Doctor-patient communication and satisfaction with care in oncology
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Purpose of review
This review summarises current knowledge on the impact on patient satisfaction of initiatives undertaken to enhance the communication between doctors and their patients in oncology.

Recent findings
Recent studies have assessed the effectiveness of different approaches aimed at improving doctor-patient communication in oncology. These have been assessed on outcomes related to the patient (e.g., anxiety, quality of life, medical knowledge, satisfaction) or to the doctor (e.g., communication behaviour, attitudes). Patient satisfaction has been recognised as a particularly relevant outcome, and a positive effect of recent initiatives to improve the interaction between cancer patients and their doctors on patient satisfaction has been suggested.

Summary
To better respond to cancer patients' health care needs, various strategies focusing on doctor-patient communication have been developed. Addressing patients' overall needs and sharing complex information in an emotionally charged context and under time constraints is a daily challenge for the oncology clinician, resulting often in cancer patients' dissatisfaction. Recent interventions elaborated to facilitate doctor-patient communication in oncology focus on patients, such as handing out of videos or written preparatory information; or doctors, such as patient self-rating feedback to doctors or communication skills training; or on both, such as the audiorecording of the consultation or the provision of consultation aids. Although these strategies offer promising results, further research should be implemented to assess their appropriateness across sociocultural contexts and their long-term effectiveness in clinical practice.

Keywords
doctor-patient communication, medical decision making, oncology, patient satisfaction

Abbreviation
CCPP  cancer consultation preparation package

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Introduction
In the past two decades, in Western countries, a trend toward increased information seeking with increased preference for participation in treatment decisions has been evidenced in cancer patients [1]. Recently, the process of sharing information has been stressed, underscoring the importance of an individualised information delivery adapted to patients' needs and preferences at all stages of the illness [2*]. In the context of incurable disease, most patients want detailed diagnostic information but also expect to negotiate when issues of survival or dying are to be discussed [3*].

Various studies have underscored patients' dissatisfaction with regard to aspects of their interaction with providers in oncology (e.g., information provision, attention to psychosocial needs) [4]. Different initiatives to improve the communication between doctors and cancer patients have thus been developed. Methods focus either on patients, such as handing out a 'prompt sheet' before a consultation [5] or inviting the patient to view a CD-ROM as a treatment decision support [6]; or focus on physicians, e.g., arranging a communication skills training [7]; or on both, such as the audiorecording of the consultation [8].

This review considers the effects of such initiatives on patient satisfaction, with a focus on reports published since January 2004. First we delineate relevant features of doctor-patient communication in relation to patient satisfaction.

Doctor-patient communication
Good doctor-patient communication is essential because it increases patients' coping and satisfaction with care, enhances informed consent and cooperation with care, reduces the probability of malpractice litigation, and decreases professionals' burnout.

Three purposes of the doctor-patient communication have been outlined: creating a good interpersonal relation; exchanging information; and making treatment-related decisions [9]. Health care providers' communicative behaviours help regulate patients' emotions, facilitate comprehension
of medical information, and allow for better identification of patients' needs, perceptions, and expectations. In communicating with cancer patients, doctors are often confronted with difficult issues for which they are unprepared, such as communicating bad news, preparing for aversive procedures, exploring treatment options, enrolling the patient in clinical trials, discussing prognosis, or switching from curative treatment to supportive care [10]. As a result, communication goals in oncology are often hampered. For example, studies have highlighted discrepancies in patients' and staff ratings of patients' quality of life [11], suggesting poor identification of patients' physical or psychosocial needs. Moreover, in communicating with patients with advanced cancer, doctors frequently censor information on prognosis [3•].

A good interpersonal relation encompasses human qualities such as friendliness, respect, and interest, as well as skills typical of the psychotherapeutic relation such as empathy, genuineness, and unconditional acceptance. It also refers to a style of relation integrating both a physician-centred as well as a patient-centred approach. In such instance, the medical interview successively displays communicative behaviours that follow either the patient's agenda in areas where he or she is the expert (symptoms, preferences, concerns) or the doctor's agenda in his or her domain of expertise (details of disease, treatment) [9].

The exchange of information consists of information seeking and information giving from both doctors and patients. Doctors' provision of information in oncology requires an initial clarification of patients' information needs or values, accounting for individual variability in terms, e.g., of sociocultural background, coping style, or health status. Then it involves information concerning treatment options for which the cost-benefit ratio is not always clearly established [12•]. Moreover, cancer patients' understanding of information is often affected by anxiety or denial, calling for a particular clinician's ability to elicit and discuss patients' emotions.

