How oncologists’ communication impacts patients’ information recall and emotional stress

A video-vignettes approach

Visser, N.C.

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Patients’ and oncologists’ views on how oncologists may best address patients’ emotions during consultations: an interview study

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Visser LNC, Schepers S, Tollenaar MS, de Haes JCJM, Smets EMA. Patients’ and oncologists’ views on how oncologists may best address patients’ emotions during consultations: an interview study.
ABSTRACT

Objectives
This qualitative study examines patients’ and oncologists’ views on how to best address emotions during consultations, and explores oncologists’ opinions on their own communication and on strategies to improve oncologists’ response to patients’ emotions.

Methods
Semi-structured interviews were conducted with 16 cancer patients and 13 oncologists, after watching videotaped consultations illustrating three communication strategies for addressing emotions.

Results
Most participants preferred emotion-oriented speech to address patients’ emotions; this strategy was assumed to (positively) affect a broad range of outcomes. Nevertheless, some preferred attentive silence or no emotion-oriented talk at all. Oncologists and patients had similar views on factors that may hinder oncologists to address emotions. Generally, oncologists mentioned that their response to emotions could be improved; for this, various (educational) strategies were suggested.

Conclusions
Patients and oncologists generally agree that patients’ emotions can best be addressed by empathic, explorative, acknowledging, and supportive statements. Still, oncologists need to attune their communication to the individual patient, as differences in preferences exist.

Practice implications
The findings can inform medical communication training and encourage oncologists to improve their communication. The regular videotaping of consultations might be a promising method to provide feedback and reflect, thereby improving oncologists’ response to patients’ emotions.
Chapter 8 | Patients’ and oncologists’ views on how oncologists may best address emotions

INTRODUCTION

Since emotions are inherent in most oncological consultations [1, 2], responding to patients’ emotions is considered part of high-quality oncological care [3, 4]. Not surprisingly, the impact of oncologists expressing emotional support and engagement with patients on patient outcomes has been the subject of several hypothesis-driven studies [5]. Our group recently investigated the differential impact of two emotion-oriented communication strategies, i.e. communication in response to patients’ negative emotional expressions with the intend to alleviate those emotions, on recall of medical information, and on emotional stress [6]. For this, we used videotaped scripted ‘bad news’ consultations in which the oncologist’s communication in response to a patient’s emotional expressions was varied across experimental conditions. The oncologist’s communication strategy comprised either: i) attentive silence (labeled as ‘emotion-oriented silence’), or ii) acknowledging, explorative, empathic, and supportive statements (labeled as ‘emotion-oriented speech’). Both these strategies were compared with ‘standard communication’ and were found to improve participants’ recognition of the information provided by the oncologist. However, no effects on free recall or emotional stress were found [6].

Remarkably, emotion-oriented silence and emotion-oriented speech improved participants’ recognition of information to the same extent. Therefore, one could argue that oncologists could adopt either one of these communication strategies, e.g. based on their own preference. However, differences were found in participants’ perceptions of the oncologist’s emotion-oriented communication behavior, i.e., emotion-oriented speech was perceived to be a more empathic, explorative, supportive, and acknowledging response than emotion-oriented silence. Moreover, emotion-oriented silence was not perceived differently than standard communication. These findings are important, as patients’ perceptions of their oncologist’s communication can be related to other outcomes. For example, perceived empathy has been associated with trust and compliance with recommendations [7]. Therefore, these additional findings might imply an advice in favor of emotion-oriented speech during oncological consultations. Nevertheless, as the participants in our earlier study were students, it is essential to introduce actual patients to these communication strategies and examine their perceptions. Moreover, although emotion-oriented speech is considered the most adequate response to patients’ emotions from a professional standpoint [1, 8, 9], some patients prefer another type of communicative approach [10]. For example, individuals with high trait anxiety were found to be less satisfied after consultations that involved a lot of emotional talk compared to individuals with low trait anxiety [10].

An in-depth qualitative examination of patients’ views could provide better understanding of whether and why some patients prefer one emotion-oriented approach to another. In addition, such an approach allows to explore the impact of oncologists’ emotion-oriented communication, from the perspective of both patients and oncologists, which can add to knowledge on relevant patient outcomes and the potential pathways leading to these outcomes [11].
Furthermore, oncologists are reported to respond adequately to only 22-35% of patients’ expressions of negative emotions (despite the high prevalence) [1, 2, 12]. Studies on barriers to effective communication by oncologists when addressing emotion-laden topics, such as the end of life [13], might provide insight into factors that hinder an adequate response to emotions. However, some barriers might be specific to addressing emotions. For example, oncologists may not always recognize their patients’ emotions [14] which, in turn, could be related to oncologists’ level of communication skills or to patients’ reluctance to express their emotions [15]. Interviewing both cancer patients and oncologists could improve insight into the factors specifically hindering oncologists to respond to their patients’ emotions. Moreover, it is important to examine how such barriers can be overcome to help oncologists deal with cancer patients’ emotions more frequently and/or more adequately.

This qualitative study examines cancer patients’ and oncologists’ views on emotion-oriented communication (specifically: emotion-oriented silence/speech), focusing on their perceptions and preferences, and opinions on outcomes and barriers. The study also examines oncologists’ evaluations of their own emotion-oriented communication performance and their perspectives on potentially successful ways to improve such communication in current practice.

