the main ethical issues that you believe your study may raise.

[< 1200 characters]

1. Whakapapa- duty of care of participants
2. Treaty of Waitangi- to ensure actions are taken in regard to protection participation and partnership with Māori participants.
3. Identifying potential participants- to ensure potential participants are not coerced or feel pressured into taking part in the study.
4. Recruitment methods- it is essential potential participants are able to give informed consent and are willing to take part in the study.

Advertising- this will only be done via posters to gain attention that the research project is happening.
Reimbursements- These are petrol vouchers for participants in phase one. They will be offered in recognition of time and not as payment.
Role conflict- Acknowledging and informing participants and colleagues of the researcher's dual role as nurse and researcher at her place of work. Plans in place to mitigate this risk. data management- plan in place

a.2.1. Does your study aim to improve knowledge of:

○ diagnosis ○ early
detection / screening ○
prevention ○ treatment

○ rehabilitation ○
lifestyle/behaviour ● other:
communication

a.2.1.4. Which of the following best describes your observational study?

○ case control study ○ cohort study ○ cross-sectional study ○ case report

○ case series

● descriptive study ○ audit or related activity ○ device usability assessment ○ other

a.2.2. Please select the ANZSRC field of research that best describes your study from the drop-down menus.

Level 1: 11 Medical and Health Sciences

Level 2: Other Medical and Health Services

Level 3: Medical and Health Sciences not elsewhere classified

Investigators

Co-ordinating Investigator (CI)

The CI has overall responsibility for the conduct of the study, including adherence to established ethical standards.

In student research, the student him- or herself is the CI.

a.3.1. Are you the CI for this study?

● Yes

○ No

a.3.1.1. *The CI must authorise this application (through the “Authorisations” tab) before it can be submitted to an HDEC for review. You should request authorisation once you have completed all questions in the Online Form, or sign this form as the Co-ordinating Investigator in the Authorisations tab.*

Please provide the following information on the study’s CI.

	Title:	Forename/Initials:	Surname:
	Ms	Wendy	English
Mailing Address:	47a Hawford Rd Opawa		
Suburb/Town:	Christchurch		
Postcode:	8023		
Country:	New Zealand		
Organisation:	University of Auckland		
Department*:	School of Nursing		
Position:	Doctoral candidate		
E-mail:	weng888@aucklanduni.ac.nz		
Phone (BH):	0211995699		
Phone (AH)*:	021800214		
Mobile*:			
Fax:			

Other Investigator(s)

Other than the Co-ordinating Investigator, Investigators at all localities in a multi-centre intervention study must be listed as Investigators. Supervisors of student research must also be listed as Investigators.

You may list any other Investigators at your discretion.

a.3.2. Will any co-investigators be involved in conducting your study?

● Yes

○ No

a.3.2.1. *You should request authorisation from each Investigator in your study (using the “Authorisations” tab) once you have completed all questions in the Online Form.*

(For each co-investigator:)

Other CI 1

	Title:	Forename/Initials:	Surname:
	Professor	Merryn	Gott
Mailing Address:	The School of Nursing Faculty of Medical and Health Sciences The University of Auckland		

Suburb/Town:	Auckland
Postcode:	1142
Country:	New Zealand
Organisation:	University of Auckland
Department*:	School of Nursing
Position:	Director, Te Ārai Palliative Care and End of Life Research Group, Co-Associate Head (Research)
E-mail:	m.gott@auckland.ac.nz
Phone (BH):	+64 9 923 1655
Phone (AH)*:	
Mobile*:	
Fax:	+64 9 367 7158

Other CI 2

	Title: Forename/Initials: Surname: Dr Jackie Robinson
Mailing Address:	The School of Nursing Faculty of Medical and Health Sciences The University of Auckland
Suburb/Town:	Auckland
Postcode:	1142
Country:	New Zealand
Organisation:	University of Auckland
Department*:	School of Nursing
Position:	Senior Lecturer, School of Nursing, University of Auckland; Lead Nurse Practitioner, Auckland District Health Board
E-mail:	j.robinson@auckland.ac.nz
Phone (BH):	+64 9 923 2883
Phone (AH)*:	
Mobile*:	
Fax:	+64 9 367 7158

a.4 Primary contact person

a.4.1. Are you the primary contact person for this study?

