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Communication about symptoms and quality of life issues in patients with cancer: Provider perceptions

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Abstract

This study used qualitative data collection and analysis methods to describe provider perceptions of addressing patient-initiated communication about common or sensitive symptom and quality of life issues (SQIs) in oncology. Eligible participants were healthcare providers who had participated in a larger trial testing a patient-centered technology to assess cancer SQIs and support self care. Audio-recorded vignettes were simulated based on recorded clinic visits from the larger trial and presented during semi-structured cognitive interviews with each participant. Transcripts of the interviews were content analyzed. Twelve providers participated. Participants' responses included four themes: the institutional and clinical context, the complexity of addressing SQIs, strategies used to understand SQIs, and creating a plan to address SQIs. Participants felt that approaching SQIs inside and outside of the clinic required ongoing communication within a multidisciplinary team both to gather information and manage the SQI. Forming a relationship with the patient was one strategy to facilitate assessing SQIs. Most participants expressed a need for guidance about effective SQI communication. Providers perceived approaching SQIs as a routine part of interdisciplinary clinical care. The specific symptom and the complexity of its management influenced the process of assessing and managing SQIs. Findings have implications for institutional processes, training, evaluation, and program development.

Introduction

It is estimated that 1,665,540 people will be diagnosed with one of over 200 different types of cancer in 2014 [1]. Each cancer and its treatment have side effects and are associated with symptom and quality of life issues (SQIs). In order to best support patients living with cancer and cancer treatment, effective communication between patient and provider regarding SQIs is essential to promote quality cancer care and optimal health[2].

Quality communication can indirectly lead to improved health outcomes by increasing adherence to health recommendations and access to treatment [3, 4]. Healthcare providers

have the responsibility to listen to patient reports of symptoms, side effects, quality of life, or other concerns and then intervene to maximize the efficacy and safety of therapy to improve patient outcomes[5]. This process can be challenging as patients may not be poised with the knowledge and ability to effectively communicate SQIs, and providers may not have the resources to identify and address important issues. In oncology care, the importance of mastering this communication process is heightened due to the wide range of symptomatology associated with cancer and its treatment, as well as the influence these symptoms can have on quality of life and treatment outcomes.

In order to address this concern, Berry and colleagues [6, 7] developed and tested the Electronic Self Report Assessment-Cancer (ESRA-C II) from 2009–2011[7]. The web-based program queries patients on SQIs, provides a graphical summary report to providers, and instructs patients on self-care and communication strategies. The ESRA-C was shown to be efficacious in enhancing patient-provider discussion of SQIs [6] and lowering symptom distress [7] while patients were in active cancer therapy. The main objective of the trial was to understand patient outcomes related to the ESRA-C intervention.

This study reports findings from a secondary aim of the ESRA-C II trial. Provider participants at Dana-Farber Cancer Institute (DFCI), an ambulatory cancer center, were invited to give feedback on exemplar SQI discussions abstracted from audio recorded clinic visits collected during the larger trial. The purpose was to describe providers' perceptions of communication about specific common or sensitive SQIs. The specific aims were to: 1) understand the process by which providers responded to patient SQI reports; 2) describe strategies providers used to address SQIs; and 3) explore perceived potential barriers and facilitators to communication about SQIs.

Method

Study design

This cross-sectional, descriptive study used qualitative data collection and analytic methods. The design was guided by Social Information-Processing theory, a dynamic model of cognitive processes that describes how an individual formulates a response to data based on cues, interprets cues, analyzes social or contextual factors, and develops goals for a response in a social interaction[8, 9]. Originally developed to be used in understanding cognitive processes in children, the concepts of this model are applicable to health communication as an overall model to depict how an individual responds to a social situation[8]. This theory delineates variables that influence information processing outcomes and has been applied in research settings focused on nurses responses to the emotional expressions of patients with cancer [10].

Participants

Approval was obtained from the Dana-Farber Institutional Review Board prior to initiating study recruitment. Eligible participants were DFCI medical doctors and nurse practitioners who participated in the parent study. Participants were recruited from both staff meetings and through institute email and asked to respond if interested in participating.