METHODS

Design and ethics statement
In this qualitative study, participants were interviewed after watching three versions of a scripted videotaped ‘bad news’ consultation in which the oncologist’s communication behavior in response to a patient’s emotional expressions was varied. Supplement A illustrates the variations in scripts between the three videos: 1) standard communication: minimally responding to emotions; 2) emotion-oriented silence: responding with attentive silence to emotions; and 3) emotion-oriented speech: responding by providing empathic, explorative, acknowledging and supportive statements. These videos were previously developed in the context of our experimental study investigating the relationship between emotion-oriented communication and information recall [6]. The videos established a shared frame of reference across participants regarding the communication behavior of interest, and showed variations in that behavior in an otherwise standardized consultation.

The board of the Medical Ethical Committee of the Academic Medical Center (AMC; Amsterdam) approved this study (W16 053 # 16.068).
Chapter 8 | Patients’ and oncologists’ views on how oncologists may best address emotions

Sample

Purposive sampling was used to generate a heterogeneous sample of (former) cancer patients and oncologists, with regard to their gender, age and oncological experience (Tables 1, 2), and therefore rich and diverse data. Recently diagnosed patients (within < 5 years) were recruited via announcements on a healthcare communication research sample panel (www.panelcom.nl) and webpages of patient organizations. Medical oncologists, oncological surgeons and radiotherapists (hereafter, collectively referred to as ‘oncologists’) were recruited through snowball sampling. Sample sizes were based on data saturation: after interviewing 10 initial patients and oncologists, recruitment stopped when additional interviews provided no relevant new information.

To recruit 16 patients and 13 oncologists, 18 patients and 21 oncologists were provided with study information by email. Of those, one patient declined participation due to the anticipated burden and one was not available during working hours. Of the oncologists, six declined participation due to lack of time and two did not respond.

Table 1. Characteristics of the sample of (former) patients

<table>
<thead>
<tr>
<th>Patient ID no.</th>
<th>Gender</th>
<th>Age (years)</th>
<th>Educational level</th>
<th>Primary cancer diagnosis</th>
<th>Current status</th>
<th>Time since diagnosis (years months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>M</td>
<td>72</td>
<td>3</td>
<td>Lung &amp; urological</td>
<td>Check-ups after treatment</td>
<td>3 5</td>
</tr>
<tr>
<td>02</td>
<td>M</td>
<td>76</td>
<td>3</td>
<td>Urological</td>
<td>Only check-ups</td>
<td>4 2</td>
</tr>
<tr>
<td>03</td>
<td>F</td>
<td>50</td>
<td>1</td>
<td>Blood or Lymphatic</td>
<td>Check-ups after treatment</td>
<td>4 4</td>
</tr>
<tr>
<td>04</td>
<td>F</td>
<td>49</td>
<td>4</td>
<td>Breast</td>
<td>Check-ups after treatment</td>
<td>2 11</td>
</tr>
<tr>
<td>05</td>
<td>M</td>
<td>61</td>
<td>3</td>
<td>Urological</td>
<td>Treatment</td>
<td>3 9</td>
</tr>
<tr>
<td>06</td>
<td>M</td>
<td>65</td>
<td>3</td>
<td>Colon</td>
<td>Treatment</td>
<td>1 1</td>
</tr>
<tr>
<td>07</td>
<td>M</td>
<td>68</td>
<td>4</td>
<td>Lung</td>
<td>Treatment</td>
<td>3 5</td>
</tr>
<tr>
<td>08</td>
<td>M</td>
<td>58</td>
<td>4</td>
<td>Urological</td>
<td>Treatment</td>
<td>3 6</td>
</tr>
<tr>
<td>09</td>
<td>F</td>
<td>53</td>
<td>1</td>
<td>Gastric or Liver</td>
<td>Check-ups after treatment</td>
<td>3 0</td>
</tr>
<tr>
<td>10</td>
<td>M</td>
<td>69</td>
<td>2</td>
<td>Urological</td>
<td>Check-ups after treatment</td>
<td>2 6</td>
</tr>
<tr>
<td>11</td>
<td>F</td>
<td>44</td>
<td>3</td>
<td>Gynecological</td>
<td>Check-ups after treatment</td>
<td>2 4</td>
</tr>
<tr>
<td>12</td>
<td>M</td>
<td>25</td>
<td>3</td>
<td>Urological</td>
<td>Check-ups after treatment</td>
<td>4 8</td>
</tr>
<tr>
<td>13</td>
<td>M</td>
<td>72</td>
<td>4</td>
<td>Colon</td>
<td>Check-ups after treatment</td>
<td>4 10</td>
</tr>
<tr>
<td>14</td>
<td>F</td>
<td>43</td>
<td>2</td>
<td>Breast</td>
<td>Treatment</td>
<td>1 1</td>
</tr>
<tr>
<td>15</td>
<td>F</td>
<td>47</td>
<td>2</td>
<td>Gynecological</td>
<td>Check-ups after treatment</td>
<td>3 0</td>
</tr>
<tr>
<td>16</td>
<td>F</td>
<td>31</td>
<td>3</td>
<td>Gynecological</td>
<td>Check-ups after treatment</td>
<td>0 9</td>
</tr>
</tbody>
</table>