Medical communication is aimed at enabling doctors and patients to make decisions about treatment. A shared decision-making model has been recently promoted. This model means that the doctor and patient share information about treatment options to arrive together at a consensus regarding the preferred option [13]. A participative patient role may have benefits in that patients who perceive that they have control in treatment decision making may regain a sense of control and mastery over their disease or treatment [14]. Doctors need to evidence and then attune to patients' desired level of participation in treatment decision making.

Different surveys performed in the oncology setting suggest tentative conclusions on the impact of specific communicative behaviours on cancer patient satisfaction. Patients' higher satisfaction with a patient-centred communication style in the consultation, particularly when the patient has a poor prognosis, has been observed [15]. In the history-taking phase of the medical oncology consultation, informal talk in establishing rapport is correlated with patient satisfaction, whereas patients tend to be dissatisfied if psychosocial exchanges occur during the physical examination [10]. Concerning the exchange of information, the perception of information needs by patients and doctors may diverge, resulting in patients receiving either more or less information than desired [16]. With regard to medical decision making, compared with a decision made by either the patient or the doctor exclusively, a shared role in decision making is associated with higher patient satisfaction with the consultation [17].

**Patient satisfaction assessment**

In surveying patients' perception of doctors' communication skills or assessing the effectiveness of initiatives to improve communication in the medical encounter, patient satisfaction is the most widely recognised outcome measure [9]. Concerning human aspects of care such as communication skills, patients' opinion conveys a perspective that objective sources of evaluation cannot provide. Patients' satisfaction ratings reflect the extent to which patients' health care needs, expectations, or preferences are met. These data may help develop more appropriate communication guidelines [15].

Patient satisfaction scales often show a pronounced positive skew in responses, which complicates their interpretation. Different rigorously developed and validated questionnaires have proved their practical usefulness, however, in either prioritising aspects of care to improve in the oncology setting overall [18] or specifically in the oncology outpatient consultation [19], or to assess interventions aimed at improving communication skills [7]. The assessment of doctor-patient shared decision making requires additional specific items addressing the patient's satisfaction with the decision [20].

**Examples of initiatives to improve doctor-patient communication and their effect on patient satisfaction**

Initiatives to improve doctor-patient communication focused on the patient, the doctor, or both.

**Interventions focused on patients**

Among interventions targeting patients, a consultation preparatory video and a cancer consultation preparation package (CCPP) have recently been tested in two randomised studies [21,22•]. These interventions were designed to enhance information provision and involvement in the oncology consultation. The 19-minute preparatory video was an orientation program providing information on the
typical patient's experience of the medical appointment and including examples of basic questions the patient might wish to ask professionals [21]. Compared with the control condition (informational pamphlet), among minority patients, those in the video condition revealed higher satisfaction with the overall clinic appointment.

The CCPP included a question prompt sheet (i.e., a list of questions relevant to patients in the situation), booklets on clinical decision making and patient rights, and an introduction to the clinic [22]. This information package proved to elicit more patients' asking and more physicians' facilitative actions (enquiring for patients' agenda, checking understanding). Compared with the control group, however, CCPP patients' satisfaction with the consultation was not increased and patients were not more likely to believe they had achieved their involvement preference.

**Interventions focused on doctors**

As for doctors, interventions have been designed to facilitate the detection of physical and psychological problems through the use of quality-of-life questionnaires in the routine oncology practice [23] as well as to improve communication skills through the implementation of specific training [24].

In a recent prospective study involving 28 oncologists, 286 cancer patients were randomly assigned to either an intervention group (regular completion of quality-of-life and anxiety and depression scales on touch-screen computers in the clinic, and subsequent feedback of results to physicians), attention-control group (completion of questionnaires, but no feedback), or control group. In addition to a positive effect on patients' quality of life and emotional well-being, improvement of communication was also observed. Nevertheless, no information was collected on a possible impact on patient satisfaction.

Consultations with cancer patients pose many difficulties. Doctors are often confronted with the pressure of time constraints while having to impart bad news to severely ill and anxious patients. Interventions elaborated to help doctors communicate within oncology encompass a variety of approaches and methods, including the provision of guidelines for breaking bad news and the implementation of communication skills and workshops [25]. A recent review of the effectiveness of various communication training methods in oncology concluded in modest improvements in communication skills as assessed through audio or video, professionals' self-report, or patients' assessment [26]. The best results were reported for longer training programs and with smaller groups encouraging active participation.

