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DOI
10.1016/j.ssmqr.2025.100652

Publication date
2025

Document Version
Final published version

Published in
SSM - Qualitative Research in Health

SSM - Qualitative Research in Health 8 (2025) 100652

Contents lists available at ScienceDirect

SSM - Qualitative Research in Health

journal homepage: www.journals.elsevier.com/ssm-qualitative-research-in-health

Uncovering clinicians' inquiry-based and impression-based efforts to tailor information in oncology consultations: A focus group study

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ARTICLE INFO

Keywords:
Medical communication
Information tailoring
Information needs
Cognitive abilities
Cancer patients

ABSTRACT

Tailoring of health-related information is recommended to address cancer patients' diverse information needs and abilities to understand and process information. While tailored information can improve patients' satisfaction, recall of information and emotional wellbeing, little is known about how oncology clinicians tailor information during consultations. This study examined Dutch oncology clinicians' perceptions and experiences with tailoring of information to individual cancer patients' information needs and cognitive abilities during clinical consultations. Focus group and dyadic interviews were conducted involving 25 clinicians (physicians and clinical nurse specialists). Results show that clinicians interpret information tailoring as a multifaceted act: it occurs in dialogue, involves clinicians and patients, and includes assessing and adjusting of information. Furthermore, two pathways to tailor information emerged: 1) tailoring based on inquiry, which refers to adjusting information based on patients' stated needs and cognitive abilities (e.g., providing requested information), and 2) tailoring based on impressions, referring to the adjusting of information based on assumptions about patient characteristics and behavior (e.g., streamlining information for emotional patients). Last, clinicians mentioned contextual and interpersonal challenges like cultural differences, language barriers, and clinical regulations. Clinicians thus use inquiry-based and impression-based approaches to provide information that is sensitive to patients' (assumed) individual needs and abilities, interaction dynamics and the clinical setting. To ensure that information is accurately tailored, clinicians are encouraged to verify assumptions with patients and be attentive to patients' cultural backgrounds and possible language barriers. Future research should observe how information is tailored in real clinical interactions and how patients perceive these efforts.

1. Introduction

When discussing the provision of information to patients by clinicians, a one-size-fits-all approach does not apply (Smets et al., 2024). In the context of cancer care, it has become clear that patients do not share uniform information needs. Instead, studies report that patients' information needs vary and change over time (Koedoot et al., 2004; Oostendorp et al., 2016; Shim et al., 2016). Also, patients have different abilities to understand and process information (Cox et al., 2011; Kessels, 2003). To address the diverse needs and abilities of patients during the clinical encounter, tailoring of health-related information has been widely recommended (Lehmann et al., 2020; McNair et al., 2013; Oostendorp et al., 2016; Shim et al., 2016; Thorne et al., 2010). Such continuous and conscious tailoring of information to meet patients'

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https://doi.org/10.1016/j.ssmqr.2025.100652
Received 8 May 2025; Received in revised form 28 August 2025; Accepted 10 October 2025
Available online 16 October 2025

needs is a crucial component of patient-centered care (Epstein et al., 2005), and plays a key role in Shared Decision Making models (Bomhof-Roordink et al., 2019).

Indeed, tailored information is particularly valuable for cancer patients. After receiving a cancer diagnosis, patients' lives are changed; they suddenly need to make sense of complex health information and must make tough decisions about treatment, and do this while grappling with the possibility of death (Mills & Sullivan, 1999). During this time of physical and emotional turmoil, patients rely on their clinicians for support (Arora, 2003) and benefit from information that is adequate, understandable and fitting to their individual situation. Tailored communication is suggested to contribute to the fulfilment of patients' needs, improved patient information recall, and decreased feelings of uncertainty and distress (van Dulmen, 2011). Furthermore, as Carrard et al. (2016) show, when clinicians adapt their communication style to match patient preferences, consultation outcomes, including patient satisfaction, trust, and perceived physician competence, improve. Cancer patients also value clinicians who recognize their unique needs and individualize the information they provide, seeing this as a helpful aspect of communication (Thorne et al., 2010).

Nevertheless, studies report that cancer patients do not always receive information that fully aligns with their needs (Faller et al., 2016; Shim et al., 2016). For instance, some patients report receiving either too few or too many treatment options and information about these options from their clinician (Westendorp et al., 2023). Moreover, clinicians report difficulties in adequately assessing patients' needs for information and abilities to understand the information (Oostendorp et al., 2016). This highlights the risk of information mismatching: that is, when clinicians provide patients with more or less information then desired. Such information mismatches could increase patients' feelings of uncertainty and anxiety, and thus harm the patient (Westendorp et al., 2023). The occurrence of information mismatches underscores the importance of clinicians accurately assessing patients' needs, preferences, and cognitive abilities during consultations, and adjusting of information according to these assessments.

Despite the recognition of information tailoring as a crucial aspect of patient-centered communication, there is limited understanding of how clinicians actually tailor information in clinical practice. Except for the studies by Dekkers et al. (2018), Elit et al. (2015) and Walsh et al. (2010), little is known about clinicians perceptions of whether and how they tailor information to individual patients. Instead, most existing literature mentions information tailoring as an element of clinicians' communication practices or good care practices, for instance in supporting patients with lower and higher health literacy skills who are treated with radiotherapy for cancer (Smith et al., 2013), in disclosing a dementia diagnosis (Wollney et al., 2022) or in delivering physical activity recommendations in cancer care (Ladefoged Kopp Schmidt et al., 2022). Although these studies stress the importance of information tailoring in medical communication, they often fail to define it precisely. For examples, studies rarely distinguish between tailoring of information to patients' diverse information needs and cognitive abilities, nor do they differentiate between the various approaches to information tailoring and the underlying processes. A deeper exploration is then needed to understand how clinicians tailor information to individual patients and what influences their decision to do so.

Therefore, this study aims to explore physicians and clinical nurse specialists' (referred to as clinicians) perceptions of and experiences with tailoring of information to individual cancer patients' information needs and cognitive abilities during clinical consultations. We have decided to use the following definition of information tailoring: tailoring is "a co-constructive process involving *patients revealing* (invited or uninvited) aspects of their current *needs, preferences, and abilities* and clinicians using that *to decide what information to provide, when to provide it, and how to do it*." (Smets et al., 2024, p. 3). We define patients' information needs as *what* information the patient wants to receive and *when* and *how* they wish to receive it. Patients' cognitive abilities refer to their capacity to *understand* and *process* information, which can be influenced by patient characteristics such as educational level, or situation-specific factors like pain, medication or emotional distress, that may affect attention, memory, or decision-making.