Notes: Educational level 1 = lower level vocational education, 2 = general secondary education, 3 = higher level vocational education, 4 = university degree.
Table 2. Characteristics of the sample of oncologists

<table>
<thead>
<tr>
<th>Oncologist ID no.</th>
<th>Gender</th>
<th>Professional experience (years)</th>
<th>Oncological specialty</th>
<th>Work setting</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>M.D.(^1) in oncology(^2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>01</td>
<td>F</td>
<td>≤ 15 ≤ 10</td>
<td>Medical oncologist</td>
<td>Academic hospital</td>
</tr>
<tr>
<td>02</td>
<td>M</td>
<td>&gt; 15 &gt; 10</td>
<td>Surgeon</td>
<td>General hospital</td>
</tr>
<tr>
<td>03</td>
<td>M</td>
<td>≤ 15 ≤ 10</td>
<td>Radiotherapist</td>
<td>Academic hospital</td>
</tr>
<tr>
<td>04</td>
<td>M</td>
<td>≤ 15 ≤ 10</td>
<td>Surgeon</td>
<td>Academic hospital</td>
</tr>
<tr>
<td>05</td>
<td>F</td>
<td>≤ 15 ≤ 10</td>
<td>Medical oncologist</td>
<td>General hospital</td>
</tr>
<tr>
<td>06</td>
<td>F</td>
<td>≤ 15 ≤ 10</td>
<td>Radiotherapist</td>
<td>Academic hospital</td>
</tr>
<tr>
<td>07</td>
<td>F</td>
<td>&gt; 15 &gt; 10</td>
<td>Medical oncologist</td>
<td>General hospital</td>
</tr>
<tr>
<td>08</td>
<td>M</td>
<td>&gt; 15 &gt; 10</td>
<td>Radiotherapist</td>
<td>Academic hospital</td>
</tr>
<tr>
<td>09</td>
<td>F</td>
<td>≤ 15 ≤ 10</td>
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<tr>
<td>10</td>
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<td>Radiotherapist</td>
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<td>Medical oncologist</td>
<td>Academic hospital</td>
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<td>13</td>
<td>F</td>
<td>≤ 15 ≤ 10</td>
<td>Medical oncologist</td>
<td>Academic hospital</td>
</tr>
</tbody>
</table>

Notes. Age was not included as a characteristic, and professional experience was categorized to ensure oncologists’ anonymity; ‘Range 4-41 years; ‘Range 2-36 years.

Interview protocol and procedures

All participants provided written consent and completed a questionnaire on characteristics. Next, participants viewed the three video versions in the following order: 1) standard communication; 2) emotion-oriented silence; 3) emotion-oriented speech. They were informed that the oncologist’s communication in response to the patient’s emotional expressions was varied across the three videos, but they were not informed how. After viewing, semi-structured interviews were conducted with each participant. The open-ended questions of this interview are presented in Supplement B. Patients were interviewed at the department of Medical Psychology, AMC. Oncologists were interviewed at their own hospital. Interviews lasted approximately one hour and were audiotaped; all interviews were conducted between April and August 2016 by L.V. and S.S. (a researcher and research assistant, both with a background in psychology).

Analysis

All interviews were audiotaped and transcribed verbatim. MAXQDA12 software (VERBI Software, Germany) was used to assist in coding, sorting and extracting the data. All transcripts were independently read and coded by S.S. and L.V. Codes were compared and discussed until consensus was reached. Qualitative content analysis was used to systematically organize the data. Participants’ thoughts and opinions were first deductively categorized by interview question. The extracted
data were then inductively categorized further, with subcategories emerging from participants’ statements [16]. Summaries of the extracted data across interviews, including illustrative quotes (translated from Dutch), were written by L.V. and critically reviewed by S.S.

RESULTS

Preferences and perceptions regarding communication in response to emotions

Most patients and oncologists preferred the video in which the oncologist responded with emotion-oriented speech to the patient’s expressions of emotions. In general, both groups explained their preference by stating that the oncologist’s response in that video was “more empathic” than the oncologist’s response in the other two videos. They substantiated this by mentioning various verbal and non-verbal communication behaviors that they perceived only in the emotion-oriented speech video, such as the acknowledgment of emotions, asking questions about concerns, and variation in the tone of voice.

In addition, in the emotion-oriented speech video, patients perceived the oncologist to be more supportive, because he displayed behaviors ensuring that, e.g., the patient would get home safely, which they considered to be important. Furthermore, many patients reported difficulties detecting differences between the oncologist’s behavior in the standard communication and the emotion-oriented silence videos. They disliked both of these communication versions, as illustrated by the following quote:

#P05: “... the first two video versions [standard communication and emotion-oriented silence], in my opinion, didn’t differ that much. They displayed rather technical, factual conversations, like ‘this is a case, not a person, and this case has an esophageal tumor’, and I thought that was wrong”.

Oncologists were better able to differentiate between the three communication strategies. In general, they judged the quality of the oncologist’s response to emotions to improve from standard communication to emotion-oriented silence to emotion-oriented speech.

#O01: “So, in the first conversation [standard communication] the information was immediately provided, in the second conversation [emotion-oriented silence] it was based a bit more on questions from the patient, such as ‘what about chemo?’, and in the third conversation [emotion-oriented speech] a lot more was asked about what the person wanted to know, what the concerns were, and information was provided in such a manner”.

