

What Patients Value When Oncologists Give News of Cancer Recurrence: Commentary on Specific Moments in Audio-Recorded Conversations

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LEARNING OBJECTIVES

After completing this course, the reader will be able to:

1. Incorporate the three themes identified in this study to refine discussion with patients of their cancer recurrence.
2. Manage discussion with patients of cancer recurrence with recognition of the impact of the news on the patient and guidance as to next steps.



This article is available for continuing medical education credit at CME.TheOncologist.com.

ABSTRACT

Purpose. Recommendations for communicating bad or serious news are based on limited evidence. This study was designed to understand patient perspectives on what patients value when oncologists communicate

news of cancer recurrence.

Study Design and Methods. Participants were 23 patients treated for a gastrointestinal cancer at a tertiary U.S. cancer center within the past 2 years, who had

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semistructured qualitative interviews in which they listened to audio recordings of an oncology fellow discussing news of cancer recurrence with a standardized patient. Participants paused the audio recording to comment on what they liked or disliked about the oncologist's communication.

Results. Three themes were identified that refine existing approaches to discussing serious news. The first theme, recognition, described how the oncologist responded to the gravity of the news of cancer recurrence for the patient. Participants saw the need for recognition throughout the encounter and not just after the news was given. The second theme, guiding, describes

what participants wanted after hearing the news, which was for the oncologist to draw on her biomedical expertise to frame the news and plan next steps. The third theme, responsiveness, referred to the oncologist's ability to sense the need for recognition or guidance and to move fluidly between them.

Conclusion. This study suggests that oncologists giving news of cancer recurrence could think of the communication as going back and forth between recognition and guidance and could ask themselves: "Have I demonstrated that I recognize the patient's experience hearing the news?" and "Have I provided guidance to the next steps?" *The Oncologist* 2011;16:342–350

INTRODUCTION

Giving bad or serious news is a fundamental communication task for oncologists [1], yet limited empirical data are available to support current recommendations. Prior studies show that patients have varied reactions to serious news such as receiving a diagnosis of cancer [2] and have high information needs [3], that the physician's communication correlates with the patient's adjustment to illness [4], and that patients tend to recall general physician characteristics such as trustworthiness [5]. However, few studies address how patients respond to specific moments in communication [6], and most depend either on patient recall about an event that, although memorable, occurred some time in the past [2, 7], or on expert coding that may not capture patient perspectives [8].

Moreover, oncologists seeking to improve their communication about serious news find recommendations that present apparent contradictions. For example, oncologists are supposed to be honest but also to be hopeful [9]. They should be empathic, yet also maintain distance [10]. They should be aware of their own feelings, yet also contain the expression of those feelings [11, 12]. Perhaps because of the difficulty of managing these apparent contradictions, some recent literature emphasizes the value of practices such as pessimism [13] and collusion [14, 15].

In this study, we asked patients with a personal history of cancer who were still at risk for recurrence to comment on oncologist communication about cancer recurrence, to establish what communication practices they value. Our motivation in conducting this research was to gather empirical data that could guide physician practice in giving serious news and inform communication skills training. Because prior research has focused on general descriptors (e.g., the physician displaying empathy) rather than specific communication practices that are valued by patients in this

situation, our study was designed to elicit patient feedback tied to specific moments in the conversations.

METHODS

Participants and Setting

Study participants had been treated for a gastrointestinal cancer within the past 2 years and were recruited from the Seattle Cancer Care Alliance, a tertiary U.S. cancer center. These patients were currently cancer-free but had been treated recently enough that they were still "at risk" for cancer recurrence. Potential participants were identified by reviewing clinic appointments and initially approached by their treating oncologist or nurse. Participant eligibility required willingness to complete the interview, fluency in English, age ≥ 18 , pre-interview distress thermometer score of $<4/10$, and signed informed consent. All study procedures were approved by the Fred Hutchinson Cancer Research Center/University of Washington Cancer Consortium IRB.