2. Methods

2.1. Methodology and study design

This study was methodologically inspired by grounded theory and employs as a series of semi-structured group interviews (i.e., focus groups and dyadic interviews) with clinicians to gain an understanding of their views and experiences with information tailoring in clinical practice. Specifically, the findings presented here are "grounded" in the collected data (White & Cooper, 2022), instead of having been defined a priori (Pope et al., 2000). Emerging findings were intended to clarify and/or explain the process of information tailoring within the specific context of the clinical consultation room. Furthermore, the data were analyzed using grounded theory techniques. This process of analysis was full of iterative movements as findings from the group interview informed refinements to the topic guide to further disentangle clinicians' information tailoring practices. However, this study did not fully adopt the grounded theory methodology, as it used predefined research questions – translated into the interview topic guide – to guide data collection, rather than allowing the data alone to direct the research process. Overall, approval for this study was granted by the Medical Ethics Committee of the Amsterdam University Medical Center (2023.0673) and the study protocol was prospectively registered on the OSF website: https://osf.io/dy4vb.

2.2. Participants and sampling

Dutch speaking physicians and clinical nurse specialists who provide medical information to cancer patients during consultations were included in the study. Participants were recruited using purposive and snowball sampling methods. We started with purposive sampling (Boeije, 2009, pp. 1–240) to intentionally select participants who met the inclusion criteria. The clinicians invited to participate had previously contributed to research projects conducted by members of the project team, and were therefore knowledgeable about research on medical communication. In addition, a snowball sampling approach was used: participating clinicians were asked for the names of other clinicians who could be contacted for study participation. In result, our sample size expanded and became more diverse, including clinicians who were less familiar with medical communication research. Written informed consent was obtained from all participants. An overview of the participants' demographic and professional characteristics is provided in Table A.1.

2.3. Data collection

Twenty-five clinicians from three Dutch hospitals, including two academic medical centers and one hospital specialized in oncology care, participated in face-to-face group interviews. In total six focus group interviews, consisting of three to five participants, and two dyadic interviews with two participants, were conducted. Although the focus group interviews were small in size, this format allowed participants to share their intensive experiences related to the topic under investigation (Wong, 2008). Both types of interviews supported clinicians to exchange ideas and share experiences (Boeije, 2009, pp. 1–240; Marková et al., 2007; Morgan, 2016; Szulc & King, 2022). In "sharing and comparing" experiences, group interviews are useful to explore a phenomenon of interest in the broadest sense (Lucassen and Olde Hartman, 2007, p. 55). Such sharing of experience can, at the same time, raise participants awareness about certain issues, and thus be potentially transformative (Marková et al., 2007; Tracy, 2013). In our study, clinicians indicated learning from each other and supported one another's strategies to tailor information. Such mutual influence sheds light on the intricate dynamics of power that play out during group interviews (Ayrton, 2019).

While all participants were homogenous with regard to profession (i.e., physicians and clinical nurse specialist took part in separate group interviews), they were heterogenous in terms of gender, age, and seniority within the same profession (e.g., junior physicians (residents) and senior colleagues). We conducted separate interviews with physicians and clinical nurse specialist because of differences in their professions, specifically in terms of consultation length, clinical responsibility, and practice, which may affect their experiences with information tailoring. A homogeneous group can therefore support group discussion and interaction without much group conflict (Lucassen and Olde Hartman, 2007). We did however included both junior (residents) and senior physicians in the same group interviews to shed light on the range of experiences between clinicians in the same profession. In doing so, we were aware of the potential power dynamics that may affect junior physicians behaviors and experiences (Crowe et al., 2017).

All group interviews were conducted from December 2023 to April 2024 at two academic centers in the Netherlands. The various group interviews were conducted in Dutch, lasted approximately 1 h, and were moderated by the first author (AvO) and observed by the second author (RD). The first author (female), a PhD candidate with an educational background in anthropology and trained in qualitative interviewing, was initially unfamiliar with the field of medical communication. The outsider position allowed the researcher to come in with a "naïve perspective", which is helpful to see what is going on with new eyes, instead of building upon assumptions and/or existing knowledge of the setting (Morse, 2010). The group interviews were audio recorded and verbatim transcribed by the second author (RD). Accuracy of the transcripts were checked against the audio recordings. The second author also transcribed various observations from the group interviews, such as participants' emotions and demeanor.

At the start of each group interview, clinicians were asked to fill out a short questionnaire assessing their demographic and professional characteristics, then the interview proceeded by use of a semi-structured interview guide (Appendix A.1, including the Dutch guide and the English translation thereof). The guide was pilot tested and refined with input from project partners, fellow researchers in the field of medical communication sciences, and members of the projects' advisory board. This study's advisory board consisted of eight cancer patients and survivors, recruited via PanelCom (www.Panelcom.nl), a patient panel comprised of patients and survivors who had participated in prior communication studies, set up by members of the research team (ES and JvW). Members of the advisory board collaborated with the researchers on the study design, execution and interpretation of the findings. Specifically, members were asked to provide input on the activity-oriented interview questions (for more information see the next paragraph), (early) results of the study, and matters of dissemination. With the help of the interview guide, we asked clinicians about the factors that informed their impressions of patients' information needs and cognitive abilities, how these impressions' steered their information giving, and what tailoring efforts they use in practice.

In order to engage clinicians in the group interviews activity-oriented questions were used, these are "exercises that are enjoyable and productive supplements to questions" (Colucci, 2007, p. 1422). For instance, to explore clinician's impressions of patients, clinicians were asked to write on a sticky note what they generally notice about a patient when meeting them (e.g., patients' condition, expression, physical appearance, and manner of speech, and so on.). Another activity-oriented exercise revolved around the discussion of two consultation scenario's. The research team developed two contrasting scenarios, each involving a different type of patient: an information seeker and an information avoider (Case et al., 2005). In the first scenario, the information seeker consults with an attentive and engaged clinician. In the second scenario, the information avoider interacts with a clinician who appears rushed and disinterested. These contrasting combinations of patient and clinician types were designed to stimulate discussion and reflection. With the scenarios we explored clinicians' experiences, encouraging them to reflect on whether and how the clinicians in the scenarios tailored information, and to what extent the patients' and/or clinicians' behaviors influenced the information exchange.

2.4. Data analysis

To analyze the data, the researchers (AvO and RD) used a stepped approach: they each independently analyzed one interview and then discussed this together. This process continued until all group interviews were analyzed. Overall, the data analysis was guided by grounded theory techniques. A process of open and selective coding was used to code the data (Boeije, 2009, pp. 1–240). This meant that the researchers (AvO and RD) immersed themselves in the data by listening to the audio-recordings and by reading verbatim transcripts of the group interviews. All transcripts were uploaded, read, and analyzed by using the software Maxqda. After this, meaningful text-fragments were identified and assigned a code. Codes were compared amongst the researchers and fragments addressing the same topic were provided with the same code. Eventually, connections and meaningful patterns were established between the codes to make sense of the data. Thus, by first dividing fragments into codes and then reassembling the codes, the researchers were able to identify overarching themes. Any disagreements or questions about the coding process were discussed within the research team (AvO, RD, JvW, and ES). Data collection stopped when data saturation was achieved, namely when the data did not yield new insights. Moreover, the entire team reflected on the key themes identified from the data to confirm validation. These key themes were directly written in English and integrated in the Result section of this manuscript. Participant quotes were translated from Dutch to English by the first researcher (AvO), with support from ChatGPT to refine the translations. Subsequently, two additional researchers (IH, RD), reviewed all translated quotes to ensure their accuracy. To enhance the overall quality of the study, reflexivity of the researchers and the research process was practiced (Mays & Pope, 2000). Specifically, personal attitudes and potential biases were openly discussed at the outset of the research (e.g., perspectives on "good" medical communication).