Nevertheless, some patients and oncologists preferred emotion-oriented silence to emotion-oriented speech. They perceived the emotion-oriented speech behaviors by the oncologist to be somewhat oppressive, excessive or artificial, as illustrated by these quotes:
... and in particular the naming of emotions, the naming of the behavior of the patient, that made me feel a bit oppressed - certainly not in all instances, but a few times. I’d find that too much really...”.

“...and I don’t know, then I’d think... ‘well, you’re showing me a trick you’ve learned in your communication skills training; I can see that you are...’, and yes, for me that wouldn’t be necessary. But... so, personally I think I would be fine with the second [emotion-oriented silence] way”.

Furthermore, one patient preferred standard communication to the other two strategies, because of his personal unwillingness to talk about emotions with an oncologist:

“I prefer the first video [standard communication], because that’s who I am. I’d rather just receive information and yes, personally, I’d like to keep my emotions to myself.”

The following additional reactions to the videos are noteworthy. First, in all three videos, patients strongly missed information from the oncologist about the possibility of psychological support, e.g. a referral to a psychologist or social worker. Second, oncologists varied remarkably in their perception of the emotional state of the patient in the video. Some oncologists spontaneously argued that the patient was unrealistically calm and perfectly able to process information. However, others commented that the patient appeared to be in shock and that it was difficult for the oncologist to make contact.

**Assumed effects of oncologists’ emotion-oriented speech**

Based on the data, the six-function model of medical communication [3], which encompasses the functions ‘responding to emotions’, ‘providing information’, ‘fostering the relationship’, ‘decision making’, ‘gathering information’, and ‘enabling disease and treatment-related behavior’, appeared to be a useful framework to subcategorize the assumed effects. The results showed that, regarding the first four of these functions, the effects assumed by patients and oncologists were to a large extent similar. Table 3 summarizes the participants’ assumed effects, organized by function and illustrated by quotes. Although both positive and negative effects were mentioned, negative effects were less frequently reported. Moreover, the negative effects were mostly expressed by the oncologists.
Table 3. Effects assumed by participants of emotion-oriented speech on outcomes, categorized according to the six-function model of medical communication [3]

<table>
<thead>
<tr>
<th>RESPONDING TO EMOTIONS</th>
<th>PROVIDING INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Similar views(^1)</strong></td>
<td><strong>Views by patients only(^2)</strong></td>
</tr>
<tr>
<td>Emotion-oriented speech makes bad news more bearable. It could also result in patients' feeling more positive, less anxious, uncertain and stressed. Moreover, it makes patients feel acknowledged, seen as a person, heard and taken seriously. Furthermore, emotion-oriented speech stimulates patients' emotions and the expression of, and conversation about emotions. P10: “The shock becomes more, let’s say, acceptable for the patient, or at least more bearable”. O02: “Well, you better hope that the patient feels less stressed, anxious, and uncertain”.</td>
<td>Emotion-oriented speech stimulates the expression of, and conversation on, emotions outside of the medical consultation, e.g., with family. It also helps patients to maintain dignity and therefore contributes to their quality of life. Moreover, it offers (some) hope, yet this could also be false hope. P02: “The patient will try to hold on to something... Him [the oncologist] being more understanding, could result in her [the patient in the video] getting her hopes up, while this hope is actually unjustified”.</td>
</tr>
</tbody>
</table>

**Similar views\(^1\)**

<table>
<thead>
<tr>
<th><strong>Views by patients only(^2)</strong></th>
<th><strong>Views by oncologists only(^3)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotion-oriented speech enables patients to better take in, organize, and process the provided information. This leads to better recall of information afterwards. Emotion-oriented speech also results in patients asking more questions and oncologists providing information based on those questions. Therefore, emotion-oriented speech would result in patients being provided with the information they need or want. P12: “So that is, yeah, because of that [emotion-oriented speech] you notice that the conversation has a better flow, and that, in my opinion, the processing or storing of information is easier for the patient”.</td>
<td>Providing information in an emotion-oriented manner, results in higher levels of trust in that information. P09: “Well, one of the effects is that... that the provided information... that you would trust that information more, because if there is more empathy, then it concerns you, and not certain statistics provided by the doctor”.</td>
</tr>
</tbody>
</table>
Table 3. Continued

<table>
<thead>
<tr>
<th>Similar views¹</th>
<th>View by oncologists only²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotion-oriented speech positively impacts patients' trust in, and evaluation of, the oncologist. Moreover, it encourages patients to contact their oncologist in case of questions or concerns, and to address difficult or sensitive matters, such as a second opinion. Furthermore, it results in patients feeling more at ease during the consultation, and comfortable enough to be themselves.</td>
<td>Emotion-oriented speech contributes to a good oncologist-patient relationship. This relationship enables oncologists to guide their patients through preference sensitive decision making. Moreover, a good relationship makes their job as an oncologist nicer, more fun, and easier. It also results in lesser communication problems and patient complaints.</td>
</tr>
</tbody>
</table>
| P09: “If I would talk to such a doctor, then I would certainly feel... have the feeling that I could turn to him if I would have more questions”. | O13: “Why you would act like that [responding by emotion-oriented speech]? Because you are a fellow human being, trying to support someone. Partially because you know that technical information in this setting is often quickly lost, so you will gain the most by investing in the relationship”.