Design

In this study, cancer patients listened to audio recordings of an oncologist talking to a standardized patient (SP) (Figure 1). The audio recordings were produced during the Oncotalk communication skills retreats held during 2002–2006. These retreats enrolled medical oncology fellows, who learned and practiced the SPIKES protocol (a linear six-step strategy for discussing serious news) [16] and underwent pre-retreat and post-retreat evaluation with a number of SP encounters. At both pre- and post-retreat time points, one of the SP encounters required the fellow to give news of cancer recurrence to a patient who had previously been treated for cancer. The SPs portrayed a man with colon cancer and a woman with ovarian cancer, both abdominal cancers initially treated with surgery and postoperative chemotherapy; in each

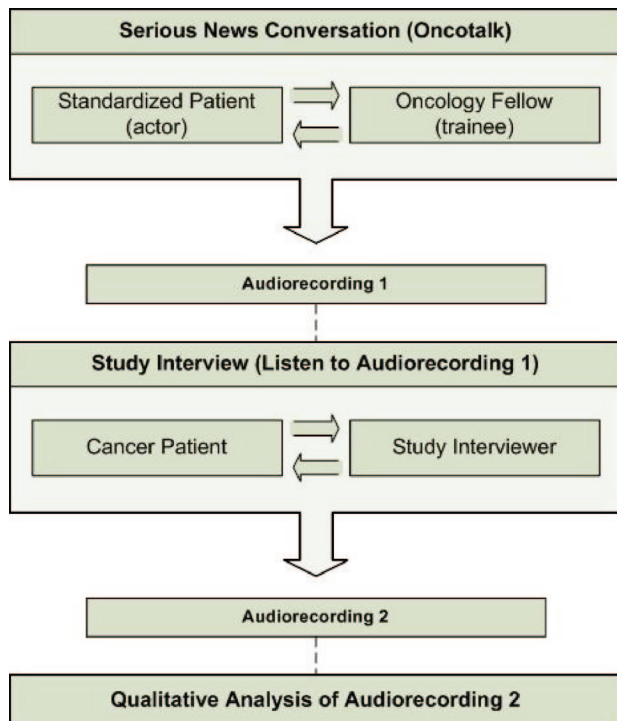


Figure 1. Overview of study design.

encounter, the physician was instructed to discuss the news of cancer recurrence detected by CT scan. These encounters were digitally audio-recorded, and in a previous study we reported the presence or absence of specific communication behaviors [17]. For the current study, 3 pairs of pre- and post-retreat audio recordings were selected, with fellows whose communication skills and post-retreat skill improvement were at the median score in the prior study [17].

Semistructured study interviews were conducted by an experienced qualitative interviewer (E.K.H.), occurred mostly at participants' homes, followed a detailed semistructured interview guide, and lasted 1.5–2 hours. During the interview, participants listened to two audio recordings in which a single fellow discussed news of cancer recurrence with two different SPs. The interviewer provided participants with a remote control to allow them to stop the audio recording at any time to make a comment, and participants were invited to comment on what they liked and did not like about the doctor's communication. The interviews were audio-recorded and transcribed verbatim.

Analysis

Our multidisciplinary team included clinicians who participate in clinical cancer care as well as researchers without clinical roles, and researchers who were involved in Oncotalk as well as researchers without prior involvement. The team met during data collection to discuss interviews as

they were being conducted, and read and discussed selected transcripts as a group. From these discussions, an initial coding scheme and a preliminary concept map [18] were developed inductively, based on participant comments.

We performed a qualitative analysis using the constant comparison method [19, 20]. The research team met weekly to discuss interviews, refine the conceptual model and coding scheme, and review the coding in conjunction with field notes made by the interviewer. The entire dataset was double coded (S.B.T., A.L.B.), and coders met to reach consensus on all coded passages and review coded transcripts with the interviewer.