3. Results

Clinicians' experiences with information tailoring should be understood in light of their perceptions of the concept. Some clinicians referred to information tailoring as the act of asking questions to assess the patient's needs. Others said that information tailoring is the act of adjusting information to the patient or person (implying a person-centered approach), "Well, I think tailoring would be information tailored to the wishes of the patient and the patient themselves, so the person, who they are" (female, physician in training). Yet, other clinicians referred to information tailoring as the act of engaging in dialogue and addressing patients' emotions. These descriptions illustrate that information tailoring could be considered a multifaceted communication act that occurs in the context of dialogue, involves clinicians and patients, and entails efforts to assess patients' information needs, preferences, and abilities, and the adjustment of information accordingly (including emotion work). In this article we zoom in on the latter aspect of information tailoring, namely clinicians' information tailoring efforts, by outlining two themes that were identified in the data. Theme 1: Assessing patients' information needs and cognitive abilities by use of inquiry-based and impression-based approaches – a first step to information tailoring,. Theme 2: Adjusting information to patients' information needs and cognitive abilities by use of inquiry-based and impression-based approaches – a second step to information tailoring. These themes represent two interconnected steps in tailoring information: first, assessing patients' information needs and cognitive abilities, and second, adjusting the information accordingly. Moreover, this process of information tailoring was found to be guided by either inquiry-based or impression-based strategies. With the term *inquiry-based tailoring* we refer to deliberate strategies clinicians reported to employ to adjust information to individual patients based on patients' expression of information needs and cognitive abilities. *Impression-based tailoring* refers to more intuitive strategies clinicians reported to use to make adjustments to their information provision that are guided by assumptions about patients' information needs and cognitive abilities based on patient characteristics and behaviors. It furthermore needs to be stressed that in the two themes we also discuss challenges that clinicians face when tailoring information. These challenges are linked to specific tailoring efforts. See figure A1 for an overview of the themes and relate subthemes presented in this article.

3.1. Theme 1: Assessing patients' information needs and cognitive abilities by use of inquiry-based and impression-based approaches – a first step to information tailoring

The first step in tailoring information, as described by clinicians, involves understanding patients' information needs and their ability to comprehend and process information. Clinicians reported using both inquiry-based and impression-based methods to assess these aspects.

3.1.1. Inquiry-based assessment of patients' information needs and cognitive abilities

Inquiry-Based Assessment Using Questions. To assess patients' information needs, clinicians reported explicitly asking patients about the type and amount of information they would like to receive. For example, they might ask if the patient has any questions at the start of the consultation, if there is anything they do not want to hear, or ask more specific questions like, "Do you prefer it if I share numbers?". Certain clinicians also indicated to ask questions to gauge patients' expectations, such as, "What are your expectations for today's visit?".

Inquiry-Based Assessment Using Teach-Back. Additionally, clinicians indicated to ask questions to check for comprehension to assess whether the patient could understand the provided information. Some clinicians referred to using 'teach-back' questions to verify if the patient had understood and could recall the information: "If I really have doubts, I ask the patient if they could repeat it for me once more, so I know if I have explained it correctly. That is how I always approach it" (female clinical nurse specialist).

3.1.2. Tension between tailoring and overwhelming patients

According to clinicians, patients' responses regarding their information needs and cognitive abilities should be carefully considered. This is because patients may not fully recognize their needs and capacity to understand and process information. As a result, clinicians risk overwhelming patients with information, even if it is something that the patients said they wanted to hear. For instance, a patient may express having high information needs, but after receiving the information, they may feel overwhelmed: "It is the same with prognosis. In some cases, a patient immediately says, "Yes, I want to know everything", and then you tell them, and that's okay. And sometimes it is way too early, and you overwhelm them with it" (female clinical nurse specialist). The possibility of overwhelming patients raises concerns about how and when information should be tailored to avoid information overload, " [...] it can also become too much, but people do want to know. So when do you provide the information, and when you do not? And how much information do you give to avoid causing distress later on" (female clinical nurse specialist). In such situations, it remains unclear for clinicians whether tailoring of information to the patients' expressed need may do more harm than good.

3.1.3. Impression-based assessment of patients' information needs and cognitive abilities

Impression-Based Assessments Based on Patient Characteristics. Clinicians reported to observe patients' demographic and physical characteristics to assess their information needs and cognitive abilities. Generally, clinicians assumed that older patients had fewer information needs than younger patients, particularly regarding certain topics, such as sexual activity and fertility. Also, certain clinicians said that the profession of a patient (e.g., academic) could be indicative of their ability to understand information. Furthermore, various other clinicians addressed using a patients' physical appearance (e.g., clothing, use of accessories, wearing make-up, smell, and so on) to estimate their wishes for information. For instance, patients' information preferences could be informed by signs of religiosity, like a patients' wearing a hijab or cross necklace. Clinicians believed that in some cultures, like within the Islam, mentioning the diagnosis 'cancer' or discuss the transition to palliative care (even if the patients' situation calls for it) is sometimes considered inappropriate, "People with an Islamic background tend to, uhm, I have the experience, that they tend to lean more towards a curative approach rather than a palliative approach. So that is something I am aware of when entering such a conversation" (female physician in training). Such generalized notions about the information needs and treatment preferences of religious patients could, on the one hand, inform clinicians impressions of patients on the basis of assumptions; on the other hand, these notions could also raise clinicians' awareness about the preferences of religious patients and with that make the implicit explicit. A few clinicians also addressed to use the patients' physical appearance to assess their ability to comprehend health-related information, especially if the patient seemed to take less care of themselves: "How someone looks – well-groomed or unkempt – can lead you to draw conclusions more quickly, thinking that is a person who takes less care of himself, or perhaps, understands less about what health is" (female physician).

Impression-Based Assessments Based on Patient Behaviors. Moreover, various clinicians indicated to use behavior displayed by the patient to assess what information this patient wants and can understand and process. Specifically, some clinicians provided examples of using the patients' emotional state to assess their ability to process information, that is, if the patient showed high emotions they were not able to assimilate the information. In contrast, patients who appear strong – ready to take on the information - are assessed as wanting to receive extensive information, "If you see that someone is very emotional and nervous, I think they tend to close themselves off more? Like, well, whereas others show up in a really combative way, with an attitude of "bring it on", who want to receive everything" (female clinical nurse specialist). Other clinicians also mentioned taking notice of a patient's demeanor (e.g., posture and attitude) to assess the amount of information the patient might want to receive. It was addressed that patients who seemed prepared for the consultation, e.g., having various questions for the clinician, were likely to have high information needs.