● Yes
○ No

Title: Forename/Initials: Surname:

Ms Wendy English

Mailing Address: 47a Hawford Rd
Opawa

Suburb/Town: Christchurch
Postcode: 8023
Country: New Zealand
Organisation: University of Auckland
Department*: The School of Nursing
Position: Doctoral candidate
E-mail: weng888@aucklanduni.ac.nz
Phone (BH): 0211996599
Phone (AH)*: 021800214
Mobile*:
Fax:

Sponsor

The sponsor has overall responsibility for the initiation, management, and financing arrangements of a study.

a.5.1. Which of the following best describe the sponsor(s) of your study?

☐ pharmaceutical company ☐ medical device company ☑ academic institution ☐ collaborative research group
☐ district health board (DHB)

☐ other government agency ☐ non-governmental organisation (NGO) ☐ other

☐ no sponsor

a.5.2. ***The sponsor(s) must authorise this application (through the "Authorisations" tab) before it can be submitted to an HDEC for review. You should request authorisation once you have completed all questions in the Online Form.***

Please provide the following details for your study's sponsor(s).

Sponsor 1

Title: Forename/Initials: Surname:

Mailing Address:

Suburb/Town:
Postcode:
Country:
Organisation:
Department*:
Position:
E-mail:
Phone (BH):
Phone (AH)*:
Mobile*:
Fax:

humanethics@auckland.ac.nz

Third party performing sponsor's duties or functions in New Zealand

a.5.3. Will a third party (such as a contract research organisation) perform one or more of the sponsor's duties or functions in relation to this study in New Zealand?

○ Yes
● No

Localities and participants

New Zealand

It is a standard condition of HDEC approval that locality authorisation be obtained (through the "Authorisations" tab) ***before a study commences at a locality****. This authorisation confirms that the locality has addressed research governance issues that may arise as a result of the study.*

However, locality authorisation ***does not*** *have to be obtained prior to submission of your application to an HDEC.*

Other organisations involved in studies may prefer or require that their involvement in studies be recorded as an authorisation. You should check with these organisations before proceeding with your study.

Contact details for DHB research offices are available here

a.6.1. At which type(s) of locality do you intend to conduct your study?

☐ district health board ☐ tertiary education institution

☐ primary health care centre

☑ private organisation ☐ other - please specify:

a.6.2. Approximately how many participants do you intend to recruit in New Zealand?

54

Other countries

a.6.3. Will your study also involve participants recruited in countries other than New Zealand?

○ Yes

● No

a.7 Prior review

a.7.1. Is this application related to one or more previous applications for HDEC review?

○ Yes

● No

a.7.2. Has an application for this study (or a substantially similar study) previously been declined approval by an HDEC in New Zealand?

○ Yes

● No

a.7.3. Has an application for this study (or a substantially similar study) previously been declined approval by an overseas ethics committee?

○ Yes

● No

a.8 Clinical trials of new medicines

Open/closed meeting

HDECs are public administrative bodies, and their meetings are open to the public. Your study may be reviewed in a closed meeting only if grounds may exist to withhold information about it under the Official Information Act 1982.

a.9.1. Do you want your application to be considered in a closed meeting?

○ Yes

● No

HDEC review preference

b.1 Research should be based around a clear study question that can produce benefits.

b.1.1. Briefly and in plain English, what is the principal study question (hypothesis) that your study will test? *You can refer to page numbers of your study's protocol for further detail if you need to.*

[< 2000 characters]

Research Question(s)

1. What are the patients and families experiences of rapport with health professionals in palliative care telehealth?
2. How do health professionals manage rapport in palliative care telehealth encounters?

b.1.2. Please briefly describe the scientific basis for your study (including, where appropriate, brief discussion of previous research).
You can refer to page numbers of your study's protocol for further detail if you need to.