Once coding was completed, two further data reductions were performed to improve our ability to look for patterns within and across participants. Using code reports from ATLAS.ti, we constructed a case table [21] identifying physician behaviors or qualities, by participant, that were valued or critiqued. We then constructed a second case table capturing key quotations for each of our three major conceptual categories, again by participant to assure representation of all views. We used a secure website to create an audit trail accessible to all analysts.

During the last phase of analysis, the interviewer performed member checks, in which a subsample of participants underwent additional brief phone interviews that provided additional confirmation that the analytic results represented participants' views [22, 23]. We stopped data collection when saturation was reached for the three major concepts defined in the analysis reported here [24, 25]. Finally, the analysis was reviewed by two independent analysts (R.M.A., W.F.B.) to review data and contest themes.

RESULTS

Participant Demographics

Twenty-eight potential participants were approached; 4 declined ("too busy" or interview seemed "too stressful"), and 1 other was inadequately fluent in English. Participants had a mean age of 58 years. Most were Caucasian, and participants were evenly divided by gender. Nearly all had undergone surgery (96%) or chemotherapy (91%) within the past 2 years (Table 1), and none had experienced cancer recurrence at the time of the interview.

Themes

We identified three major themes representing key qualities that participants valued about how oncologists communicate news of cancer recurrence. The first theme, recognition, described how the oncologist communicated that she recognized the gravity and emotional impact of the news on

Table 1. Participant demographics			
	Participants (n = 23)		Declined (n = 5)
Sex			
Men	12	52%	3
Women	11	48%	2
Race			
Caucasian	20	87%	4
African American	2	9%	
Asian/Pacific Islander	1	4%	1
Age			
Minimum	37		41
Maximum	79		71
Mean	59		54
Married/partnered			
Yes	16	70%	
No	7	30%	
Self-reported health status			
Excellent	6	26%	
Very good	11	48%	
Good	5	22%	
Fair	1	4%	
Poor	0		
Cancer dx			
Pancreatic	3	13%	
Colorectal	12	52%	
Neuroendocrine	3	13%	
Esophageal	2	9%	
Hepatocellular	1	4%	
GIST	1	4%	
Gastric	1	4%	
Prior anticancer therapy			
Surgery	22	96%	
Chemotherapy	21	91%	
Radiation	12	52%	

that individual patient. However, participants also felt that recognition alone was not sufficient. Of equal value was a second theme, guidance, that described the physician's ability to use her biomedical expertise to guide the patient in how to frame the news and identify next steps in treatment. The third theme referred to the oncologist's ability to move fluidly between recognition and guidance based on her assessment of patient needs in the moment, which we called responsiveness.

Recognition

Participants valued the ability of an oncologist to recognize the gravity of the news of cancer recurrence for an individual patient and make a connection at the "human-to-human" level (Table 2). One participant summed up a definition of recognition as she described a key moment in the audio recording: "I think [what was good about this encounter was] the doctor acknowledging the emotional content of this [serious news] and her own resonance with the patient . . . also, the doctor not being overwhelmed herself with the momentous nature of this occurrence."

Participants distinguished 2 primary characteristics of this formulation of recognition. First, participants valued the oncologist's ability to acknowledge or reflect the patient's emotion, by "getting inside the patient's frame of reference, as somebody who is on the same wavelength as the patient." Notably, participants did not look for the oncologist to have the *same* emotions as the patient. What our participants valued was when the oncologist recognized the significance of the moment and appreciated its effect on the patient. Another participant described a physician's reflection of an emotion this way: "She's commiserating with him, you know, that he's scared and he's expressing that he's scared, and she's giving him the right to be scared, giving him permission to be scared."

In the second characteristic of recognition, participants valued the oncologist's ability to convey their understanding of the patient's perspective and willingness to help without becoming engulfed in the patient's emotions. Participants were concerned about oncologists who they perceived as overwhelmed by their own emotions, as when "he [the oncologist] almost seems defeated before he's started." However, participants also bristled when they felt the oncologist give advice from a distance. "I struggle a little bit with the doctor trying to say some of those things like 'Every day is good.' It's hard, because you're the one there that's dying, and it's not them."