3.1.4. Tension: impression-based assessments are prone to bias

Clinicians however pointed out that these impressions of patients' information needs and cognitive abilities, have the evident risk of being mere assumptions and incorrect when checked with the patient, as illustrated by this quote:

> [...] A male with a very long beard. I thought this looked unkempt. So at first, I did not immediately realize that I was dealing with a very intelligent man. In fact, I had already formed my first impression based on the photo I had seen [in the medical file]. (female physician)

Another clinician, more broadly speaking, addressed misjudging immigrant patients' abilities to comprehend information:

> So you have people with a migration background, which is often challenging. Sometimes you think, "Well, due to the language

> barrier, they do not understand anything", so you end up explaining much less than they wanted. But later, it turns out that they actually understood more than you initially estimated, and that you did not properly assess that. (female clinical nurse specialist)

However, generally, clinicians seemed highly aware of their own biases and the inherent risk of misjudgment, emphasizing the importance of checking assumptions with the patient, "it is important to objectify, to ask questions, to check if it really is that way for them [the patient], […] your prejudices, because these could be wrong" (male physician).

3.2. Theme 2: Adjusting information to patients' information needs and cognitive abilities by use of inquiry-based and impression-based approaches – a second step to information tailoring

Based on clinicians' experiences, a second step of information tailoring, involves the adjusting of information to match patients' wishes for information and abilities to process information at a given moment. These adjustments again include inquiry-based approaches, which are build on what clinicians have come to know about the information needs and cognitive abilities of patients, and impression-based approaches, which are guided by clinicians' assumptions.

3.2.1. Inquiry-based adjusting of information to patients' information needs and cognitive abilities

Providing Information the Patient Wants and Can Process. First, illustrating explicit tailoring efforts, clinicians referred to situations where they had adjusted their information giving to patients' expressed needs, like patients' wanting limited or detailed information, for example, "Well some say, "No, I really do not want to know, no, no, do not tell me anything". Then I do not share numbers, no" (female physician). Other clinicians also said they tended to provide limited information or proposed a second appointment when patients expressed difficulties with processing the information. To give an example, "Sometimes I simply ask, "Has it been a long day? Or are you managing to process all the information you are receiving?" And then if someone says, "Honestly, it is too much", then I keep it brief" (female physician).

Providing Culturally Sensitive Information. A similar tailoring strategy was mentioned when talking to patients with a different cultural background. In these situations, clinicians expressed providing information that is culturally sensitive, that is, information that is fitting to the patients' cultural beliefs. Several clinicians addressed checking for the patients' information needs, "It is more about awareness and then probing – what do people want in that regard? And just respecting that people have different perspectives on it" (female physicians in training). Another clinician also indicated providing information that aligns to the patients' religious needs, for example to not discuss certain information, "[…] So faith – what is important to you? Uhm well, what things you will or will not discuss?" (female clinical nurse specialist).

3.2.2. Family dynamics when tailoring information

A tension related to the aforementioned strategy, is that what patients say they want to hear is not always aligned with their family members' need for information. While the presence of family members is said to serve as an emotional anchor for patients and aids information recall, differences in information needs make tailoring complex. A pertinent example is when the patient does not want to receive certain information (for example, about side effects), but their partner wants the information to be prepared. In this case, one clinician exclaimed: "How can you still tailor sufficiently then?" (female, clinical nurse specialist).

3.2.3. Tension in culturally sensitive information provision

Moreover, providing culturally sensitive information is also fraught with tension between patients' beliefs and those of the clinician. In one particular example, a clinician highlighted her struggles in providing information to a patient who decided to forego treatment based on religious grounds:

> Recently I saw a young woman, 32, with ovarium carcinoma, probably metastasized. […] She said, "I know cancer has been diagnosed", but as it turned out, she is very religious and believes that that God will heal her. […] that certainly does not make it easier for me, because you really think, "Ahh, but …". Yeah, and then you just hope – you just hope that you do explain it well. And I did mention that, I said, "What I find important is that you truly understand what I am telling you, what it means if you decide not to have treatment". So I had her say it out loud because I thought that maybe if she says it out loud, it might hit harder? […] But well, she stuck to her decision. (female physician)

If patients with a different cultural background also have a language barrier, information tailoring becomes even more complicated. In these situations, clinicians highlighted working with a professional translator or family members who function as translators. Using translators involves the risk of information not being translated properly or that the needs of the patient are not heard. One clinician provided a telling example depicting this problem during an encounter with an Islamic non-Dutch speaking patient whose daughter, who did speak Dutch, refused to translate to her mother that she was diagnosed with cancer. In this situation, tailoring of information to the patient is impossible, because of the patients daughters' wish to not translate the cancer diagnosis. So the clinician may end up tailoring information to the preferences of a patients' family member instead.

Using Additional Tools. Second and in line with the aforementioned, most clinicians referred to using additional tools to provide more extensive information about the disease and treatment if this would align with the information patients' desire, like medical graphics, "Recently, I had a patient who wanted to know what the mesorectum was. […] They wanted to see it […]. So I took out anatomical images and pointed it out" (female physician in training). Furthermore, a few clinicians explained that they sometimes show videos to provide more details about the disease. Whether these clinicians showed videos depended on the patients' needs, "Sometimes patients ask, "How does that work?" And then I say, "If you really want to see it, I can show you a video" (female physician). Another tool mentioned was the sharing of information leaflets, which were provided to patients at the end of the consultation.

Integrating the Patients Needs in The Clinical Agenda. Third, clinicians may also explicitly tailor information by answering the patients' questions, "And then I would indeed answer all 48 questions before telling my own story – well, actually your story is already woven into it" (female clinical nurse specialist). As can be derived from this quote, clinicians emphasized that they occasionally integrate the patients' information needs in their clinical agenda (i.e., the medical information clinicians' ought and plan to share with the patient). According to one clinician, negotiating the informational agenda is necessary to facilitate information alignment between themselves and the patient.

Patients' affective needs were also considered important to take into account to know when and how to provide information. Some clinicians said to proceed with the information provision cautiously with anxious patients, and also to ease patients' fear: to ask them what is causing their fear. Moreover, when anxious patients asked various questions, clinicians shared that these questions needed to be answered first before any further information could be provided:

> Yes, this is something we see very often – people are very anxious and thinking about their prognosis. And as long as that question hasn't been answered, they can not really hear anything else. […] Those questions need to be answered first - at least, that is how I interpret it - before they can, uhm, listen to the rest of the oncologists' story. (female physician)

3.2.4. Tension between tailoring and standard practice

Despite these explicit efforts, clinicians addressed difficulties in tailoring information to individual patients' information needs and abilities, whilst also providing all relevant information that is in line with clinical guidelines, e.g., (inter)national guidelines regulating what information patients should receive:

> The only thing that I sometimes find difficult is really checking whether a patient uhm, fully understood everything. But then, that is then part of the WGBO [Dutch Medical Treatment Agreement Act on the rights and obligations of clients in health care], yeah, we have to explain everything about the procedure, we are required to tell them. (female physician)

A few clinicians also struggled with providing information at the time preferred by the patient. What information is shared during which consultation was reported as rather standardized and structured, leaving little room for adjustments:

> [Information tailoring], I think the topic is incredible, yet we never truly provide the right information at the right time. Because when does a patient actually want information about their post-operative recovery? Not around the time of the surgery, because then they are only thinking, "Oh god, how will I wake up from the anesthesia? Will I survive the surgery?" They actually want to know about recovery and rehabilitation when they are at home after climbing the stairs three times and feeling sharp pains in their abdomen, wondering: "Was that too much? Is this normal? Do I have post-operative bleeding? […] Even though they received this information earlier, it was not yet applicable. (female clinical nurse specialist)

The sentiment that the timing of information is never right, was shared amongst a few clinicians. Clinicians overall indicated to struggle to tailor their information giving, with only three clinicians, of whom two out of nine clinical nurse specialists, expressing being confident: "But I think that [tailoring] is not that hard […]. That is going well, yes" (female clinical nurse specialist).