Procedures

Audio-recorded vignettes were created by simulated patients and providers, using verbatim transcripts from actual recorded clinic visits from the ESRA-C II trial. The topics for the vignettes were three common or sensitive SQIs: cancer-related fatigue, fear/worry, and sexual activities and interests. Fatigue was chosen as a commonly reported SQI by patients in the parent trial and the remaining two SQIs (fear/worry and sexuality) were chosen because each was frequently self-reported by patients in the ESRA-C II trial, yet infrequently discussed with providers [6]. Each simulated vignette was less than two minutes long. The purpose of these vignettes was to provoke conversation and cognitive processing in the participants about their own practice and communication strategies.

One-time, semi-structured individual interviews (see Table 1) were conducted and lasted up to 45 minutes. Participant demographic information was collected at the time of the interview. The interview was guided by a *think aloud* cognitive interviewing method [11–13] in order to understand the cognitive processes occurring while listening to and considering the three vignettes [11, 12, 14]. Prior to beginning each interview, participants were oriented to the process of think aloud interviewing and the purpose of the study [10]. Each participant listened to the vignette and then was encouraged to share thoughts and impressions throughout the interview and how they approach similar situations within their own clinical practice [10, 11]. The recordings were played in small segments to allow the participant to respond to each component of the conversation. The interviewer, trained in qualitative research and interview methods, responded to verbal and non-verbal cues from the participant and prompted more in-depth discussion. At the completion of each interview, participants were asked to reflect on their own clinical experiences with communication about SQIs [10, 12].

Data analysis

All data were transcribed verbatim and de-identified for analysis. The researchers used content analysis [15] to identify patterns, consistencies and differences throughout the interviews as a whole [13, 15]. NVivo 9 software (QSR International (Americas) Inc., Burlington, MA) was used for data management and analysis. Verification of results occurred through comparison to existing literature, the guiding theory, expert team consensus, and through a member check [13]. Participants were emailed a summary of the themes and Figure 1 (described in the results) and were then able to provide written comment on the brief summary of the findings.

Results

Demographic Characteristics

Of the 96 potential participants contacted by email or during staff meetings, 17 responded to the recruitment contacts. Of those, 7 medical doctors and 5 nurse practitioners consented to participate. Eight participants were female and 4 were male. Most participants were Caucasian (n=10) and worked within medical oncology (n=10). Years of oncology experience reported ranged from 3–23 years with a median of 10 years. Demographic data is not available for those clinicians who did not participate in the study.

Overview

Analysis of participant responses to the vignettes resulted in themes and processes relevant to approaching the three specific SQIs and patient-reported information in general. Table 2 summarizes the themes, sub-themes, and exemplar quotations. Four participants responded to the request for a *member check* [ref] of the results and each verified agreement with the summary of findings.

Theme 1: Institutional and clinical context

Patient expectations—The context of the clinical practice was perceived as an important factor that influenced the needs of patients and the approach of the provider. Since the needs and expectations of patients were formed even before cancer care begins, they were considered to add multiple layers of complexity which created formed even before cancer care begins, they were considered to add multiple layers of complexity which created difficulty when the provider began assessing and analyzing the SQIs.

Physical environment—The institutional context theme included available support and resources within the cancer center, the structure of staffing and scheduling provider time, and the physical environment. Lighting and window placement were described as components of the physical environment that influenced both communication and physical assessment. Having access to interdisciplinary colleagues and institutional resources were viewed as facilitators to communication. Competing time demands of priorities outside of patient care throughout the institute were often described as challenging, precluding a comprehensive assessment of SQIs.

Disease-specific factors—The specific clinical context influenced disease-specific priorities and common symptoms, factors that focused the communication during the visit. For example, issues with sexual activity were perceived as being addressed directly in the prostate cancer specialty clinic rather than through referral, because these issues were more clinically relevant and described as a priority. Participants talked about being “in the context” of the patient’s specific disease and prioritizing SQI communication based on the patient’s needs.

The specific clinic flow and nature of the disease impacted how providers approached SQIs. Participants could only have seen the patient at one time point (second opinion) or could have had weekly visits (radiation therapy). Therefore, the participants had varying levels of communication priorities and needs based on the frequency with which the patient was seen.

Theme 2: Complexity of assessing and managing SQIs

Symptom specific factors—For each symptom, participants described a level of complexity. Participants discussed a difference between “tangible” and “intangible” symptoms. It was perceived to be more challenging to manage symptoms that were not directly observed, measured or “quantified” or were difficult for patients to define. This challenge was commonly described when discussing the SQIs sexual activity or fear/worry. The complexity of approaching an SQI also was judged by the availability of clinical treatments to help the patient. Providers expressed frustration in recognizing a symptom as a

problem for the patient, but not having readily available tools or resources to address and “fix” the concern.