**DECISION MAKING**

<table>
<thead>
<tr>
<th>Similar views¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotion-oriented speech enables patients to regain some control and contributes to patients’ belief that they can have a say in (any) upcoming decisions. Emotion-oriented speech therefore stimulates ‘shared decision making’ (oncologists used this specific terminology).</td>
</tr>
</tbody>
</table>
| O01: “Yes, I think that is positive... shared decision making. To acknowledge the patient, where he stands in the conversation, and what is important for him. That’s how you can decide together better”.

**GATHERING INFORMATION**

<table>
<thead>
<tr>
<th>Views by oncologists only³</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients (are encouraged to) provide oncologists with more (detailed) information, as a result of oncologists’ emotion-oriented speech, e.g., information about their needs, preferences, opinions, feelings, expectations, concerns, uncertainties and fears. This information is considered essential for oncologists to properly treat the patient.</td>
</tr>
</tbody>
</table>
| O12: “Well, I hope, but I don’t know if it’s true, that if you’re open for that [patients’ emotions], then patients will feel encouraged to actually express those [emotions] and feel more inclined to discuss their fears and thoughts. Because, eventually, in the third [emotion-oriented speech] version, the doctor gets to hear that she [the patient in the video] is really worried about chemotherapy, and that is information you did not receive in the other versions”.

**ENABLING DISEASE AND TREATMENT RELATED BEHAVIOR**

<table>
<thead>
<tr>
<th>Views by patients only⁴</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotion-oriented speech results in patients following (or considering to follow) oncologists’ advice sooner/better.</td>
</tr>
</tbody>
</table>
| P06: “Well, [it would result in] that I would follow any advice immediately”.

**Notes.** ¹Impact on outcomes as mentioned by at least one patient and at least one oncologist; ²Impact on outcomes as mentioned by at least one patient and no oncologists; ³Impact on outcomes as mentioned by at least one oncologist and no patients; ⁴Notes.
Table 4. Patients’ and oncologists’ views on factors hindering oncologists to respond (adequately) to patients’ emotions

<table>
<thead>
<tr>
<th>FACTORS RELATED TO THE PATIENT</th>
<th>Similar views¹</th>
<th>Views by patients only²</th>
<th>Views by oncologists only³</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual differences:</strong> both patients and oncologists mentioned that patients are different in how they want to be approached with regard to their emotions. Nevertheless, patients and oncologists brought up different characteristics underlying these individual differences (see columns on the right).</td>
<td><strong>Communication behavior:</strong> patients are more empowered and (emotionally) expressive these days.</td>
<td><strong>Communication behavior:</strong> low levels of introspective abilities or emotional intelligence complicate a conversation on emotions. Furthermore, patients with higher levels of intelligence or intellect focus more on the technical information than on emotions. Patients’ personality might also complicate an adequate response, as some patients are hard to read.</td>
<td><strong>Communication behavior:</strong> socially desirable behavior complicates an adequate response, e.g., if a patient states to feel fine, but actually he/she is still feeling very emotional. Responding to emotions is also difficult when patients do not (seem to) respond to the oncologists’ emotion-oriented communication behaviors, or shut the oncologist out. Furthermore, some patient-related communication barriers are rather implicit, for example when patients’ have had communication problems with previous doctors.</td>
</tr>
<tr>
<td><strong>The connection:</strong> sometimes there is no (intuitive) connection between patient and oncologist, which complicates emotional talk. <strong>Significant others:</strong> it is more difficult to respond to a patient’s emotions when family members or others take an active part in the conversation. <strong>The emotions:</strong> high intensity emotions are more difficult to respond to. <strong>Communication behavior:</strong> patients and oncologists mentioned different factors related to patients’ communication behavior (see columns on the right for examples by patients and oncologists).</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

P06: “And the empowerment of patients these days, well that’s far from easy. I really get that”.

OO1: “The biggest pitfall, the thing I find the most difficult, because it should be about the patient and you don’t want to do that, is those situations in which you have the conversation with the partner, who keeps the conversation going, while the patient remains quite or shuts down”.

Chapter 8 | Patients’ and oncologists’ views on how oncologists may best address emotions
P06: “And the empowerment of patients these days, well that’s far from easy. I really get that.”

O01: “The biggest pitfall, the thing I find the most difficult, because it should be about the patient and you don’t want to have the conversation with the partner, who keeps the conversation going, while the patient remains quite or shuts down.”

The connection:

The connection or relationship is usually better, which makes it easier for patients to express their emotions and for oncologists to read patients’ emotional state. Furthermore, patients sometimes appear to be on a different page emotionally or cognitively, patients are more empowered and (emotionally) expressive these days.

O11: “Again, the difference between males and females, the feminization of the medical profession impacts this [oncologists’ addressing patients’ emotions] in a positive way. Because women are in general better at communication and picking of signals regarding emotions, they have an extra antenna for that.”