3.2.5. Impression-based adjusting of information to patients' information needs and cognitive abilities

Provide Age-relevant Information. Our data shows that a number of clinicians also tailor their information giving based on assumptions about patients' information needs and abilities that are derived from patients' characteristics and behaviors. For instance, a few clinicians shared examples of tailoring information by discussing topics more or less depending on the patients' age, yet offered limited reflection on why they tended to do so:

> When a patient sitting in front of me has young children, well, then I provide different information than when an 80-year old were sitting there. That is well, that is a difference. […] It depends on who is sitting in front of me. You know, uh, with a patient who has young children, I give guidance on how to involve their children in the process. And with an 80-year-old, well, I might provide more information about […]. Well, yeah it is just a different way of … [communicating]. (female clinical nurse specialist)

Use Simpler Language to Patients to Match Patients' Level of Education. A second tailoring effort informed by clinicians' impressions of patients is the adjusting of information based on perceptions of patients' information needs as inferred from the patients' educational background. In result, clinicians may decide to change the language they use:

> I ask – well, only if people ask very intelligent questions – I ask: "Do you have a background in Biology or Medicine? […] Then I will use different words. […] You have to adjust to their level. If you keep talking about "these little cells here" and the other person is thinking, "Yeah sorry, I already know what that is", then that is just annoying. (female physician)

Streamline Information to Patients' Emotional State and Demeanor. A third impression-based tailoring effort concerns clinicians streamlining the amount and timing of the provided information based on perceptions of patients' abilities to understand and process information. These perceptions were derived from patients' emotional state and demeanor. For instance, various clinicians indicated providing limited information to patients who displayed high emotions as it was generally assumed that emotions block patients' ability to assimilate the information. In terms of a patient's demeanor, some clinicians took note of a patient's open or closed off attitude (like the patient having slumped shoulders and crossing their arms). A patient's closed-off attitude was considered an indicator of the patient's inability to process the information, which led clinicians to only provide practical information at the time of consultation and share more detailed information at a later time. Clinicians also mentioned that they might streamline information if a patient presented a "glazy look" (i.e., blank stare):

> With some people you can immediately see that they do not understand anything, and then you think, "Okay, step back" [laughing]. Then I look at the bare minimum they need to understand and I focus on that. So you often start in more or less the same way, but based on an increasingly blank stare, you decide to stop elaborating. (female physician)

Using Additional Tools. Clinicians indicated that if they perceive the patient to struggle to understand the information, they will occasionally provide information on paper, "For people I assess as having lower comprehension, I sometimes write out very detailed follow-up instructions. And for those I feel understanding things better, I might just jot down a few substantive points" (female physician). Additionally, if clinicians appraise that a patient finds the information too complex they might tailor their information provision by drawing information on a piece of paper.

4. Discussion

Despite the widespread recognition of information tailoring, little is known about how clinicians tailor information to individual patients during clinical consultations. This study undertook a first step to broaden insight in the process of information tailoring by exploring oncology clinician's perceptions and experiences with tailoring information to individual cancer patients' information needs and cognitive abilities during clinical consultations. To this end, we identified information tailoring efforts that are based on inquiry and impressions, which we divided into clinicians' efforts to assess patients' information needs and cognitive abilities, as well as their efforts to adjust information to match the needs and abilities of patients. Clinicians also pointed out various challenges that hinder them from adequately tailoring information. In this next section we will further explore these findings.

4.1. Two tailoring pathways - inquiry-based and impression-based approaches

Clinicians reported various ways in which they try to tailor information to individual patients during the consultation. We identified two pathways to tailor information: 1) an inquiry-based approach and 2) an impression-based approach. Clinicians mentioned gauging patients' information needs and cognitive abilities by asked them direct questions, for instance, about the information they want to receive, if the information is understandable, and if the patient is able to recall the information by using teach-back. These assessments guide clinicians to tailor information in the following ways: providing patients with their preferred (amount of) information, answering their questions, influencing what and when information is provided, and using tools to address patients' specific needs (e.g., video or images to explain treatment). In terms of tailoring based on impressions, clinicians indicated to make assumptions about patients' needs for information and their abilities to understand and process information. These assumptions were based on patient characteristics (such as age, profession, or physical appearance) and behavioral cues (including demeanor and emotional state) observed during the consultation. Tailoring efforts based on these impression-based assessments included: providing little to no information to older patients about topics perceived as less age-appropriate (e.g., sexual activity), using simpler language for patients with lower educational backgrounds, streamlining information for patients exhibiting high emotions or a closed-off posture, and using additional tools to accommodate what clinicians believed were patients' information needs and abilities to understand and process it. It should be noted that all these tailoring efforts are self-reported. Further observational studies ought to be conducted to check how clinicians actually tailor information in clinical practice. At the same time, interviews, specifically video elicitation interviews, could be used to uncover clinicians' tacit knowledge (e.g., thoughts, intensions, and experiences), and allow them to reflect on their recorded information tailoring behaviors (Van Braak et al., 2018).

4.2. Is there a danger in tailoring based on impressions?

Both inquiry-based and impression-based tailoring call on clinicians to display – what Carrard and Mast (2015) call – behavioral adaptability: "[…] a physician's ability to flexibly change his or her verbal and nonverbal behavior when facing different patients and to adapt his or her behavior according to the patient's different preferences" (p. 1244). According to Carrard and Mast (2015), clinicians only show adaptable behavior if they correctly infer patient's actual preferences. When clinicians tailor information based on inquiry, patients' actual needs are considered. Yet, when information is tailored based on impressions, it remains unsure if clinicians decode patients' actual needs or only what they assume patients' needs are. Although implicit assessments are inherent to human interaction (Kawakami et al., 2017, pp. 1–80); tailoring based on such assessments may thus not yield the desired outcome. As reflected in this study, clinicians do not always infer patients' actual needs, preferences or abilities. Instead, clinicians speak of episodes of information misalignment (e.g., providing a capable migrant patient with limited information because it is assumed that they might not understand the information). Thus, clinicians interpersonal sensitivity skills (that is, the ability to perceive the patient accurately in terms of their feelings, intentions, needs, etc.) could be improved (Hall, 2011). As evidence for strong associations between clinicians perceptions of patients' information needs and patients' actual needs are absent, clinicians tailoring efforts become problematic (Dekkers et al., 2018).