More pragmatically, participants valued the oncologist's ability to remain distinct because they believed that an oncologist who was overwhelmed by her own emotions would be less able to access her medical expertise. Yet participants also wanted this distinctness to be nonhierarchical; they wanted the physician to meet the patient without judgment. One participant, for example, valued "being able to communicate with your doctor and say stupid things and not have the fear that they're gonna go 'Wow, you're really a head case!'"

Participants linked recognition to an oncologist's ability to make a connection with a patient and commented on this theme all through the audio recordings—not just after the

Table 2. Recognition: Illustrative quotes

SP: "I'm scared of dying . . . of having this damn thing in me that's eating me."

MD: "Cancer is a scary thing."

PPT: "I liked the fact that she [the doctor] recognized that it is scary. She used his emotion and clarified back to him, [as if to say] 'I hear you.'" [5]

MD: "It's certainly not the news that either one of us wanted."

SP: "Ohh [sob], I didn't want to hear that [4-second silence]."

MD: "It's a lot to have thrown at you all at once."

PPT: "I appreciate the fact that that doctor was very respectful of the emotion and the impact that that was going to have on that person and that he . . . he lowered his voice and he became more intimate, for that moment, in talking to her. [16]

SP: "I gotta tell you, I am really scared."

MD: "It is scary. This is scary."

SP: "Whew!"

PPT: "That's good . . . It is scary, and it's gross, what you have to go through. But you just don't want someone who's going to say, 'You'll be fine. It won't bother you at all.' You need to know the reality of it. So [when the doctor reflects 'scary'] you have some sort of feeling that they're hearing you." [20]

Abbreviations: MD, oncology fellow in the audio recording; PPT, study participant whose study code is identified in square brackets at the end of each quote; SP, standardized patient in the audio recording.

news was delivered. One participant commented on a physician's acknowledgment of the patient's fear: "I appreciated the courage of her willingness to touch in on the emotional piece of shocked, scary, frightened," and this participant said later in the interview that what she looked for was "what level of commonality have they [patient and oncologist] created in that little room, over this medical issue."

Guidance

Participants did not consider recognition alone to be adequate for the task of giving serious news (Table 3). As one participant said, "His attempt at being kind and soft, in some respects, frightened me more because . . . He's kind of like, 'Wow, you're really up a creek, aren't you?' I don't want to have that feeling! I want somebody with a plan!" Participants wanted oncologists to offer a way forward in this difficult situation, which would include anticancer treatments as well as practical next steps such as testing or consultation with other specialists and suggestions about how to live with the news of cancer recurrence. One participant commented on the absence of guiding by noting that

the oncologist was "not a strong person . . . kind of like in a chair sitting back and thinking, 'Oh, I don't know how I can do this . . . ' No authority." Another participant exhorted the oncologist to provide more guidance, saying "You've got to get them [the patient] out of that funky 'Oh god, I got this cancer again.'" Participants wanted the oncologist to help shape how the patient could think about the news, and this shaping had two primary characteristics.

First, participants valued the oncologist's willingness to take initiative in directing the conversation. Even while they valued the oncologist's recognition of the patient's feelings, they did not want the oncologist to simply let the patient "wallow" in a chaotic swirl of emotions. As one participant said, "Someone has to take charge—it's a crisis!" When participants talked about wanting the oncologist to take charge, they were not just referring to the next medical tests. Participants also liked when oncologists reminded the patient of his own capacities and resources. After listening to a oncologist comment on the patient's family support, one participant said "[The oncologist is] making her realize that she's got all this support . . . and the patient is realizing that yes, indeed, she has a husband who was supportive [through her original chemotherapy treatments] and is going to be supportive this time."

