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Patient centered communication with cancer patients

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"People don't care how much you know until they know how much you care"

-Teddy Roosevelt

The words "you have cancer" almost always have a devastating affect on the patient who receives this diagnosis. Common reactions are feelings of uncertainty and loss of control over one's life.[1] Over time, cancer patients will encounter situations which will further disrupt their quality of life (QOL). Examples include: understanding complex medical information; making difficult treatment decisions; dealing with adverse affects from the medications; living with the fear of recurrence; and for some impending death.[2] Apart from prolonging survival, another key goal of cancer care, is to minimize the disease and treatment of patients' functioning and well-being.[3] The significance of doctor-patient interactions and in particular patient-centered communication (PCC) and their potential to influence patients' well-being and behaviour has been illustrated.[4-8] Whereas, the paternalistic medical model that once dominated patient-physician interaction is increasingly being replaced by a shared decision making or patient-centered model of communication especially with chronic illnesses such as cancer.[9-10]

The aim of patient centered communication is to help physicians provide optimal care that is in accordance with the patient's values, needs and preferences, and therefore allows patients to participate actively in decisions regarding their health and health care.[13] According to a review of the literature on communication in cancer care conducted by the National Cancer Institute, there is a framework of six key functions of effective PCC which are as follows:

1) Fostering clinician-patient relationships;
2) exchanging information;
3) responding to patients' emotions;
4) managing uncertainty;
5) sharing the decision making process; and
6) enabling patient self-management.[11]

In order to measure outcome of such interaction, patient satisfaction is by far the most used and recognized tool. In addition, studies have also implemented interaction analysis systems (IAS) to systematically identify and categories doctor-patient communication.[14]

Communication between doctors and patients greatly influences patient outcomes. Psycho-oncological studies have reported that poor physician communication with the cancer patient could lead to denial and uncertainty,[15] depression and anxiety,[16] non-compliance,[19] and difficult psychological adjustment to cancer.[17, 18] At every stage of their illness, oncology patients depend on their physician to meet several of their information and support needs, which if met, may reduce the disruption in their QOL.[21, 22] Furthermore, if a trusting environment is not cultivated by the physician, patients tend to change doctors.[20]

A good interpersonal relationship between the doctor and the patient is characterized by compassion, caring, respect and trust which can significantly help patients to better adjust to their illness.[2] However, it has been observed that cancer patients experience inadequate support over time.[3, 21]

The continuation of support is important, as having cancer is associated with uncertainties regarding treatment and outcomes. Thus, cancer patients often require a significant amount of reassurance about their concerns and reactions.[21] They may also seek comfort from their physician to compensate for self-image issues and the stigma associated with having cancer.[2]

It is essential in cancer care for the physician to establish a warm and trusting atmosphere in which the patient is treated as a "person" and feels that the doctor shows interest in and is sensitive to his/her problems and concerns.[23, 24] This facilitates successful information exchange and collaborative decision-making to occur.[2] Other recommendations include active and uninterrupted listening to the patient in order to attain a subjective account of his/her experience. This is likely to result in treatment plans which can minimize disruption in patient's QOL.[2] However, on many occasions, cancer patients are reluctant to disclose their psychosocial concerns believing that problems such as depression and fatigue, for instance, are consequences of the disease.[15, 23] This lack of open communication is sustained by the reluctance of the physician to inquire actively about feelings and concerns.[25] Studies show that follow-up consultations predominately involved biomedical exchanges rather than psychosocial exchanges.[26] As one study showed, oncologists, indeed, find eliciting and dealing with the psychosocial problems of cancer patients as one of most difficult communication challenges.[27]

Clinicians need to engage in behaviors that encourage patients to disclose their concerns. This can be accomplished by doctors listening attentively and empathetically, asking open-ended questions and directly inquiring about psychological aspects. As a result, this also satisfies the needs of the patient "to be known and understood."[28] In addition, patients appreciate physicians who encourage questions and answer them fully, clearly and appear unhurried.[29]

Information exchange is an important communication function in all stages of cancer care. It is critical to create a pathway for the flow of information from the physician to the patient or family members and from the patient or family members to the clinician. According to the Mazor et al. (2013) study, insufficient information can lead to patient stress or distress. Sufficient information about the procedure of care, adverse affects of the therapy and preparation were considered very helpful and reassuring.[29] Above all, reassurance and optimism from the physician helped in reducing the fear and distress the patient felt.[29]

One purpose of effective medical communication is to enable doctors and patients to make decisions pertaining to treatment. Furthermore, the desire to be fully informed about diagnosis, prognosis and treatment is greater in patients with life-threatening diseases.[28] However, not all patients want to assume responsibility for treatment decisions.[2, 28] A number of them prefer the clinicians to make decisions on their behalf.[2] Hence, physicians have been recommended to extensively assess the extent to which their patients want to be involved.[22]

Most of the research has focused on verbal components of the medical interaction and the non-verbal has been neglected. Affective behavior is not only perceived through discussion. Only 7% of emotional communication is verbally transmitted; 22% is attributed to voice tone; and 55% is based on visual cues, like eye contact, hand gestures and body positioning. Having cancer usually involves emotions such as anxiety, fear an uncertainty and patients will look for subtle clues to actively search for information concerning their health.[28] On some occasions, non-verbal communication 'leaks' messages that are not meant to be expressed. Clinicians can consciously become aware of such gestures and modify them.[29]

Patient-centered communication during cancer care must take into account organizational and environmental factors as well. Effective communication may be influenced by the pressure physicians face due to organizational insistence to increase efficiency; and financial incentives reward technical procedures rather than the provision of emotional support. While increased awareness and training are important to cultivate good communication skills, as Beckman and Frankel have

observed, "synnchronicity between expectations and the practice environment" is needed for physicians to provide patient centered communication. Policy makers must become active participants by acquiring training grants, providing incentive programs, certification requirements to promote and reward effective communication.[29]

Results from empirical studies have shown that positive clinician behavior is significantly beneficial to patients. However, more studies in cancer care focusing on the relationship between physician behavior and patient outcomes should be encouraged. It is hoped that such research will improve the quality of care for cancer patients and create training programs which will also benefit clinicians.

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