[< 2000 characters]

This is a qualitative study, using an interpretive interactionist methodology. This is designed to investigate participants experiences of palliative care at home via telehealth.
This follows on from a phenomenological study on rapport for patients families and nurses in hospice care conducted by CI Wendy English completed in 2018. There is a recent scoping review (2020) conducted by this research team on rapport in the hospital setting. The key findings are that rapport is poorly defined with an assumed meaning at the same time as being valued as essential to effective communication and collaboration of care. The major research gap identified was the lack of patient and family experiences of rapport. A lack patient and family experiential data on rapport also exists in telehealth. There is very little research on rapport in palliative care telehealth at present and it is now more timely after our recent isolation and lock-down experiences of COVID-19 and increased use of telehealth methods.

b.1.3. Please briefly explain how your study will contribute to new knowledge and improve health outcomes.

[< 2000 characters]

Patient and family members will be interviewed about their experiences of rapport. Topics from these interviews will be discussed in focus groups with palliative professionals to define their understanding and practice of rapport.
This data will then be used to provide understanding and guidelines for rapport building in telehealth and research.
With increased use of technology in patient and family care generally this will be useful and applicable knowledge.
This knowledge is anticipated to positively influence telehealth patient and family outcomes by improving rapport understanding.

b.2 Research should be well-designed, so that it can answer the study question.

b.2.1. Please briefly describe and justify the design of your study.

[< 1200 characters]

The research questions are derived from two of the gaps in the literature on rapport having an assumed meaning and the lack of patient and family experiences of rapport. A qualitative research design is appropriate to answer the research questions.

The design has two parts: 1. semi-structured interviews with patients and families at home either in-person or via video call. These interviews are to gain their perspective on rapport what is means and how it is experienced with palliative professionals when using telehealth methods.

2. the second part will be focus groups discussing the topics related to rapport that come from the patient/families interview findings.

Once these two phases are completed the data will be analysed to provide a model and guidelines on rapport in palliative care and telehealth.

b.2.2. Please indicate whether peer review of the scientific and statistical quality of your study has been obtained from one or more of the following.

☐ the Standing Committee on Therapeutic Trials (SCOTT) ☐ the study's funder (e.g. the Health Research Council)

☐ the study's sponsor

☑ experts within the research team ☐ senior colleague(s) in the field ☐ other

b.2.2.1. *Evidence of favourable peer review for this study must be uploaded in the "Documents" tab before submission to an HDEC.*

Please briefly describe the peer review process that has been carried out for your study.

[< 1200 characters]

Dr Jackie Robinson and Professor Merryn Gott are very experienced world class researchers who have reviewed this study design and found it to be appropriate and useful as a research project. Professor Gott as primary supervisor completed the attached peer review form.

b.3 Research should be conducted by an appropriate Principal Investigator, to ensure that the study protocol is respected and followed.

b.3.1. *A CV for the study's Co-ordinating Investigator must be uploaded in the "Documents" tab before submission to an HDEC.*

Please briefly summarise the Co-ordinating Investigator's qualifications and experience relating to conducting studies of this nature.

[< 1200 characters]

CI for this study is Wendy English.

WE is a palliative care nurse with hospice and community care experience. She is a registered nurse with a broad clinical experience over decades. Her work as a district nurse and her current work in hospice have inspired a passion for palliative care and communication. She has a particular interest in rapport as it is experienced with patients families and health professionals. She has commenced on a research pathway to further explore this interest with a HScDip endorsed in palliative care and a MHSc focusing on rapport in palliative care. This current project before the HDEC review is a continuation of this interest in rapport and is an area that has clear research needs.

b.4 Where possible, research should generate material that is useful for future research.

Reporting and dissemination of results

b.4.1. How do you intend to report or disseminate the results of your study?

☑ article(s) in peer-reviewed scientific journals

☐ internal reports ☑ conference presentations
publication on website

☑
☐ other publications

☐ submission to regulatory authorities (e.g. Medsafe, TGA, FDA, EMA) ☐ other

☐ no plans to report or disseminate results

b.4.2. Will any restrictions be placed (for example, by your study's sponsor or funder) on the publication of the results of your study?