Moreover, tailoring based on impressions is likely informed by clinicians' implicit biases about individual patients. This type of tailoring could then be questioned for ethical reasons. Such implicit bias refers to the unconscious, automatic, stereotype-based assumptions about individuals and associations between members of particular social groups (age, gender, socioeconomic) and certain traits (e.g., openness, agreeability or actively engaged) and affective responses (e.g., display of emotions) (Hernandez, 2023; Puddifoot, 2019). Although implicit bias is not the result of "ill-will towards patients", it does potentially affect the clinical interaction and/or increase health disparities, and likely have a negative impact on patients from stigmatized groups (FitzGerald & Hurst, 2017; Hernandez, 2023). Research shows that there is strong evidence that implicit bias influences treatment choice, determines the conditions considered in the diagnostic process, and affects patient-centered behavior of clinicians (Puddifoot, 2019). In our study, tailoring efforts seem to be associated with biases regarding group-based characteristics of patients. For instance, clinicians assumed that older patients wanted to know less about fertility or sexuality, that patients who were groundworkers would not want to hear the details about their disease, and that patients who took less care of their appearance were incapable of understanding the information, and so on. Interestingly, clinicians often did not reflect on the assumptions they have about patients. Yet, assumptions about patients' age, profession and appearance could promote group-based inequalities and a culture of biased communication. Indeed, there is a danger in tailoring based on impressions, one that clinicians themselves seem to be aware of as they consistently spoke out about the need to check assumptions with the patient. We then recommend that clinicians check their assumptions against the patients' information needs and cognitive abilities to adequately notice and activate what information would be salient to a particular patient and provide information that helps the patient process the information. Moreover, in order to move beyond individual change, system-level change might be facilitated by institutions in the form of bias training for medical students and practicing staff to foster greater accountability.

4.3. Who guides the process of information tailoring: the clinician or patient?

The aforementioned findings reflect another pertinent point of discussion: 'Who should guide the process of information tailoring – the clinician or the patient?'. Ignoring patients' information needs constitutes a clear paternalistic practice. Similarly, tailoring information based on assumptions about patients' information needs or cognitive abilities also reflects a paternalistic approach. In contrast, tailoring that is grounded in patients' expressed needs demonstrates a more patient-centered practice. Although the latter approach aligns well with todays' paradigm of patient-centered care, it raises the question of whether patients' expressed needs alone should guide the process of information tailoring. Although patients' may benefit from information that is salient to them, disclosure of some information could still emotionally and/or cognitively overwhelm them. This raises the question: should clinicians provide patients with the information they desire even if it may too much for them to handle? Furthermore, patients may sometimes express to not receive certain information, while clinicians may have clinical or ethical reasons for disclosure. For instance, in the context of end-of life care, withholding prognostic information from patients – if desired – presents moral dilemmas for clinicians: should one go along with patients non-disclosure preferences when death is near (van der Velden et al., 2022)? Adjusting information provision to patients' expressed needs may seem appropriate; however, it remains uncertain whether this approach will produce the desired outcomes. We argue that information tailoring should not be viewed as solely clinician-driven or patient-driven but rather as a co-constructive process. Like all forms of communication, clinician-patient communication is a two-way-street (Epstein, 2006), and the same principle applies to information tailoring. This idea is supported by Smets et al. (2024), who write that clinicians adapt their information giving to the emerging needs of patients, emphasizing that clinicians should be attentive to cues and feedback during the consultation, thus framing tailoring as a dialectical process. This view aligns with the logic of care concept coined by Mol (2008), which emphasizes that care involves continuous adjustments, attention and collaboration between caregivers and patients; from this perspective, information tailoring is not a unilateral act, but a shared act towards information alignment.

4.4. How to tailor information against contextual and interpersonal challenges?

Clinicians identified several challenges that hindered their ability to tailor information to patients during consultations. These included possibly overwhelming patients with information when trying to meet their needs, the risk of unintentionally adjusting information to patients due to biases, the necessity of adhering to clinical guidelines, and the difficulties of communicating with patients who bring family members to the consultation with opposing information needs, and patients who have a language barriers or a cultural background different from the clinician's. The tension that was most often mentioned by clinicians concerned informing patients with cultural diverse backgrounds. This is not surprising since intercultural clinician-patient encounters are found to pose unique challenges for clinical communication (Schouten & Meeuwesen, 2006). In order to bridge the language barrier, clinicians in this study indicated working with formal (e.g., professional translators) and informal translators (e.g., family or friends of the patient). Although working with an informal translator posed difficulties for clinicians to adequately tailor information (that is because clinicians could not check for patients needs and understanding, check if information was completely translated or cultural norms and values were mediated), studies also show that patients themselves may actually feel more positive about the use of informal interpreters (Zendedel et al., 2018). Thus, if preferred by the patient the use of informal translators is recommended to support information tailoring.

Aside from talking to patients with language barriers, clinicians indicated that the cultural values, beliefs and needs of patients specifically impacted the process of information tailoring. This study shows that cultural factors can influence communication between clinicians and patients, particularly around sensitive topics like end-of-life care. These findings are in line with existing literature, which highlights that communication regarding prognosis and end-of-life care plans is challenging when clinicians, patients and their families uphold varying and diverging personal, cultural and religious beliefs about this type of care (Brooks, Bloomer, & Manias, 2019). Moreover, clinicians' reflected upon the implicit biases and stereotypes they hold regarding patients' religious beliefs, which influenced their perceptions of patients' information needs and subsequent tailoring efforts. Nonetheless, clinicians demonstrated awareness of these biases and actively engaged in self-reflection. In order to prevent doing harm and avoid conflict, that is, if cultural needs are not communicated and/or accommodated, we argue that clinicians ought to be sensitive to the patients' cultural (non) disclosure preferences. This calls for a culturally sensitive approach to providing health-related information that fits culturally diverse patient (Brooks, Manias, & Bloomer, 2019).

4.5. Strength and limitations

Using focus group and dyadic interviews was a worthwhile approach to explore what physicians and clinical nurse specialists think about information tailoring and what efforts they use to tailor information in practice. We had the impression that in all interviews clinicians were open about their experiences with information tailoring, sharing rich examples of how they tailor information to individual patients. Social desirability did not seem to limit clinicians' candor. Although similar content came to light in the interviews, they differed in terms of interaction dynamics. In some focus group interviews participants tended to talk shorter, using less time to articulate their perspectives, whereas the dynamic between participants in dyadic interviews appeared to comprise more longer and intertwined exchanges. Dyadic interviews might thus facilitate a high degree of attunement (Morgan, 2016; Szulc & King, 2022), and were of added value to investigate information tailoring in depth. Additionally, of added value was the involvement of clinical nurse specialists, as their perspective on medical communication is often overlooked, this while clinical nurse specialists are keen and helpful providers of information during clinical consultation (Droog et al., 2014; Koutsopoulou et al., 2010).