The second characteristic of guidance that participants valued was how the oncologist framed the serious news. For example, participants uniformly disapproved of oncologists' attempts to preface the news with a comment about unfavorable consequences of the news, which is one kind of "warning shot" that has appeared in some recommendations about giving serious news [26]. After listening to an oncologist who prefaced the news of cancer recurrence by saying "Unfortunately . . .", one participant said, "That word just automatically [snaps fingers] takes all the hope out of it, right there." Participants valued an oncologist's ability to give the patient a sense that regardless of the gravity of the situation, there was still a next step to take and the oncologist knew what it was. Participants specifically talked about not wanting the oncologist to give false hope but rather that the oncologist could be "hopeful for a good fight," or help the patient identify new hopes. The participants insisted on describing serious news as "manageable" or "workable" rather than "unfortunate," and this view was linked to this view of the oncologist's critical role in framing how the patient could view their situation. "[The patient's] world was spiraling out of control," said one participant as he voiced approval of the oncologist's approach, "and [the oncologist is] trying to say, 'Maybe you can't see the big picture now, so what I want you to do is just focus on today and what you can do.'"

Table 3. Guidance: illustrative quotes

INT: “Did the doctor do or say anything that influenced your impression of the whole conversation?”

PPT: “I’m reflecting back on what I went through, the day I got the news. . . . I was in shock, you know. And I don’t know what I said. I don’t know what I wanted. But I do know I walked out with a plan. And that was important.” [1]

SP: “I don’t know how I’m going to tell my husband . . . or my kids. . . .”

MD: “It’s um . . . it’s gonna be a tough . . . you know, phone call to make to your children. Or have to sit down with your husband and go over that. I’d certainly like to help, in any way I can . . . maybe give it a try, on your own. You know, at least approach the subject. If you’re not able to do it, that’s fine. . . .”

PPT: “It feels overwhelming and like [the doctor] hasn’t taken charge. It just feels like she’s bearing this entire burden and he’s not helping her with any of the load.” [7]

MD: “This is a setback. There’s certainly no doubt about that. . . .”

SP: “That it is.”

PPT: “Everybody has in their mind that it’s horrible news. But when your doctor says it’s horrible news, then it’s twice as bad. . . . I just want hope from them, until I’m ready to hear something else. And I’ll ask for it, when I’m ready to hear it. But . . . not false hope, but find the hope. There’s always hope. You just gotta find it. And then say it. Your child brings you a picture that’s just really ugly, you don’t say it’s a beautiful picture. You say, ‘Oh, I love the colors.’”

SP: “Do you think there is any hope for a cure?”

MD: “. . . many people are able to manage for quite some time . . . we don’t have a drug that’s so effective that we can realistically promise you that we can . . . have the ovarian cancer go away forever . . . but on the flip side I think it’s very realistic to say that we have drugs that can treat this.”

PPT: “[The doctor] said, ‘A cure is unlikely, but on the other hand, the positive aspect is we can treat this. It’s manageable.’ So, I think that’s very positive information for a patient to hear, ‘manageable.’”

Abbreviations: INT, study interviewer; MD, oncology fellow in the audio recording; PPT, study participant whose study code is identified in square brackets at the end of each quote; SP, standardized patient in the audio recording.

Responsiveness

Participants spoke of recognition and guidance as distinct but complementary qualities of oncologist communication that were mediated by responsiveness, the oncologist’s capacity to move between them (Table 4 and Figure 2). These comments occurred most often at the end of the interview, when participants were thinking about the audio recordings in a holistic way. Responsiveness involves an iterative, back-and-forth process from recognition to guidance and back that unfolds during the conversation. For example, one participant commented: “That male patient voiced all of his emotions as best he could at the time. ‘Oh god, I didn’t think this was gonna happen. Why me?’ All of those things. And you just have to shut up and let ‘em go through that and then say, finally, ‘I know this is not good news and it’s been a shock. And I want you to sit . . . if you want to sit and think about this a little bit longer, I’ll just sit here and you ask me anything that comes into your head. And then once you’ve done that, I want to suggest some things that could be done.’”