○ Yes ● No

Future research using data generated in your study

b.4.4.

Might data generated in your study be made available for use in future research?

● Yes ○ No

b.4.4.1. *You should explain this clearly to potential participants.*

Which of the following best describes the form in which data generated by your study might be made available to other researchers?

○ identified
○ potentially identifiable

○ partially de-identified
● de-identified ○ anonymous ○ other – describe:

Risk of physical harm to participants

r.1.1. Briefly and in plain English, please describe:

- the procedures to be undertaken by participants in your study, and any risks associated with these procedures
- that potential participants may reasonably wish to be informed of.

***Do not** describe procedures that will be undertaken as part of normal clinical care regardless of participation in your* study*, or the risks of such procedures.*

[< 2500 characters]

The research procedures are semi structured interviews for patients and family members and focus groups for palliative professionals.
These are low risk to participants. There is no risk of physical harm.
The potential for discomfort exists in uncovering unforeseen or incidental findings.

r.1.2. Will you seek consent from participants to inform health practitioners with responsibility for their health care that they are taking part in your study?

● Yes ○ No

r.1.3. Will your study involve withholding standard treatment from participants?

○ Yes ● No

Compensation for injury to participants

r.1.7. Will any participants seek or be given treatment by or at the direction of a registered health professional (as defined in the Accident Compensation Act 2001) as part of your intervention study?

○ Yes ● No

Ionising radiation not needed for normal clinical management

r.1.13. Will your study involve the administration of ionising radiation that is not needed for participants' normal clinical management?

○ Yes ● No

Risk of breach of privacy and confidentiality

Before the study

r.2.1. Will your study involve reviewing or screening health information, for example in order to identify potential participants?

The term "health information" is defined in the Health Information Privacy Code

● Yes ○ No

r.2.1.1. Please briefly explain how you will ensure the confidentiality of this health information before the study.

[< 600 characters]

Patient health information will be reviewed to identify participants as meeting inclusion criteria and gathering some basic demographic data. This activity will be carried out by health professionals employed by the palliative care provider, not the researcher.

During the study

r.2.2. During your study, who will have access to health information used in your study?

[< 600 characters]

CI Wendy English and co-investigators Dr Jackie Robinson and Professor Merryn Gott.

r.2.3. Please briefly explain how you will ensure the confidentiality of this health information during the study.

[< 600 characters]

Patient identifying information such as consent form data will be kept in locked storage file. Any linking documents with patient data and codes will be stored there too. This will be stored separate from interview data.

r.2.3.1. Will your study involve the use of surveys or questionnaires?

○ Yes ● No

After the study

r.2.4. Which of the following best describes the form in which data generated in your study will be stored after the study has finished?

○ identified
○ potentially identifiable
● partially de-identified
○ de-identified
○ anonymous ○ other – describe:

r.2.4.1. Please briefly explain your answer above.

[< 600 characters]

All participant identifiers will be removed from transcribed data. Name, place of residence etc... This will be stored safely on a password protected University database with access only available to the investigators of this project. In a separate locked file will be kept the linking document for coding and the consent forms with patient identifying data which is required to be kept for 6 years.

r.2.5. *The Health (Retention of Health Information) Regulations 1996 require that* ***some*** *health information be retained for a period of ten years.*

For how long will health information generated in your study be stored?

[< 600 characters]

10 years.

Publication of results

r.2.6. Will the results of your study be published in a form that identifies (or could reasonably be expected to identify) individual participants?

○ Yes ● No

r.3 Risks associated with the use of human tissue

Risk of unexpected clinically significant findings

r.4.1. Might any aspect of your study produce findings that may be both unexpected and clinically significant for participants, donors of existing stored human tissue, or their families?

○ Yes ● No

Risk of potential conflict of interest

Funding and remuneration

r.5.1. Please briefly describe the main source(s) of funding for your study.