However, the results of this study must also be seen in the context of its limitations. Due to the use of a snowball and purposive sampling method, only clinicians interested in the study's topic participated. Additionally, some clinicians had previously participated in similar medical communication research, which may have resulted in demand bias, although no such differences were observed by the researchers. Moreover, the researchers had limited control over the diversity of the research population that consisted of mainly white and female clinicians. We acknowledge that the study findings may have differed if this study had included clinicians with more diverse backgrounds, or if it had included multiple contexts across different hospitals in the Netherlands or elsewhere. Nevertheless, we found no differences in how clinicians with different genders and ages talked about their experiences with information tailoring. This may partly be explained by the consultation scenario used, which depicted two clinician and patient types likely relatable to all participants. At the same time, the researcher could not prevent the effects of any potential power relations between the participating physicians on the group discussion. Although all participants were given equal speech time, junior physicians (residents) were found to contribute less to the discussion and often times agreed with their supervisors. This finding support those of other studies, where junior physicians (residents) were found to defer to their superiors (Simons et al., 2024). This behavior may stem from their relative inexperience or lower level of confidence. In this study we can not account for such differences. At last, the differences in experiences regarding tailoring between physician and clinical nurse specialist were not examined in this study. Such difference may be explained by differences in educational background, training or contextual factors, such as consultation time, and should be addressed elsewhere to further unravel how different clinicians can be supported in tailoring of information.

5. Conclusion

This article highlights the various strategies physicians and clinical nurse specialists use to assess cancer patients' information needs and cognitive abilities, in order to tailor information to each individual patient. Such tailoring of information is carried out by inquiring about patients' information needs and cognitive abilities, or is built on clinicians' impressions of patients' information needs and cognitive abilities, inferred from assumptions about patient characteristics and behavior. The appropriateness of tailoring based on impressions is questionable, as assumptions about patients' needs and cognitive abilities may not align with patients' true desires and capabilities. Furthermore, information tailoring is not easily managed in clinical practice due to interpersonal and contextual challenges. Notwithstanding, this study was a first step to gain insight into the process of information tailoring and contributes to the eventual development of communication guidelines that are sensitive to the patient and the consultation context.

CRediT authorship contribution statement

A. Van Ooijen: Writing – review & editing, Writing – original draft, Visualization, Project administration, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **S.R. Dalhuisen:** Writing – review & editing, Investigation, Formal analysis, Data curation. **I. Henselmans:** Writing – review & editing, Supervision. **H.W.M. van Laarhoven:** Writing – review & editing. **J.C.M. van Weert:** Writing – review & editing, Supervision, Methodology, Conceptualization. **E.M. A. Smets:** Writing – review & editing, Supervision, Methodology, Conceptualization.

Funding statement

This study is funded by the Dutch Cancer Society (study no. 14776).

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Acknowledgements

We would like to thank dr. Filip de Vos for his help in recruiting participants for the focus group interviews.

Appendix A.1. Interview Guide (Dutch)

EERSTE INDRUK: OBSERVATIES EN VERONDERSTELLINGEN

Post-it activities:

Schrijf op post-its waar je op let om een eerste indruk van de patiënt te vormen tijdens het consult? Welke observaties maak je? Denk hierbij niet aan de medische conditie van de patiënt, maar al het andere waar je op let om een beeld van de patiënt te vormen. Schrijf op iedere post-it één observatie. De moderator plakt vervolgens de post-its op de flipover.

- Welke observaties maken jullie om een eerste indruk van de patiënt te vormen tijdens het consult?
  - o Wat zegt (gen) een *[deze]* observatie(s) jullie over de patiënt?
  - o Blijven jullie bij deze eerste indruk van de patiënt, of veranderd deze indruk gaande weg het consult, en waarom?
- Wordt jullie indruk van de patiënt ook gevormd door informatie die te vinden is in het medisch dossier van de patiënt?
  - o Welke informatie uit het dossier gebruik je om een indruk van de patiënt te vormen? *(o.a. ook psychosociale informatie)*
  - o Wat zegt/verteld (al) deze informatie jullie over de patiënt?
- Maken jullie ook bepaalde veronderstellingen over patiënten aan de hand van de eerste indruk die jullie vormen?
  - o Welke veronderstellingen maken jullie dan?
  - o Waarop baseren jullie deze veronderstelling?
  - o Kunnen jullie en voorbeeld noemen van een veronderstelling die je had over een patiënt?

BEHANDELINFORMATIE DELEN EN AANPASSEN:

- Welke behandelinformatie delen jullie met patiënten tijdens *(face-to-face)* consulten?
  Wat is de rol van de verpleegkundig specialist in het verstrekken van behandel-informatie aan patiënten? Hoe verschilt jullie rol met dat van de arts?
  - o Is dit standaardinformatie of passen jullie de informatie aan op de individuele patiënt tegenover je tijdens een consult?
  - o Welke standaardinformatie delen jullie zoal?
  - o En welke informatie passen jullie zoal aan op de individuele patiënt tegenover je tijdens een consult?
- Op grond waarvan maak je de keuze om behandelinformatie aan te passen op de individuele patiënt tegenover je tijdens het consult (en wanneer niet)?
  Aanvoelen informatiebehoeften en vaardigheden patiënten?
  - o Passen jullie de behandelinformatie aan op de informatiebehoeften van patiënten? Zo ja, hoe voelen/proeven jullie wat de informatiebehoeften van een patiënt zijn?
  - o Passen jullie de behandelinformatie aan op de informatievaardigheden (o.a., begrip en verwerking) van patiënten? Zo ja, hoe voelen/proeven jullie wat de informatievaardigheden (o.a., begrip en verwerking) van een patiënt zijn?

  Invloed patiëntkenmerken?
  - o Passen jullie de behandelinformatie aan op patiënten met bepaalde kenmerken *(o.a., gender, religie, leeftijd, opleidingsniveau, etniciteit, Nederlands sprekend of niet)*. En waarom?
  - o Merken jullie een verschil in informatiebehoeften en informatievaardigheden (o.a., begrip en verwerking) tussen patiënten met bepaalde kenmerken?

  Invloed patiënt gedragingen?
  - o Heeft bepaald gedrag (verbaal of non-verbaal) van patiënten tijdens een consult invloed op de behandelinformatie die je wel of niet deelt?
  - o Zo ja, welke gedragingen van patiënten hebben hier invloed op? En waarom?
- Hoe proberen jullie tijdens het consult behandelinformatie op maat te verstrekken aan patiënten?
  - o Gebruiken jullie bepaalde tools om informatie aan te laten sluiten op de patiënt? Zo ja, welke tools gebruiken jullie zoal?
  - o Kunnen jullie aan de hand van een voorbeeld toelichten hoe je tijdens een consult behandelinformatie op maat probeert te verstrekken aan de patiënt?