The symptom of fatigue was considered a “tough nut to crack.” Fatigue was considered a common symptom and yet complex and difficult to assess and manage by both physician and nurse participants, and it was the symptom that generated the most discussion within the interviews. Even so, in comparison to sexual activity/interest or fear/worry, participants reported feeling more comfortable managing fatigue themselves in the clinic instead of referring to other institutional resources.

Comfort and experience discussing SQIs—All participants reported that SQIs were viewed as complex depending on the provider’s comfort or experience with the symptom: the less experience, the more complex. Overall, most participants felt comfortable talking with patients about fatigue and fear/worry. However, one participant stated that discussing fear/worry was not a “strength” and that (s)he did not discuss the symptom with the patient in depth, instead typically referred the patient to a social worker. The sexual activity and interest vignette elicited the most discussion about participant comfort or experience. Participants described comfort with talking about sexuality, but not routinely initiating the topic and addressing it only when the patient starts the conversation.

Participants talked about the length of their experience in clinical care as helping to build a “repertoire,” self-identify communication strengths, and develop approaches to difficult conversations. Based on the clinic setting, specific SQIs were “expected” to be discussed, and this expectation provided entry into discussing the symptom. For example, discussing sexual activity was more common in a genitourinary cancers clinic. For providers in other clinics where such issues are not as prevalent, the discussion of sexual activity/interest was considered challenging, as the clinical priority was often medical issues and not the symptom experience.

Theme 3: Strategies to assess and manage SQIs

Building a relationship—The patient-provider relationship informed both communication strategies and the prioritization process used by the participant to approach SQIs. The relationship allowed the provider to understand the information reported by the patient and, depending on the clinical setting, get to know the patient over time. Additionally, having this relationship allowed for future conversations about SQIs to occur.

Knowing the patient provided insight into the patient’s goals and was also linked to tailoring communication strategies for the individual patient. This relationship influenced how symptoms were assessed and prioritized within the visit. For example, a new or more severe symptom experience became the priority for the provider given the familiarity with a patient that had developed over time. Additionally, having a relationship allowed the participant to feel “more comfortable” treating symptoms, especially those that were more sensitive in nature such as sexuality.

Gathering information—Face-to-face verbal patient report was the main source of information described by participants. The provider interpreted patient cues by listening to

their choice of words, cadence of speech, appearance, body language and other nonverbal sources of communication to “read between the lines” and obtain information. Participants described synthesizing other sources of information beyond patient report, including a review of the medical record, laboratory data, and information provided by family and other members of the patients’ care team. The participant would assess the consistency of the verbal, nonverbal and clinical messages.

The relationship between the patient and provider facilitated gathering information. For example, one participant described knowing a patient and his/her hobbies and, during the conversation, assessed the patient’s general mood or energy level by discussing engagement in the hobbies. This method of gathering information was common to many participants, but was described as a “non-quantifiable way” and challenging to document or report. One participant described surveying patients about symptoms prior to clinic as a strategy to gain access to information. Others described patient report summaries, such as those presented in the parent ESRA-C II study, as helpful in gaining information about the patient’s symptom experiences.

Communicating within and outside of the clinic—Multiple strategies to facilitate communication about SQIs were described by the participants. One strategy was “play[ing] the part” by tailoring the communication style based on the patient needs and priorities for the visit. Another participant described bringing up more sensitive symptoms, such as sexual activity, during the physical exam as entry into discussion and assessment. Being empathetic was described as an important communication strategy discussed by all participants. Empathy was described as validating the patients’ concerns, reassuring patients that symptoms were common and showing concern about expressed worries. Part of this process was “expectation management,” or helping patients verbalize their needs and set goals about what to expect during their treatment.

Participants used a multimodal approach to communicate with the patients about SQIs. In addition to ambulatory clinic visits, some participants described using email and telephone calls to follow up and facilitate ongoing discussion about SQIs or to identify new problems. Telephone was the main method for patients to contact the oncology team outside of the clinic. Specifically, providers described the benefit of having a dedicated nurse to take the calls. Telephone communication raised challenges such as the timeliness of a response. Email communication was another way some providers were able to communicate quickly and efficiently with their patients. Email allowed for a written documentation of the recommendation to the patient. Not all providers reported comfort with email. Those who used email to communicate with patients stated that there were billing and documentation challenges with this method.