When an oncologist demonstrated the ability to move responsively between recognition and guidance, participants commented on a mutuality in the “flow” between oncologist and patient. One participant described an exchange he liked as the oncologist “interacting with [the patient], not just lecturing her.” Another participant said, “I liked how he allowed her to

have her time, after he gave information, and just let her deal with it. I liked that. And sometimes he allowed her to lead.” Another participant described responsiveness as “what I call the ‘baby gaze’, back and forth, as from the time we’re infants, we do that back-and-forth connection.”

Notably, participants did not expect this back-and-forth responsiveness to be balanced. They were not looking for equal amounts of recognition and guidance, or for the oncologist to combine recognition and guidance in a single sentence. Rather, participants described the back-and-forth process as a way for the oncologist to tailor her responses to an individual patient.

Although these data on oncologist responsiveness could not include the oncologists’ perspectives, when participants imagined themselves in the oncologist’s role they often emphasized responsiveness. In describing why he preferred a particular audio recording, one participant noted that the oncologist “was more cognizant of the human emotions and said ‘I’ve gotta deliver the message, but I’ve also got to get this person back on the road to recovery.’”

DISCUSSION

This study found that patients who had been treated for cancer and were still at risk for recurrence valued three aspects of oncologist communication when discussing cancer re-

Table 4. Responsiveness: illustrative quotes

Quotes illustrating the subject's "overall impression" of the conversation:

PPT: "Comforting, supporting, but to me, what would've been good [in addition] would be knowing where I'm gonna go. In that sense, they're supporting my emotions. You know, telling me the full story and getting me moving onto, 'Ok, this is where you're gonna go next.'" [8]

PPT: "I would want the doctor to have told me, 'I know it's news that you don't want to hear, but this is the reality.' Obviously the patient is going to react and you have to be empathetic to those reactions . . . but then be very, just be very straightforward and say, 'Ok, here are the things that we can do.'" [18]

PPT: "I think so. She [the doctor] sorta picked up on the cues, like she saw that [the patient] was very family oriented. . . . So she was able to gather a lot of background information, in a short period of time. So I felt like she was really concerned about the patient as a person. She wasn't just a number or, you know . . . So I like that. And the way that she did it, the patient didn't feel like she was being interviewed or something. She just really just kind of let the conversation flow." [22]

SP: "I've got to tell you doctor, I'm scared. I mean I'm really scared."

MD: "I can understand that. This is not what you were expecting to hear today."

SP: "No, but I mean, if it's now in my liver, it can be any place, right, I mean [voice trails off]."

MD: "From what we can see on the CT scan it's only in the liver. And there's not very much of it."

PPT: "This doctor needs to get sent back for re-training. . . . she's decided on the agenda and forgotten about involving the patient in it. The guy is paralyzed by fear and shock, and it's just not time to launch out into [the plan] without answering his questions in any real way and without giving him any sign of hope." [25]

Abbreviations: INT, study interviewer; MD, oncology fellow in the audio recording; PPT, study participant whose study code is identified in square brackets at the end of each quote; SP, standardized patient in the audio recording.



Figure 2. A patient-derived approach for discussing news of cancer recurrence. The figure describes an iterative process between recognition and guidance. Responsiveness is the capacity of the physician to move back and forth between recognition and guidance as the physician responds to a patient.

currence: recognition, guidance, and responsiveness. By recognition, we mean the ability of an oncologist to tune in to the gravity and emotional impact of the news, and participants commented on the need for recognition from the very beginning of the encounter. By guidance, we mean the ability of oncologists to provide a view of the steps needed to move forward for that particular patient, which might be concrete steps (e.g., "we need another test") or more abstract views of the future (e.g., "there are treatments worth trying"). By responsiveness, we mean the ability of an oncologist to recognize that in one moment the patient needs recognition and in the next moment the patient needs guidance—and the oncologist can move back and forth between recognition and guidance throughout the visit rather than following a standard "script."

