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

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Abstract

Interactions with rapport are considered essential to palliative care and beneficial to patient outcomes. With the current interest in telehealth, more knowledge is needed about rapport during telehealth encounters in palliative care from the patient and family viewpoint. The objective of this study was to explore patient and family experiences of rapport with health professionals during telehealth interactions in the community palliative care setting. This was a qualitative Interpretive Description study, with 18 patients and 11 family member participants recruited from four hospice locations in Aotearoa, New Zealand. Semi-structured interviews were conducted, and audio recorded between November 2020 and May 2021. Data was transcribed and analysed using Reflexive thematic analysis. A COREQ checklist was completed. The major theme was “The health professional’s vibe” which developed into two subthemes: 1) Relaxed comfortable encounters, with behaviours that aided developing rapport, and 2) difficult uncomfortable encounters with behaviours detracting from developing rapport. A key finding is that the health professional’s care, presence, and communication skills affected development of rapport more than the telehealth medium used. Participants perceived rapport in telehealth calls depending on how they experienced the health professionals’ “vibe.” Rapport occurred in relaxed, comfortable encounters with health professionals who demonstrated intentional presence and caring. However, patients and families experienced uncomfortable encounters without rapport attributable to a lack of health professional presence and caring. More compelling training options are needed for health professionals regarding the development of rapport in telehealth along with further research into the impact of rapport on telehealth outcomes.

Keywords

Interpersonal relations, family and patient experiences, rapport, telehealth, therapeutic presence, palliative care, qualitative research.

Introduction

Rapport between health professionals, patients, and family members is considered essential to provide high quality palliative care.^{1,2} Interactions characterised as having rapport can alleviate patients' anxiety and distress while enhancing involvement in decision making, and adherence to treatment. Such interactions can also lead to patients **and** reporting higher levels of satisfaction with their care.^{3,4} 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.⁵ Organisations providing palliative care have been faced with a need to rapidly implement telehealth, often for the first time.⁶ 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.^{4,7-10} Some studies have suggested a general equivalence between levels of satisfaction with telehealth when compared to in-person visits.¹¹⁻¹³ Telehealth is also perceived as generally acceptable by health professionals and sometimes preferable for patients.^{9,14-16}

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 telemental health.¹⁷ In our previous scoping review, there was a noticeable scarcity of research into patient and families experiences of rapport in palliative care generally.¹⁸ 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.¹⁹⁻²¹ Whilst the evidence base is building, the effects that telehealth may have on meaning making and experiences of rapport for patients and families in the palliative care setting have not yet been adequately investigated.

Table 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.” ³⁶ |

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.^{22,23} 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.²⁴ Family are vital to the successful delivery of telehealth in palliative care as they often facilitate telehealth meetings as well as attending appointments.^{25,26} Although studies are emerging that include family satisfaction with telehealth^{21, 27-29} families need to be involved in palliative care research²² exploring the development of rapport in telehealth calls.

Even though rapport is perceived as essential in both palliative care and the use of 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.³⁰ 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.³⁰ We determined a qualitative interpretive approach was necessary to address the research aim,¹⁸ as such the study design followed the Interpretive Descriptive methodology (ID).³¹⁻³² Interpretive Description is an approach used to investigate complex experiential clinical phenomena and generate knowledge that is relevant and useful in healthcare settings.³¹⁻³⁴ Underpinning this study is the Theory of Human Relatedness³⁵ chosen as a middle-range theory based in an interpretivist and humanistic paradigm. The theory has also 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^{30,35} 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 1).

Setting/Participants

Participants were patients and family members recruited from four hospices providing community services in the North and South Islands of Aotearoa, New Zealand (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 ID methodology³¹ and the Information Power model.³⁷

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 participants 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.

Table 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 |

Analysis

Reflexive Thematic Analysis (TA)^{38,39} was used for data analysis as 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.^{38,39} As part of this experiential orientation we considered our conceptual approach to language as active and symbolic.³⁹

Transcriptions and field notes were loaded onto NVivo 12 software and analysed using Reflexive TA.^{38,39} 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.^{38,40} 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.^{38,41} 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,^{38,41} and reflexive memos written at each stage of the analysis, to provide an audit trail of decision

making. Other decisions to build quality into the study included a reflexive journal, regular meetings regarding analysis with research team members, and completion of a COREQ checklist. 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.⁴²

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.⁴³

Family participants were mainly of European descent with one person identifying as NZ Māori. Most were female and under 70 years of age. 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 2.)

Table 3: Participant 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 1 declined 21 not offered | 19 Would accept video calls if offered 9 likely to decline 1 unsure |

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 3). Phone calls were from a variety of health professionals after referral to palliative care, including General practitioners, 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.

Our analysis developed one theme that addressed the research aim: “The health professional’s vibe” (Table 4).

Table 4. Theme: The Health Professional's Vibe

| Sub themes | |
|---|---|
| 1. Relaxed comfortable encounters | 2. Difficult uncomfortable encounters |
| <p>Health professional behaviours aiding rapport building</p> <ul style="list-style-type: none"> • Caring words and tone, • Time to talk, • Knowing who I am • A bit of a laugh | <p>Health professional behaviours detracting from rapport building</p> <ul style="list-style-type: none"> • 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".⁴⁴ The health professional vibe was more than a spontaneous "clicking" with each other.⁴⁵ Rather, the vibe included the therapeutic "presence" of the health professional, as an intentional, holistic being there for the other.^{46,47} The participants' experiences of the health professional 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. Yeab, 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)

Knowing 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 of the phone or video 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)

There was one negative video call. The patient involved 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 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 had 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.⁴⁶ 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.⁴⁷ Presence implies that the encounter is real and affects how participants experience enjoyment, and involvement.^{48,49} 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.⁵⁰ 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.^{51,52} Telehealth interactions with rapport can have a meaningful impact on a patient's life, especially during times of isolation.⁴⁸ 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.^{53,54} Telehealth itself can be exhausting for health professionals, particularly video calls due to the frequency and intensity of the sensory work needed.^{55,56} The strain of constant telehealth use can result in fatigue and "technostress" for the providers.⁵⁵ However, in this study there may be factors under health professional 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, and they can be aware of their tone of voice and the vocabulary used on telehealth calls, 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.”⁵¹

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.^{9,16} 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 be more consistently patient-centred⁸ and to prioritise patient choice and comfort.⁵⁷ 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.⁵⁸

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.^{57,59} 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.⁶⁰ 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 outcomes.⁶¹ Equally, more compelling education and commitment to training is needed for rapport building and telehealth etiquette for health professionals.^{62,63}

There are limitations to this study. Firstly, despite efforts to recruit a diverse population of participants, overall, most participants were NZ European and therefore may not reflect diverse cultural approaches to telehealth. Secondly, all participants either had a diagnosis of cancer or engaged in caring for cancer patients. The views expressed may therefore differ from persons with different diagnoses. 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. 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 “vibe check”⁶⁴ 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.

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