[< 600 characters]

University of Auckland doctoral scholarship

r.5.2. Does the Co-ordinating Investigator, any Co-Investigator, or any direct member of their families have any commercial interest in the intervention(s) to be studied, or any financial relationship to the study sponsor or funder(s), that may inappropriately influence his or her conduct in the study?

○ Yes ● No

r.5.3. Will the Co-ordinating Investigator or any Co-Investigator be remunerated for their involvement in the study in a way that may inappropriately influence his or her conduct in the study (for instance, bonuses for favourable results or high recruitment rates)?

○ Yes ● No

Health or disability support service providers

r.5.4. Will the Co-ordinating Investigator or any Co-Investigator also be the usual health or disability support service provider for one or more participants in your study?

○ Yes ● No

r.5.5. Will the usual health or disability service provider for one or more participants in your study receive any remuneration (or any other valuable consideration) for referring potential participants to the research team in your study?

○ Yes ● No

Other potential conflicts of interest

r.5.6. Please briefly describe any other potential conflicts of interest that may arise for researchers in your study and describe how they will be minimised and managed.

[< 600 characters]

The investigator works as a registered nurse in a hospice. There may be a potential conflict of interest if home care interview participants are admitted to this hospice. The co-investigator has discussed this with hospice management and if this situation eventuates the participants care can be and will be allocated to another nurse. There is also a potential conflict of interest for the focus group who would be colleagues of the researcher. The research officer for this hospice will mediate this particular focus group and the researcher (WE) will assist only.

Risk of stigmatisation

r.6.1. Please briefly indicate whether the results of your study may risk stigmatising individuals or population groups, and if so, how this risk will be minimised and managed.

[< 600 characters]

There is low risk of stigmatising participants. This risk will be managed by using the researchers (WE) experience as a palliative care professional working with dying patients and families. She is committed to taking care of participants and ensuring their human rights and cultural safety are taken very seriously.

Risks to researchers and third parties

r.7.1. Please briefly indicate whether your study may pose any significant risks to researchers and/or third parties, and briefly explain how such risks will be minimised and managed.

[< 600 characters]

Risk to researcher is very low. The researcher is aware of how to access professional support if needed. WE has 2 experienced and highly responsive supervisors for professional support and guidance.

r.8 Summary: the risks of research should be proportional to its expected benefits.

r.8.1. Please briefly explain why you consider the risks of your study to be proportional to its expected benefits.

[< 1200 characters]

This study is about rapport and connection. The benefits are likely to outweigh risks to participants and participating organisations. The benefits are related to improving communication and outcomes for palliative patients and families having telehealth encounters at home.

Participants should consent to their participation in research.

p.1.1. Briefly and in plain English, please describe what taking part in your study will involve for participants.

[< 1200 characters]

Participant patients and families will be involved in an interview about their experiences using telehealth. The

p.1.2. Will **all** participants in your study give their informed consent to participate?

● yes, all participants will give informed consent

○ no, one or more participants will not give informed consent

p.1.9. Will informed consent be recorded in writing?

● Yes ○ No

Consent should be informed by adequate understanding of relevant information.

interviews are estimated at 30-60 minutes. Participant palliative care professionals will be involved in focus group or interview discussing topics from patient and family data. Estimated at 60-90 minutes.

p.2.1. Briefly explain the process by which potential participants in your study will be provided with information on the study, have the opportunity to ask questions, and asked to give their informed consent.

[< 1200 characters]

Phase one: Potential patient and family participants will be approached by a specialist nurse to inform them of the study, to ask questions or talk with whanau about it and invite them to find out more if they are interested. Phase two: palliative care staff will be invited to participate via email after a short presentation of the study design by the researcher.
PIS and CF will be given at the initial contact for both groups.

p.2.2. A **generic** version of the participant information sheet and consent form (PIS/CF) that you will provide to potential participants must be uploaded in the “Documents” tab before submission to an HDEC. You don’t need to submit information sheets specific to each study locality. *A suggested pro forma for your PIS/CF can be found here.*

p.2.3. How have you checked that the participant information sheet is appropriate for your study population?

[< 600 characters]

Checked with both palliative staff members and a "test" patient and family member.

p.2.4. How many words does your participant information sheet contain?