Table 4. Continued

<table>
<thead>
<tr>
<th>FACTORS RELATED TO THE ONCOLOGIST</th>
<th>Views by patients only¹</th>
<th>Views by oncologists only²</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emotions:</strong> oncologists’ emotions hinder their ability to manage patients’ emotions. Emotional or mental self-preservation could be a motive for oncologist not to engage in patients’ emotions. It can feel uncomfortable to engage in emotion-oriented speech behavior or a long silence, and/or it feels more comfortable, safe and easy to inform on the medical-technical side of things. Moreover, oncologists might fear that engaging in emotional talk results in patients expecting oncologists to have all the answers regarding more emotional/existential/psychosocial topics, or that it provokes/stimulates their own vulnerability or sense of failure. <strong>Personality:</strong> not all oncologists have the (same) natural ability to feel and express empathy or compassion. <strong>Communication skills:</strong> not all oncologists have sufficient skills to respond adequately to emotions. <strong>Experience:</strong> more experience results in better communication skills and allows more of oncologists’ attention to patients’ emotions. <strong>Training:</strong> not all oncologists were trained in communication skills, for example the younger generation is more properly trained than the older generation.</td>
<td><strong>Personality:</strong> not all oncologists are able to allow themselves to be vulnerable. <strong>Experience:</strong> life experience helps to identify with the patient and his situation. <strong>Attitude within the medical profession:</strong> in current medical practice the focus is on medical-technical solutions and knowledge, therefore oncologists also approach patients with that technical attitude / from that technical frame of reference. This attitude is stronger within the more technical medical specialties, such as the surgical specialties, and in the older generation of oncologists. <strong>Personal circumstances:</strong> various circumstances can compete (temporarily) with oncologists’ ability to respond to emotions, for example, fatigue, significant others who are currently ill, or an argument with a spouse.</td>
<td><strong>Gender:</strong> females are better communicators and are better in recognizing emotions.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FACTORS RELATED TO THE CONTEXT</th>
<th>Views by patients only¹</th>
<th>Views by oncologists only²</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Time pressure:</strong> (perceived) time pressure contributes to inadequate responses to/attention for patients’ emotions.</td>
<td><strong>Case load:</strong> the number of (highly emotional) consultations on a day/in a row influences oncologists’ response to emotions. <strong>Perceived support:</strong> whether oncologists feel supported by their colleagues and can share their feelings.</td>
<td><strong>Consultation agenda:</strong> (other) information has to be provided to patients, which reduces the time to talk about emotions. <strong>Medical setting:</strong> patients in an academic hospital are different from patients in a peripheral hospital. Moreover, the medical setting influences the intensity of patients’ emotions and therefore the amount of skills needed when responding, for example when the initial consultation, diagnostic testing and the discussing of results all take place of the same day. <strong>Administrative load:</strong> the growing amount of (digital) administrative procedures limits the time spend, and the quality of interacting with patients.</td>
</tr>
</tbody>
</table>

O11: “Again, the difference between males and females, the feminization of the medical profession impacts this [oncologists’ addressing patients’ emotions] in a positive way. Because women are in general better at communication and picking of signals regarding emotions, they have an extra antenna for that.”

Notes. ¹Factors mentioned by at least one patient and at least one oncologist; ²Factors mentioned by at least one patient and no oncologists; ³Factors mentioned by at least one oncologist and no patients.
Factors assumed to hinder oncologists’ responding to patients’ emotions

Factors hindering an emotion-oriented response to patients’ emotions, as suggested by patients and oncologists, were inductively categorized to be related to the patient and his/her emotions, the oncologist, or the context (summarized in Table 4). In general, a high degree of similarity was shown between factors suggested by patients and oncologists. Moreover, patients generally expressed understanding for the difficulty of responding (adequately) to patients’ emotions. One patient stated, for example:

#P13: “But okay that’s - I said already - that’s really difficult, because people are so different. It seems to me that it’s awfully hard for a physician to assess how he should act and how he should bring the news. But, in general, I think that an empathic approach is best for most patients”.

Oncologists’ evaluation of their own communication addressing emotions

Most oncologists believed that their communication could be improved at times, especially with regard to acknowledging, or reflecting on patients’ emotions and providing patients with time to process the information. For example, this oncologist stated:

#O05: “But sometimes, just to find the right words to reflect on something, that’s the hardest I think. And you notice that as well during training, if you talk to each other, or if someone asks the trainer for advice, then it’s often something like ‘well, how would you phrase that?’”.

They indicated that an adequate response sometimes means that they have to give up (some of their) control:

#O03: “Sometimes I just can’t figure it out [what went wrong]. And sometimes, indeed, then you think yes, I actually know what I could have done better. More … daring to have even more patience, to give up control even more, at least for myself that’s what I think. In my opinion, doctors want to do something for their patients. And sometimes you can’t, you can’t do something in terms of medicine. And then you have to, the times it doesn’t go that well in my conversations, I always think, yes, I have to let go of that, and try to get from the patient what he wants and what he understood”.

Oncologists’ suggestions for improving communication addressing emotions in practice

Oncologists suggested a variety of educational activities to improve oncologists’ communication in response to patients’ emotions, including: practicing difficult situations; regular videotaping of consultations to reflect on one’s own behavior; receiving feedback, for example on those videotapes, from colleagues, a supervisor, patients, or medical communication teachers; and observing others, e.g., their videotaped consultations.

#O02: “A physician in training, a young surgeon who wants to be an oncological surgeon, who specializes in oncology after four years, should video record his consultation with a patient at least 10 to 15 times”.

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Moreover, oncologists suggested changes in the medical education system, i.e., to better prioritize and attune communication skills education during the medical specialist training program, or to consider personality factors (more) seriously in the application process for a medical education program. Furthermore, oncologists would allocate more time for medical consultations when oncologists are still in training. In addition, evidence-based tips or training on how to manage emotion-oriented communicating while using the computer during consultations was considered to be helpful.