Scenario specifieke vragen:

Scenario 1. Zorgverlener Klaasse ontvangt vandaag mevrouw Bouwman voor een behandelgesprek. Bij mevrouw Bouwman, leeftijd 31, is recentelijk leukemie vastgesteld. Bij binnenkomst heet zorgverlener Klaasse mevrouw Bouwman en haar man hartelijk welkom. Bij binnenkomst merkt de zorgverlener Klaasse op dat mevrouw Bouwman een onzekere en angstige indruk maakt. Ze vertelt haar over de behandelopties om de leukemie onder controle te krijgen. Zorgverlener Klaasse wordt echter vaak onderbroken omdat mevrouw een vraag heeft: Hoe groot is de overlevingskans als ik voor deze behandeling kies? Hoe lang duurt die behandeling? Zorgverlener Klaasse luistert aandachtig, zonder tussentijds haar computerscherm te raadplegen. Nadat mevrouw Bouwman al haar vragen heeft gesteld, probeert ze deze zo zorgvuldig mogelijk te beantwoorden.

- Wat vinden jullie van dit scenario?

- o Welke indruk krijgen jullie van de arts in dit scenario?
  - Bijvoorbeeld: verwelkomt de zorgverlener de patiënt?
  - Bijvoorbeeld: Luistert de zorgverlener aandachtig?
  - Bijvoorbeeld: Beantwoordt de zorgverlener alle vragen van de patiënt?
- o En wat voor indruk krijg je van de patiënt in dit scenario?
  - Bijvoorbeeld: Stelt de patiënt veel vragen?
  - Bijvoorbeeld. Onderbreekt de patiënt de zorgverlener?
  - Bijvoorbeeld: Maakt de patiënt een onzekere of angstige indruk?
- o Wordt in dit scenario voor jullie gevoel maatwerk geleverd? En waarom?
- o Of ontbreekt er voor jullie iets aan de manier waarop de arts het consult voert om dit maatwerk te noemen? En waarom?
- o Hoe zouden jullie zelf maatwerk leveren in het gesprek met mevrouw Bouwman?

Scenario 2. Zorgverlener Vermeulen komt gehaast de wachtkamer inlopen om meneer Haru op te halen. Hij ziet meneer haru vandaag voor het eerst. Meneer Haru is 52 jaar oud en heeft prostaatkanker. Hij is vandaag alleen naar de polikliniek gekomen voor het behandelgesprek. Het vorige consult van zorgverlener Vermeulen liep 15 minuten uit, en hij had geen tijd gehad om meneer Haru hiervan op de hoogte te stellen. 'Ik ben wat laat, komt u maar gauw mee naar de spreekkamer', zegt zorgverlener Vermeulen. Bij binnenkomst vertelt zorgverlener Vermeulen in een notendop aan meneer Haru wat de behandelopties zijn om de kanker onder controle te krijgen. Meneer Haru knikt hier en daar een beetje, en stelt geen vragen. Ook oogt hij rustig; niet nerveus. Op de vraag of hij verdere uitleg wilt ontvangen over de verschillende behandelingen, reageert hij met: 'u bent de dokter, kunt u die keuze niet maken, u weet wat het beste is'. Na enige tijd rond zorgverlener Vermeulen het gesprek af.

- Wat vinden jullie van dit scenario?
  - o Welke indruk krijgen jullie van de arts in dit scenario?
    - Bijvoorbeeld: Komt de zorgverlener gehaast over?
    - Bijvoorbeeld: Verontschuldigt de zorgverlener zich omdat hij/zij te laat is?
    - Bijvoorbeeld: Verteld de zorgverlener in een notendop over het behandelplan?
  - o En wat voor indruk krijg je van de patiënt in dit scenario?
    - Bijvoorbeeld: Stelt de patiënt geen vragen?
    - Bijvoorbeeld: .Legt de patiënt de keuze over de behandeling bij de zorgverlener neer?
    - Bijvoorbeeld: Komt de patiënt rustig en niet nerveus over?
    - Bijvoorbeeld: Suggereert de naam van de patiënt dat hij/zijn mogelijk een niet-westerse etniciteit/nationaliteit heeft?
  - o Wordt in dit scenario voor jullie gevoel maatwerk geleverd? En waarom?
  - o Of ontbreekt er voor jullie iets aan de manier waarop de arts het consult voert om dit maatwerk te noemen? En waarom?
  - o Hoe zouden jullie zelf maatwerk leveren in het gesprek met meneer Haru?

Table A.1
Demographic and Professional Characteristics Research Participants

Characteristics	Category	Frequency
Gender:	Male	4
	Female	21
Age:	<40	9
	40–50	8
	>50	8
Job title:	Physician	11
	Junior physicians (residents)	4
	Physician assistant	1
	Clinical nurse specialist and/or counsellor	9
Oncological specialization:	Radiotherapy/radiation oncology	4
	Medical Oncology	15
	Gynecology	5
	Pulmonology	1
Years work experience:	<10	8
	10–20	11
	>20	6

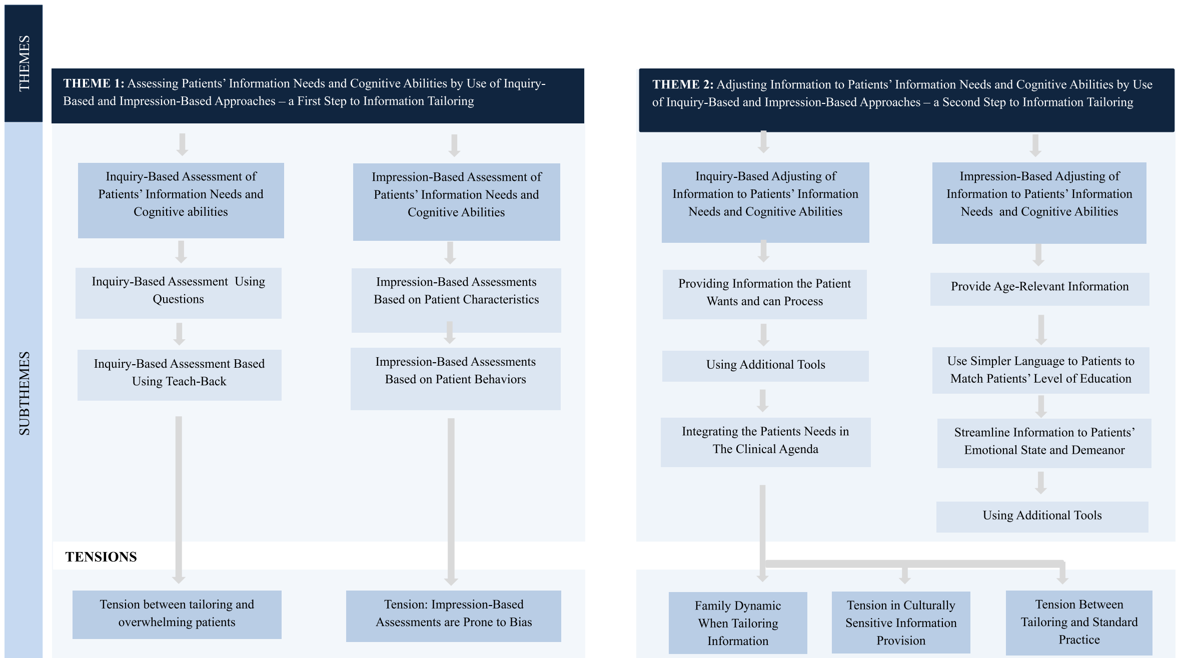

Fig. A1.

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