1590

p.2.5. What is the Flesch Reading Ease Score for your participant information sheet?
You can use Microsoft Word to calculate this score.
While there are no hard and fast rules for the readability of information sheets, a score of 65 or above usually indicates that a document is written in plain English.

60

Withholding or concealing information from participants

p.2.6. Does your study involve deliberately withholding or concealing information from participants?
Blinding procedures in randomised controlled trials are not normally considered to involve withholding or concealing information from participants.

○ Yes ● No

Information that becomes available during the study and that may be relevant to continued participation

p.2.7. How will you ensure that participants receive information that becomes available during the study and that may be relevant to their continued participation?

[< 1200 characters]

The researcher will work closely with attending palliative care staff and any change in condition or health information will come from the staff to the patient or family members, not from the researcher.

Information about the results of the study

p.2.8. Will you inform participants of the results of your study?

● Yes ○ No

p.2.9. Please *either* explain how you will inform participants or explain why you do not intend to do so.

[< 600 characters]

A summary report of results is offered to participants as part of signing the consent form. They can tick yes or no and can fill in a corresponding email/address of where they wish it to be sent to.

Consent should be voluntary.

p.3.1. *Generic copies of any advertising that you intend to use to encourage potential participants to take part in your study must be uploaded in the "Documents" tab before submission to an HDEC.*
Please explain how potential participants will be identified and approached in a way that ensures they can give informed consent free from undue influence.

[< 1200 characters]

Phase one: Sampling of patient participants will be purposive to reduce judgement whilst maintaining representation of population.
Family members will be sampled purposively
Both groups will be approached initially by a specialist nurse from their palliative care service to let them know there is a research project that may be of interest to them. The approach will be simple and clear with no coercion or sense of pressure to participate. The autonomy of participants is highly valued and willingness to participate is part of selection. Participants are reassured that withdrawal from the study is easy and may occur at any time, with no reasons given.
Phase two: palliative care staff will be approached via email by a clinical managers email so researcher is not privy to email lists. Participants will self-select for participation in focus groups. The PIS and CF will be attached to email they can sign it and return or email researcher to discuss any queries they may have. Participants are reassured that withdrawal from the study is easy and may occur at any time, with no reasons given.

Potentially vulnerable people

p.3.2. Will your study involve potentially vulnerable people – that is, people who may have a restricted ability to make independent decisions about their participation?

○ Yes ● No

Inducements

p.3.3. Will participants receive any payments, reimbursement of expenses or any other benefits or incentives for taking part in your study?

● Yes ○ No

p.3.3.1. Please describe these and explain why they are appropriate.

[< 600 characters]

A $30 petrol voucher is offered to patient and family participants to recognise their contribution of time to the research project. It will be offered even if participants withdraw at time of interview.

P.4 Population groups, particularly Māori, should be consulted in the design and conduct of research that is of relevance to them.

Consultation with Māori

p.4.1. Please describe whether and how your study may benefit Māori.

[< 1200 characters]

Māori may benefit from the study as the focus is in fact on korero with palliative health professionals and how inclusion and connection can be improved. The study is looking at telehealth services and how rapport is
experienced by participants. For example one benefit may be understanding how/if telehealth fits with kanohi ki te kanohi, the need for face to face meeting? Assistance from kaia whina and kaumatua will be sought to ensure correct understanding of both tikanga approach and understanding what is said.

p.4.2. Please identify the main cultural issues that may arise for Māori who may participate in your study and explain how these issues will be managed.

If Māori will be excluded from participating, please state this. You will be asked to explain your inclusion/exclusion criteria in the next section of the Form.