Oncologists also spontaneously mentioned barriers for initiatives to improve oncologists’ responses to emotions. In general, oncologists stressed that there is little time, or priority, to regularly reflect on communication behavior. A few oncologists also stated that oncologists may be reluctant to expose themselves to criticism. Moreover, in the opinion of some it is very difficult, or even impossible, to improve oncologists’ way of addressing emotions, as this would involve changing personality and attitudes, as illustrated by this quote:

#O09: “Because you can’t learn empathy just like that”.

DISCUSSION AND CONCLUSION

Discussion
This qualitative interview study examined patients’ and oncologists’ views on emotion-oriented communication by oncologists, i.e., behaviors enacted in response to patients’ negative emotional expressions, with the aim to alleviate those emotions. The findings indicate that most cancer patients and oncologists prefer so-called emotion-oriented speech, in which the oncologist acknowledges and explores patients’ emotions and provides statements displaying empathy and support, when compared to an oncologist minimally responding, or responding with attentive silence, to patients’ emotions. Moreover, the results indicate that emotion-oriented speech is assumed to not only positively influence outcomes directly related to patients’ emotions, such as their wellbeing, but also to improve outcomes related to fostering the relationship, providing and gathering information, decision-making, and enabling disease and treatment-related behavior.

Patients and oncologists had many similar views regarding the positive impact on outcomes related to responding to emotions, providing information, fostering the relationship and decision-making. Assumed negative effects of emotion-oriented speech were mentioned mostly by oncologists, and expressed less frequently than positive effects. Nevertheless, studies have shown that, in current practice, oncologists do not respond (adequately) to patients’ emotions in approximately two out of three occasions [2, 17]. The current findings emphasize that oncologists therefore miss many opportunities to positively influence relevant outcomes, for example improving patients’ recall of information and trust in their oncologist, and enabling shared decision-making. The findings also
provide suggestions for possible mechanisms through which emotion-oriented speech can exercise its impact. For example, emotion-oriented speech might enable patients to (re)establish their sense of control, while it forces oncologists to give up (some of) their control. This ‘shift’ in control may stimulate shared decision making, by allowing patients more room to express their preferences, concerns and to deliberate.

The findings also indicate that some patients and oncologists prefer a less active or verbal approach by means of attentive silence in response to emotions, labeled as emotion-oriented silence, or even no emotional talk at all. Moreover, the present results confirmed that many patients were unable to distinguish the oncologist’s emotion-oriented silence from a minimal response, similar to the student sample in our previous experimental study [6]. These results emphasize how difficult, but also how important it is for oncologists to attune their communication to the individual patient, as some patients prefer emotion-oriented silence while others do not even recognize it as emotion-oriented behavior. Hence, oncologists should be able to vary their response to patients’ emotions, irrespective of their own preferences. Especially oncologists who prefer to respond to patients’ emotions solely by means of silence should be aware that many patients may not appreciate such behavior.

Furthermore, both patients and oncologists acknowledged that it is difficult for oncologists to assess patients’ emotional state and individual needs. This is demonstrated by the considerable variation in oncologists’ impressions of the emotional state of our standardized video patient. Thus, the fact that oncologists do not always identify the negative emotions might explain why they may not respond to these emotions [18]. Interestingly, this and other barriers mentioned were largely similar across patients and oncologists. Studies have shown that patient-reported satisfaction with the oncologists’ communication, and their ratings of perceived attentiveness and empathy, are usually high (e.g. [19]), which is in contrast to the results from observational studies indicating that oncologists rarely respond to patients’ expression of emotions [20]. Our findings suggest that this apparent discrepancy might be explained by patients’ understanding of, and insight into the many factors hindering an adequate emotion-oriented response, i.e., they might adjust their expectations and evaluations of oncologists’ communication performance based on these ‘mitigating circumstances’ [21]. Moreover, barriers can be related to the oncologist, the patient, or to the context. Thus, both patients and oncologists suggested a large range of barriers (other than the oncologist and his/her lack of communication skills) that could explain oncologists’ inadequate response to patients’ emotions. Therefore, the present results provide (additional) targets for intervention when aiming to optimize oncologists’ communication in response to patients’ emotions.

Since research has indicated that communication skills training interventions can improve oncologists’ behavior in practice [22, 23], the pessimistic attitude of some oncologists with regard to the potential impact of such communication skills training might be one of these additional targets. Nevertheless, most oncologists mentioned that there is room for improvement and suggested the
regular videotaping of consultations as a promising method to receive feedback and reflect on their own communication, thereby improving their response to patients’ emotions. Future research should explore the potential of such a strategy; the integration of videotaping into the regular medical training and continuing education programs could stimulate the structural implementation of such a strategy, thereby overcoming the frequently-mentioned barrier of ‘limited time’.

Strengths and limitations
The present study examined both patients’ and oncologists’ views on handling emotions. Including both groups is a strength, because future development and implementation of interventions to improve oncologists’ communication in response to emotions should not only be informed by research on patients’ views [24], but also on the views of oncologists. Moreover, the present study followed good practice in qualitative research by obtaining maximum variation in the sample, triangulating of sources (combining data from patients and oncologists), using open-ended questions, and the use of a rigorous and transparent method for analysis [16] and reporting [25].