Theme 4: Creating an action plan

Participants described creating an “action plan” to respond to the patient reports of SQIs. The providers used action-based strategies including referring to other health professionals, starting medical treatment, and providing resources. Notably, participants approached SQIs based on what the patient prioritized as being the most important symptom, a strategy that

focused the outcomes and plan of a visit. Both medical and patient reported needs were weighed and prioritized to focus the response within the visit and time requirements. This was related to the patient-provider relationship, as one participant described that when a relationship was already established with the patient before discussing the difficult symptom, communicating about and treating a symptom felt more comfortable.

Sometimes the action would be to use empathic behaviors such as listening and allowing the patient “to be heard.” Therapeutic communication strategies such as validating and addressing patient concerns were described by one participant as “lightening the burden” for the patient. Interventions that were not “tangible,” such as listening and communicating, were challenging to quantify and document as strategic action and yet, these interventions were felt to be important responses to SQIs.

Inter-professional relationships within multidisciplinary teams facilitated assessment, treatment and referral for SQIs. A multidisciplinary team included medicine, nursing, psychology, nutrition, rehabilitation, social work, and/or pastoral and spiritual care. These relationships allowed providers to learn more about patients and/or have patients cared for by experts in particular SQIs. Team communication via email, telephone, and face-to-face encounters were considered important ways to share the needs of the patient with other providers and facilitate continuity of care.

Summary

Participants in this study described the process used to approach communication about common and sensitive SQIs within ambulatory oncology care. This process included gathering information by listening to the patient and assessing patient cues. These cues and patient reports were interpreted through the lens of a specific institutional and clinical context and based on the expected outcome of addressing the SQI. Participants gathered information from multiple data sources, including historical experience with the symptom, team members and family members. Relevant data, including patient reported data, scientific data about how to manage a symptom, and data related to available institutional resources, were applied to formulating a response to the patient report and cues. A decision was then made about how to respond, and that response was communicated as an action plan to the participant. How this response was communicated to the patient varied by clinic and institution specific factors, such as length of time with the patient and expectations for follow up. The four themes that resulted are cogent to the Social Information Processing model [8]. Figure 1 shows an adapted model including the study results. Here we see healthcare communication complexity as it relates to how the health care provider takes into account multiple sources of data, interprets those data based on the patient-provider and institutional context, and then creates a response and communicates that response, which is influenced by both the provider’s level of comfort with the symptoms and available resources. Results from this study add to the theory of Social Information and Processing by providing context to providers’ movement through the process of responding to SQIs.

The complexity of approaching SQIs was a theme related to all stages of the providers’ process. For the specific SQIs in the study vignettes, participants approached patients concerns both inside and outside of the clinic. Given this complexity, providers needed to

have ongoing communication within a multidisciplinary team. The participants' comfort with discussing sensitive symptoms played a role in how the participant perceived approaching SQIs. Forming a relationship with the patient was one strategy within this process that facilitated approaching SQIs. Most participants expressed a need for guidance, support, and education in approaching SQIs within the clinic. This was discussed despite the years of experience or training of the provider. Additionally, a number of participants reported that self, peer, and patient evaluation of communication skills would be important opportunities to improve this process.

Discussion

This study engaged healthcare providers in an open discussion about practical experiences communicating about SQIs in ambulatory cancer care. The provider participants discussed a number of practical strategies adopted in practice to communicate about SQIs. These included showing empathy, getting to know the patient, incorporating remote methods of communication; discussing with, and referring to, multidisciplinary colleagues; and assessing patients' symptoms prior to the clinic visit.

The findings indicate that many factors, both provider and health care system, are involved in communicating about SQIs. Perceived barriers (time, clinical priorities, and clinical flow) and facilitators (access to multidisciplinary colleagues, establishing a relationship, communicating outside of the clinic) all influenced the communication process and content. These typical barriers and facilitators to clinical care described by the provider participants occurred at the patient and health care provider level, clinical level, institutional level, and the health care system level. At each level, assessment and management of SQIs was influenced by perceived complexity of the symptom. In an analysis of audio-recorded patient-provider visits in oncology, Sheldon et al. (2010) reported that out of 31 audio-recorded clinical visits, though 57% of patient reports of distress were acknowledged by clinicians, only 22% were addressed. Our findings may help illuminate some of the reasons why certain symptoms may not be discussed by providers[16] and also indicate where efforts should focus to facilitate this communication.