How should these findings change the way that oncologists communicate news of cancer recurrence? The commentary from our study participants shifts the emphasis in discussing bad news from the act of disclosure toward rec-

ognizing patient responses and discussing what to do next. For oncologists who have mastered giving the news clearly and at a level the patient understands, these findings point to another level of expertise that goes beyond existing approaches [16, 27–29]. First, oncologists should watch for emotion even from the very beginning of the encounter and may need to begin by acknowledging the emotion in a way that does not delay the news (e.g., "I can see you have been worrying, so let's talk about the tests first."). Second, oncologists should realize that a spending a moment acknowledging an emotion by showing understanding of the patient's perspective is valued very highly by patients, and patients do not expect (or even want) the oncologist to completely share their emotion (e.g., "This is a lot to take in, I realize, so take your time and then we'll go on."). Third, oncologists should consider guidance to be a communication function that is distinct from acknowledging emotion. Guidance involves taking initiative proactively in the conversation and offering frames to think about the way forward; recognition involves seeing the patient's emotions and responding to whatever emotions occur even if the emotions seem irrational. If the oncologist tries to address emotions by talking about what to do next (i.e., moving too quickly from recognition to guidance), patients may feel rushed through the news and muddled about what to do next because they have not absorbed the information. Finally, oncologists should realize that the way they frame cancer recurrence is critical to patients. For example, the use of the word "unfortunately" was universally disliked by our sub-

jects, who saw this as negative framing. Although we did not ask specifically about alternatives, it seems likely that more neutral framing (e.g., “I have something serious to discuss.”) would have been more acceptable.

A practical way of summarizing our findings is in two questions suggested by our themes that oncologists can ask themselves (silently) during a discussion about cancer recurrence. The two questions are: (a) “Have I demonstrated that I recognize the patient’s experience of their situation?” and (b) “Have I provided guidance to the next steps?” Although stepwise approaches will undoubtedly remain useful for teaching beginners, these questions may be useful as communication expertise develops.

The strengths of this study lie in the in-depth qualitative analysis of a novel dataset from a patient population representing the exact clinical situation of persons at risk for a conversation about cancer recurrence. The use of audio recordings involving oncologists other than the participant’s own oncologist reduced social desirability effects that might have limited participants’ willingness to critique their own oncologist. Because the audio recordings included both pre- and post-training encounters, participants were commenting on untrained and Oncotalk-trained communication behavior.

The design of this study places some limitations on the generalizability of the findings. First, the oncologists in the audio recordings were oncology fellows, in their fifth or sixth postgraduate year, so they had substantial clinical experience giving serious news and may have mastered certain basic skills (such as introducing oneself) that were not commented upon. Second, the fellows were taught SPIKES for giving serious news, and this influenced their behavior in post-retreat encounters, at least as assessed by content-based coding [17]. Third, our participants could not observe non-verbal aspects of the oncologist’s communication; but it seems unlikely that such access would invalidate our findings.

Our findings triangulate with studies from other disciplines, which strengthens their importance. Our concept of recognition echoes findings from experimental psychological studies of perspective taking that indicate that the most accurate empathy occurs when a person relies not on simply how he imagines *he* would feel in a particular situation but instead tries to build a separate picture of the other person [27, 28]. Our concept of guidance echoes findings from the expertise literature, indicating that a hallmark of professional expertise is the ability to apply a body of knowledge to an individual situation [29]. Finally, our concept of responsiveness echoes findings from studies describing “flow” in conversations [30], and descriptions of clinician mindfulness [31]. Finally, a recent survey of patients receiving news of cancer indicates that many did not receive much information about a plan and concluded that providing a plan was an important part of giving serious news [32].

In conclusion, this study adds to the empirical evidence base about how oncologists should discuss news of cancer recurrence and identifies recognition, guidance, and responsiveness as patient-centered qualities of communication in this situation. Future studies could validate these findings in larger or different groups of patients, and use these findings to improve how oncologists are trained to discuss serious news.

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