However, because this study has a relatively small sample size and was conducted in the Netherlands, generalizability of the findings is limited. Furthermore, the use of scripted videos might provide an alternative explanation for the finding that some participants evaluated the emotion-oriented speech behaviors as being “somewhat artificial”. Nevertheless, the videos were extensively validated by experts and were found to be realistic [6]. In addition, the qualitative design does not allow firm conclusions to be drawn about the effects of and the factors hindering oncologists’ communication in response to cancer patients’ emotional expressions. However, the use of semi-structured interviews is particularly appropriate to identify and explore different opinions, perspectives, and potentially modifiable factors to improve oncological practice [25].

Conclusion
This study provides insight into how oncologists’ may best address patients’ emotions, and how we might improve oncologists’ communication in response to emotions. The investigation confirms that emotion-oriented speech is preferred by most as a communication strategy to address cancer patients’ emotions, and this strategy was assumed to positively impact a broad range of outcomes. However, not all patients and oncologists preferred the oncologist to be so actively engaged in patients’ emotions. The oncologists and patients had similar views on the many factors that might hinder oncologists in addressing emotions. Not surprisingly, most oncologists also mentioned that their response to patients’ emotional expressions could be improved. For this, various (educational) strategies were suggested; of these, regular videotaping of consultations was mentioned most often.
Clinical implications

The current results can be used by teachers to inform medical communication training and by oncologists to improve their communication behavior in practice. Attentive silence on its own is not sufficient for most patients; oncologists should try to acknowledge and explore patients’ emotions and provide statements displaying empathy and support. Still, it is important for oncologists to be flexible in their approach and attune their communication to the individual patient, as differences in preferences exist. This flexibility might be the most challenging task for oncologists, but regular reflection may provide insights and improve future behavior.

AUTHOR DISCLOSURES

Conflict of interest

All authors declare there are no conflicts of interest.

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Script segment illustrating the variations in the oncologist’s communication between the three communication videos/strategies

(Earlier during the consultation, the oncologist provided the patient with an incurable cancer diagnosis and explained the palliative treatment options. The consultation now approaches the end.)

**Patient:** Then I will have to say my goodbye’s soon… (with tears in her eyes)

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**Start of the script segment in which communication is varied**

<table>
<thead>
<tr>
<th>STANDARD</th>
<th>EMOTION-ORIENTED SILENCE</th>
<th>EMOTION-ORIENTED SPEECH</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Oncologist:</strong> Yes..., that is heavy news, isn’t it? (short silence) Do you have any questions at the moment? About this consultation, or other things?</td>
<td>Short silence in which the patients stares ahead, looking defeated.</td>
<td>Short silence in which the patients stares ahead, looking defeated.</td>
</tr>
<tr>
<td><strong>Patient:</strong> No. (mumbles and stares ahead, looking defeated)</td>
<td><strong>Oncologist:</strong> Yes... (short silence) That is heavy news, isn’t it?</td>
<td><strong>Oncologist:</strong> Yes, this is a lot to take in all at once isn’t it? (short silence) I can imagine that you are really shaken by it.</td>
</tr>
<tr>
<td><strong>Patient:</strong> Nods slightly, withdrawn.</td>
<td><strong>Oncologist:</strong> Attentive silence, in which the doctor looks at the patient calmly, waiting until she is ready for a next question.</td>
<td><strong>Patient:</strong> Nods slightly, withdrawn.</td>
</tr>
<tr>
<td><strong>Patient:</strong> Visibly trying to process the news; taking a few deep breaths and rubbing her face. After some time, she is calmed down and looks at the oncologist.</td>
<td><strong>Oncologist:</strong> Do you have any questions at the moment? About this consultation, or other things?</td>
<td><strong>Oncologist:</strong> short silence, in which the doctor looks at the patient calmly. Is there someone to pick you up later? Or someone you can call?</td>
</tr>
<tr>
<td><strong>Patient:</strong> No. (short silence)</td>
<td><strong>Patient:</strong> Nods slightly, withdrawn.</td>
<td><strong>Patient:</strong> Yeah, that will be fine. Takes a deep breath.</td>
</tr>
<tr>
<td><strong>Oncologist:</strong> Good. (short silence) Do you have any questions at the moment? About this consultation, or other things?</td>
<td><strong>Patient:</strong> No. (short silence)</td>
<td><strong>Oncologist:</strong> Okay (nods). If you do have any questions later, you can always contact us.</td>
</tr>
</tbody>
</table>

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**Oncologist:** Well... now you can go and see Kim, our specialist nurse, who will take care of some of the practical things.

*(Consultation continues)*
SUPPLEMENT B

The interview questions

Questions asked to patients and oncologists:

1a. If you have to choose between the three versions of communication in response to the patient’s expressions of emotions, which version do you prefer?

1b. Why do you prefer that version, if you compare the oncologist’s communication behavior across versions?

2. If oncologists would respond in an ‘adequate’ way to emotions of patients during consultations, which - positive and/or negative - effects could that communication have?

3. What are, in your opinion, possible reasons explaining why oncologists do not (always) succeed in responding in an ‘adequate’ way to emotions of patients?

Questions asked to oncologists only:

4. How do you evaluate your own communication in response to patients’ emotions?

5. What could help to improve oncologists’ communication in response to patients’ emotions in practice?