Provider experience and comfort with a particular symptom were considered facilitators when present and barriers when absent. The impact of treatment of disease on sexual activity and interest was one area that a majority of provider participants found challenging to discuss because of comfort level and experience. When providers were unsure about evidence-based interventions for managing a particular symptom, they were less likely to enter a conversation about the symptom. Lindau and colleagues (2011) reported similar findings after interviewing couples and care providers regarding intimacy and sexuality communication within the context of lung cancer [17]. Though the topics were found to be relevant, discussion was noted as infrequent by the couples and the providers. Similar to our findings, lack of provider expertise was identified as one explanation for infrequent discussion.

Complexity was a thread throughout the themes of this analysis. Other authors [18, 19] have posited that the complexity of health care systems and institutions require different

approaches to improving health outcomes than the currently utilized approaches of the past. Professional societies and regulatory or accrediting bodies have addressed complexity by promoting or requiring standard practices. For example, screening for psychosocial distress will be a required standard for certification of cancer programs in the United States by the American College of Surgeons, Commission on Cancer[20]. Further, evidence-based clinical pathways, e.g., cancer pain and fatigue [18] management pathways developed by single institutions, have the potential for removing some complexity from an individual clinician's process for adequately addressing SQI in cancer care.

Provider participants in this study called for evaluations of communication processes and for opportunities to improve the process of assessing and managing SQIs arising during cancer care. These evaluations need multiple perspectives including self reflection, peer evaluation, and patient assessment of communication processes. There are a variety of recent publications citing the importance of provider communication training to promote patient-centered care [21]. A recent Cochrane Collaboration review [22] identified forty-three randomized trials that focused on training providers in patient-centered care. Educational interventions were found to be effective in improving patient-centered communication skills in providers. Careful evaluation of communication training approaches during active anti-cancer therapy in all stages is warranted in order to improve SQI management.

As health care, especially oncology care, develops patients will be required to be more active participants in care. Patient-provider communication will increasingly include other forms of communication outside of scheduled clinic visits. Use of the Internet, email, and telephone for follow up are communication mechanisms that will need to be considered in future institutional policy and procedures [23]. Electronic communication may be a feasible way to respond to patient needs in a timely manner [24]. Multiple investigators [7, 25–28] have established feasible methods for remote cancer SQI reporting. Understanding the key components and process with which providers consider and act (or do not act) on common or sensitive SQIs adds to our knowledge of how interventions, such as ESRA-C, can contribute to both improving communication and developing theory aimed to better understand, assess, and communicate about the symptom experience.

Limitations

Data were obtained from providers primarily in medical oncology at a single site, and results cannot be generalized to dissimilar sites and participants. Exploring provider experiences in other settings is warranted. Additionally, the description reflects the experience of participants who volunteered to participate and therefore may not reflect the views of all clinicians. It is likely that providers who care about communication participated in this study, and obtaining the perspectives of others would be important for future research. Vignettes were limited to three patient-reported SQIs, and responses may have differed with other symptoms.

Conclusion

Providers perceived addressing SQIs as a routine part of interdisciplinary, ambulatory clinical cancer care. During interviews, providers described processes and strategies for

responding to three common or sensitive SQIs, sexual interest and activity, fear and worry, and cancer-related fatigue. The providers revealed perceived barriers and facilitators to addressing these SQIs. The major themes identified were institutional context, SQI complexity, constructing strategies to address SQI, and acting on those strategies. The type of symptom and management complexity influenced how providers assessed and managed the SQI. Provider participants wanted to maximize their ability to communicate about SQIs both within and outside of the clinic. These participants sought additional training for specific skills to address SQIs with efficient and effective strategies, including discussion, treatment and referral to colleagues for significant SQIs. This was especially true for those symptoms for which participants said they lacked training. This work adds to the Social Information Processing model by providing an in-depth, clinically-derived description of each concept within the model, which could help guide interventions to both improve SQI communication and target the training interventions desired by the participants.

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Figure 1.