[< 1200 characters]

Participation is voluntary and inclusive. Some purposive sampling may be used to ensure at least proportional representation of Māori. Arranging the meeting time and place for interviews will be done with assistance of kaia whina and it may be at the participants home or local marae or as they choose. The kaia whina or similar will accompany the researcher (WE) to the interview and may provide a karakia to begin and close the interview is
closed to ensure wairua is respected. A koha of food is often appropriate to demonstrate the reciprocal nature of manaakitanga. The kaia whina will guide the researcher on these processes. An informal debrief after the interview with each kaia whina (or similar) who accompanies the researcher is to ensure correct understanding of what has been said from a Māori persons viewpoint. Notes will be taken at this point and used to assist analysis. The CI (WE) will receive any information from participants as taonga and will reassure the participants the information will be treated respectfully.

p.4.3. According to the Health Research Council's Guidelines for Researchers on Health Research Involving Māori, is formal consultation with Māori required for your study?

○ Yes ● No

p.4.3.1. Please either describe your study's consultation process or explain why you do not consider that formal consultation with Māori is required.

[< 1200 characters]

It is expected numbers of Māori participants will be low (1-4) at each site. Each participating organisation has a kaia whina who the CI will make time to korero with about the project and finding out what the specific requirements for
Māori participants are in that place. These details will be included in the research proposal that goes to each organisation for their ethics approvals.
The CI (WE) is a researcher of European descent and will be accompanied to homes of Māori participants by a kuia or kaumatua from the local area with hospice affiliations. This will be explained to participants at time of consent.

p.4.4. Does your study involve kaupapa Māori research methodologies?

○ Yes ● No

Consultation with other relevant population groups

p.4.5. Will any other population groups be specifically targeted for recruitment into your study?

○ Yes ● No

Collection of ethnicity status

p.4.6. Will participants' ethnicity status be collected as part of your study?

● Yes ○ No

f.1 Where possible, research should reduce health inequalities.

f.1.1. Might your intervention study contribute to reducing inequalities in health outcomes between different populations, and particularly between Māori, Pacific peoples, and other New Zealanders?

● Yes ○ No

f.1.2. Please explain your answer above.

[< 1200 characters]

There is very little data from palliative patients and families about their experiences of rapport in telehealth. It is not known what will be revealed. Potential themes may be unconscious bias or cultural insensitivity. If so, this will form part of topics for the focus groups with palliative health professionals to discuss and consider improvements. Guidelines for rapport in telehealth will be formed from these discussions, Māori consultation will be sought in guideline formation. This will initially be from the school of Nursing Te Arai palliative care bi-cultural research unit and Dr Tess Moeke-Maxwell.

Participants and non-participants should be treated fairly compared to each other

Inclusion and exclusion criteria

f.2.1. Please briefly describe the inclusion and exclusion criteria for your study. *You can refer to page numbers of your study's protocol where further detail is required.*

[< 2000 characters]

Phase one Inclusion Criteria:
1.Patients >18 years who speak English and have a confirmed life limiting illness and; who are receiving (or have received) palliative care in their home via telehealth.
2.Informal caregivers (family/whanau/friend/neighbour) of person with life limiting illness who have had or conversations with health professionals via telehealth about patient care. This may include bereaved family members. Participants will be adults >18 years of age and speak English.

Phase one Exclusion Criterion:
1. People who cannot converse in English cannot participate in the study as our project has no resource for

interpreters

2. Children and young people under 18
3. Patients and family members who have not had telehealth interactions.

Phase two:
inclusion criteria:
Palliative care professionals from any discipline, who are interested in and/ have had experience with telehealth methods. exclusion criteria:
Senior management will be excluded as their presence may be perceived by staff to hinder the flow of discussion.

Funding restraints for this project mean no interpreter services are available.

f.2.2. Please explain how these inclusion and exclusion criteria ensure that the risks and benefits of your study are distributed fairly.

[< 1200 characters]

The research team recognises the value of appropriate inclusion and exclusion criteria to select participants safely and appropriately. Adhering to the parameters and rationale for criteria maximises the participants chances of having a positive experience during the research as they will have experiences of telehealth to reflect on. The criteria minimises risk by not selecting participants under 18 years.

Placebo-controlled Studies

f.2.3. Does your study involve the use of placebo?

○ Yes ● No

Impact on health and disability support service provision

f.2.4. Might your study adversely impact on the provision of health and disability services?

○ Yes ● No

f.3 Different groups of participants should be treated fairly compared to each other

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