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Oncologist patient-centered communication with patients with advanced cancer: Exploring whether race or socioeconomic status matter

Kathryn I Pollak,

Duke Comprehensive Cancer Center, Cancer Prevention, Detection and Control Research Program, USA; Department of Community and Family Medicine, Duke University Medical Center, USA

Stewart C Alexander,

Department of Medicine, Duke University Medical Center, USA; Center for Palliative Care, Duke University Medical Center, USA; Center for Health Services Research, Durham VA Medical Center, USA

Steven C Grambow, and

Center for Health Services Research, Durham VA Medical Center, USA; Department of Biostatistics and Bioinformatics, Duke University Medical Center, USA

James A Tulsky

Duke Comprehensive Cancer Center, Cancer Prevention, Detection and Control Research Program, USA; Department of Medicine, Duke University Medical Center, USA; Center for Palliative Care, Duke University Medical Center, USA; Center for Health Services Research, Durham VA Medical Center, USA

Sir – High-quality care for patients with advanced cancer relies on effective, patient-centered communication between oncologists and their patients.¹ Ideally all patients should experience such communication with their oncologists; however, research suggests that race and socioeconomic status (SES) may affect whether providers use a patient-centered approach.^{2,3} These differences in communication may contribute to health disparities. We examined if race and SES influence patient-centered communication among patients with advanced cancer.

Methods

This report presents a sub-analysis from the Studying Communication in Oncologist–Patient Encounters (SCOPE) trial. Details of the complete study are reported elsewhere.⁴

Recruitment

We limited the sample to 24 White oncologists who provided consent and completed a baseline survey, and then identified patients whom they ‘would not be surprised if they died within 1 year’. We did not convey this information to patients but did send them a letter describing the study and requesting participation. We then called asking to meet them at their appointment.

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Corresponding author: Kathryn I Pollak, Duke Comprehensive Cancer Center, Cancer Prevention, Detection and Control Research Program, 2424 Erwin Road, Suite 602, Durham, NC 27705, USA. kathryn.pollak@duke.edu.

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Measures

Audio recordings—At the selected visit, we placed digital recorders unobtrusively in the examination rooms before the oncologists entered. This protocol was approved by the Duke University Medical Center Institutional Review Board.

Two independent coders coded patient-centered communication using the Measure of Patient-Centered Communication.⁵ This instrument comprises three components: (i) exploring the disease and illness experience; (ii) understanding the whole person; and (iii) finding common ground (Table 1). One-quarter of the conversations were double coded. Disagreements were resolved by consensus. Inter-rater reliability for ‘exploring the disease and illness experience’ was moderate ($\kappa=0.43$); reliability for ‘understanding the whole person’ was high ($\kappa=0.66$). We attempted to code ‘finding common ground’, yet despite extensive coder training, the coding system was too vague to achieve reliability.

Demographics, health, and visit characteristics—Before their visit, patients reported their gender, age, race (White or African American), marital status, education (>high school (HS) versus not), and economic security. Economic security was assessed by ‘without giving exact dollars, how would you describe your household’s financial situation right now?’ Higher economic security included ‘after paying the bills, you still have enough money for special things that you want’, or ‘you have enough money to pay the bills, but little spare money to buy extra or special things’. Lower economic security included ‘you have money to pay the bills, but only because you have cut back on things’, or ‘you are having difficulty paying the bills, no matter what you do’.

Results

Most oncologists were male (71%) and were medical oncologists (88%); mean age was 43 years ($SD=7$). Oncologists explored patients’ illness experiences (IE) by a low to moderate amount, but more often they expressed understanding of the whole person (WP) (IE: mean=3.5, $SD=0.9$; WP: mean=2.2, $SD=0.9$).

With regard to oncologist exploration of IE, we found no difference between White or African American patients (mean (SD)), (3.5 (0.7) versus 3.4 (1.3) $p=0.72$) or between those with or without higher education (>HS versus HS) (3.4 (0.7) versus 3.6 (1.3) $p=0.54$), but did see a difference in patients of varying economic security (lower versus higher) (2.9 (1.3) versus 3.6 (0.7) $p=0.03$). We found no differences in oncologists’ responses to WP concerns.

Discussion

This analysis found that oncologists were relatively patient-centered in their responses when patients talked about their illness, yet were less responsive to patients’ expression of whole person matters. Furthermore, oncologists responded differently to patients based on their level of economic security but not based on race. That oncologists had moderate levels of patient-centered communication exploring IE is encouraging. However, they were less likely to provide a patient-centered response when patient concerns were personal rather than medical. This is not surprising given oncologists’ tendency to be more comfortable with technical rather than social aspects of care.⁶

When patients with lower economic security expressed illness experiences, oncologists were less responsive than they were with patients with higher security. It is possible that oncologists in this study perceived patients with a lower economic security to be less likely to be able to afford various treatment options (e.g. medications, chemotherapy, etc.) or were

less likely to adhere to recommendations;⁷ therefore, oncologists were less responsive to patients' expressions of their illness.

Patient-centered communication, although important, may not occur equally for all patients. Oncologists may inadvertently be less responsive to patients with lower economic security when patients discuss their illness. Education for physicians about these subtle biases could improve care for patients from lower socioeconomic strata. Patients could also be empowered to communicate with their oncologists more effectively to make their visits more patient-centered.

Acknowledgments

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Table 1

Definitions and examples of oncologist responses to patient expressions of illness

Physician response	Definition	Example
Cut-off	MD response that ends the patient's expression of illness.	PT: 'I am having a lot of fatigue lately'. MD: 'So let's set up a time to meet in a few weeks'.
Preliminary exploration	MD minimally acknowledges the patient's expression but does not explore it.	PT: 'The mouth sores are really bothering me lately'. MD: 'Okay'.
Further exploration	MD attempts to learn more about the patient's expression	PT: 'These mouth sores are really making it hard to eat'. MD: 'What sorts of things have you been doing to remedy that?'
Return	MD returns to a previously cut-off patient's expression	MD: 'You mentioned earlier you were having mouth sores. What sorts of things have you been doing to remedy that?'
Validation/treat	MD offers some type of medical intervention to remedy the problem	PT: 'This pain is really bad lately'. MD: 'I can see how that would be really upsetting to you'. Treat PT: 'The pain has really been bad lately'. MD: 'We should go ahead and adjust the dose for your morphine'.

MD: physician; PT: patient.