Most recently, Delvaux et al. [24] addressed the effectiveness of a one-week for three consecutive months psychological training program, including theoretical information, standardised role-playing exercises, and experiential exchanges, for oncology nurses. Just after the training and 3 months after, this program appeared to significantly enhance nurses' facilitative behaviours (open questions, evaluative functions) and decrease inhibitory behaviours (inappropriate information, false reassurance). This study also revealed a positive impact of this training on patients' satisfaction.

**Interventions focused on both**

Doctors and patients deciding on a treatment plan is an important, often complex goal of communication in oncology. Decision aids have been elaborated to enhance the physician and patient communication during the decision process within the consultation and to help the informed patient decide which treatment he or she prefers. Decision aids consist of a visual aid and written material based on the best available evidence, which are presented by the clinician to the patient during the medical consultation, as a support for discussion of the different treatment options available, allowing patients to express a preference for treatment.

In a recent cluster randomised study, Whelan et al. [27] evaluated the impact of a decision aid regarding surgical options (mastectomy or breast-conserving therapy) for the treatment of early-stage breast cancer on patient decision making. The decision aid appeared helpful in improving communication and enabling women to make a choice regarding treatment. Patients in the decision board group proved more satisfied with the decision making following the consultation.

**Implications for practice**

Appropriately eliciting patients' overall needs or preference and imparting information in an emotionally charged context is a particularly hard task for the oncology clinician. The five studies reviewed here offer promising results for various approaches aimed at improving the communication between doctors and patients in oncology. These involved standardised information provision through a video, a medical information package or a decision aid; standardised patients' quality-of-life self-rating feedback to doctors; and finally, communication skills training. These interventions were assessed for different outcomes. Among these, patient satisfaction was tested in four of the studies reviewed and appeared positively related to the intervention in three of them [21,24,27].

The standardised information or assessment procedures proved feasible (without increasing the consultation length) and effective in the clinical setting. This kind of convenient, reasonably priced intervention could thus be recommended as a first step in informing or assessing cancer patients in the different phases of the treatment process.
In addition, however, doctors' attitudes and communication skills should also be addressed. Butow et al. [22] stressed the importance of training in responding to more active patients involved in medical decision making. Doctors must recognise their need to be trained in assessing patients' evolving information needs as well as in responding to more assertive patients, attuning to their coping style and familial or cultural context.

Studies assessing the impact of communication skills training confirm that health care professionals can be trained to communicate more effectively with patients who have cancer. Further research should be done, however, to ensure that the significant improvement in the skills taught during the courses is maintained over time and has an effect in practice. Delvaux et al. [24] report encouraging results in this regard: the maintenance at 3 months of most skills acquired and the impact on patient satisfaction following a patient interview in the clinical setting.

Conclusion
Recent studies assessing the effectiveness of initiatives to improve the communication between doctors and patients in oncology suggest a positive effect on patient satisfaction. The initiatives should target both doctors and patients. Patients should be educated in soliciting information and expressing their preferences, and doctors must recognise the need to acquire appropriate communication skills to better elicit patients' overall needs, impart information in a sensitive manner, and respond to more assertive patients. Further research should be implemented to assess the appropriateness of these approaches across sociocultural contexts. Furthermore, communication skills training should be complemented by an opportunity for supervision and discussion of difficult interviews in clinical practice.

References and recommended reading
Papers of particular interest, published within the annual period of review, have been highlighted as:
• of special interest
** of outstanding interest


An important study on patients and their relatives' experiences of the disclosure of medical information in the context of advanced cancer disease.


An important study on patients' preferences for and predictors of prognosis information in the context of advanced cancer disease.


11 Sprangers MA, Aaronson NK. The role of health care providers and significant others in evaluating the quality of life of patients with chronic disease: a review. J Clin Epidemiol 1992; 45:743-750.


An excellent paper providing guidelines for improving communication in cancer care based on current empirical findings.


This is an excellent study providing evidence of the need to address both patients and doctors in improving the communication between them.


This paper consists of an excellent review of the experience of health care professionals, patients, and families in the 'bad news' consultation and highlights present findings on interventions to improve the communication of bad news in medicine.


This paper reports an excellent study assessing the impact of a decision aid in the context of the surgical treatment decision in breast cancer and provides in-depth comments on their results in shared decision making in medicine.