Adaptation of the social information processing model to the communication process of oncology providers responding to SQI*

* Adapted from Crick & Dodge (1994) and Sheldon & Ellington (2008)

Table 1**Cognitive Interview Guide Questions and Prompts***

Semi-structured interview questions	Prompts
What are your immediate thoughts about what you hear?	<ul style="list-style-type: none"> How is this discussion similar or different to how you would discuss this SQI?
What is the role of patient reported SQIs in your own clinical practice?	<ul style="list-style-type: none"> How do you decide what your goals will be during the face to face interaction? How do you determine your response to a patient report of the SQI? How confident do you feel when responding to patient initiated SQI reports? What role do others play in your response? (example: family, nurse, clinic assistant) Do you have any suggestions to help improve how SQIs are addressed in your clinical practice?
Where do you get information about patient SQIs?	<ul style="list-style-type: none"> What helps you address symptom and quality of life issues? What hinders you from addressing symptom and quality of life issues?
Are there any other thoughts that you have about patient and provider communication regarding symptoms and quality of life that have not yet been addressed?	

* adapted from Sheldon & Ellington (2008) and Crick & Dodge (1994)

Table 2

Themes, number of coded sections, number of interviews, descriptions and exemplar quotations

Theme	# of coded references / # of interviews *	Sub-themes	Exemplar quotations
Institutional & clinical context	62 / 8	Patient expectations Physical environment	<i>I mean again I think it's just time... You know there are a lot of logistical busywork things we have to do. And that invades into time that could be spent to talking to the patient about what they're going through...</i>
	62 / 7	Clinic specific factors	<i>A lot, you know what I find here [specific clinic] is it's not like it is elsewhere [other clinics], like you can often get a lot done in a day, but on that same level on a busy day when someone comes in that needs all of that and infusion is full then you kind of find yourself in this conundrum where they're not really sick enough to go to the emergency room. I don't necessarily want to admit them, but they live eight hours away...</i>
Complexity of approaching SQIs	55 / 9	Symptom specific factors	<i>... the very difficult symptom conversations are when there are symptoms that are bothersome to a patient that we can't do very much about and that the benefits they're getting from the treatment far outweigh the symptom in our mind, but maybe not in the patient's mind.</i>
	55 / 9	Provider comfort & experience approaching each specific symptom	<i>I don't know how comfortable patients are um talking about it (sexuality). Some are and they openly ask is it okay to have sex during chemotherapy ... So some bring it up and I think it's the vast minority who talk about it. And to be honest I probably am not comfortable just bringing it up either.</i>
Strategies to approach SQIs	202 / 11	Building a relationship	<i>Well...the first time you meet somebody...you don't really do anything, except maybe kind of just really tune in to what they're saying and listen. I don't know if you actually have to do something other than that at that point because you've got to get them to trust you before they can sort of, you know, divulge more about what they're feeling.</i>
	202 / 6	Communicating outside of the clinic	<i>I would say, you know, on any given day my other colleague and I have anywhere between like 15 and 25 messages from people. So we really do use that as a good way to chat with people and, you know, kind of just have a better sense of their overall being on days they're not actually here.</i>
	202 / 12	Gathering information	<i>If he (the patient) had children, I would say when your kids, you know, are around, do you tend to kind of want to interact with them a little bit more just to get a sense of interest or pleasure or any kind of activities that would make me think if this person has a depression or a demoralization or something else beyond the physical tiredness. If he said to me, you know, the Super Bowl's coming on, I'm staying up for that. I made it through the first quarter just fine, second quarter I was a little bit tired, but by the fourth I couldn't stay up, but, you know, that tells me a little bit something different than, you know—</i>
Creating a plan	86 / 6	Medical treatment	<i>I fix what I can fix from a medical standpoint.</i>
	88 / 11	Incorporating multidisciplinary team	<i>If things aren't brought up that I missed or they (the patient) felt more comfortable bringing up with their infusion nurse the nurse will contact me. You know so there are several layers. And then some of them may have a nutritionist who works with them. Some of them visit the social workers. So we do provide those multiple layers... we're trying to elicit a lot of these things so we make sure we're not missing some.</i>
	88 / 7	Giving resources	<i>So we also have little cards that I think we should all have in our exam rooms... It has all different kind of with psycho oncology, palliative care; Integrative therapies Center...and I oftentimes will check it off almost like a prescription.</i>

* Coded references are the number of times each theme was coded in the transcripts