Medical Education

The validity of education and guidance for clinical communication in cancer care: Evidence-based practice will depend on practice-based evidence

Peter Salmon *, Bridget Young

Division of Clinical Psychology, University of Liverpool, Liverpool, UK

ARTICLE INFO

ABSTRACT

Objective: The validity of clinical communication skills education and guidance for cancer care is sometimes portrayed as self-evident. This view needs re-examination in light of critiques of the concept of communication skills.
Methods: We critically examine principles that steer communication teaching and guidance in cancer care and draw on research that can inform the next generation of development in this field.
Results: Unlike other areas of clinical skills, communication is highly contested. Any instance of communication is open to multiple interpretations; expert principles of communication are imprecise and often contradictory. The concept of communication skills will constrain development, because of its implication that universal, expert-defined components of communication are the building blocks of clinical relationships. Research on communication in practice indicates insights that could enrich future education and guidance.
Conclusions: Communication experts have more to learn from practitioners and patients than is commonly appreciated. Inductive, qualitative research should incorporate patient and practitioner perspectives as well as observations of communication.
Practice implications: Solutions to communication dilemmas might be found in detailed study of communication in practice, rather than in current expert principles. Incorporating such evidence will help to ensure the continued authority of communication curricula and guidance as evidence-based and patient-centred.

© 2012 Elsevier Ireland Ltd. All rights reserved.

1. Introduction

Clinical communication is key to effective cancer care, from enabling accurate and timely diagnosis to ensuring adherence to treatment. Therefore clinical outcomes – even survival – depend on effective communication [1]. As well as being the vehicle for clinical care, communication matters to patients in its own right, underpinning the trust in practitioners and hope for the future upon which their morale depends [2,3]. Educationists and practitioners are therefore offered extensive education and guidance about communication [4–6].

However, despite several decades of research, it remains unclear whether patients benefit when practitioners' communication is shaped in this way. Clinical outcomes have rarely been evaluated, and a recent systematic review found inconclusive evidence for effects on patient experience [7]. Large areas of clinical education and guidance necessarily continue in the absence of outcome evidence. For example, medical students are taught clinical tasks such as how to take blood or how to pass a nasogastric tube on the assumption that they will then perform these tasks better than students who are left to discover for themselves. The case for training in these areas is that there are clearly right (and wrong) ways of performing these procedures, and that practitioners will obviously not discover these without training or guidance. Some experts portray clinical communication as this kind of area; for example when they offer generalised criticisms of practitioners' poor communication without knowing patient perspectives and local circumstances, or generalised assertions of practitioners' need for communication training [8–15].

Our aims here are: first, to examine this stance in relation to communication education and guidance in cancer care; secondly, to identify key assumptions underlying the field which help to perpetuate this stance; and, thirdly, to indicate how a different approach might inform the next generation of education and guidance. To do this, we draw on key papers in the field and representative examples of relevant research, recent critiques of clinical communication education and, finally, research that has

* Corresponding author at: Division of Clinical Psychology, University of Liverpool, Whelan Building, Brownlow Hill, Liverpool L69 3GB, UK.
Tel.: +44 151 794 5531; fax: +44 151 794 5537.
E-mail address: psalmon@liv.ac.uk (P. Salmon).

taken an inductive approach to patients' communication needs and clinicians' communication strategies.

2. The validity of communication education and guidance is not obvious

By contrast with clinical skills that practitioners obviously need to know, and obviously will not learn by themselves, the validity of communication education and guidance in cancer care is not so self-evident.

It is rarely obvious in practice whether any instance of communication was the right thing to say. Whereas assessing competence in venipuncture or intubation is relatively straightforward, the modest reliability of assessments of communication competence indicates the divergent views that observers can take of the same instance of communication [16]. Multiple interpretations are possible, from different perspectives, and even communication experts can disagree between themselves (Box 1). Indeed,

---

Box 1. Experts can disagree about communication in practice.

Seven communication experts (including psychologists and physicians) at an international workshop [91] read a transcript of consultation of a breast cancer patient with her surgeon, and summaries of interviews with the patient and surgeon about their consultation, drawn from a qualitative study [47]. The experts then rated the appropriateness of the surgeon's responses to the patient at specific points in the consultation, including the response (underlined) below, using a scale: 0 = 'could not be worse'; 10 = 'could not be better'. Ratings diverged greatly, as this example illustrates.

The data provided
Before this extract, the surgeon has told the patient that histology indicates metastatic spread to her lymph nodes. He has explained chemotherapy and has suggested that she might need this.

Patient   *So even though I don't want chemo it would be sensible?*
Surgeon   *Well, it would give a small benefit, and I guess the benefit we're talking about is in the order probably of three or four percent. Now, what that means is that about three or four people out of every hundred would benefit.*
Patient   *I don't want it [cancer] to come back, but I don't want to lose my hair. It's about the only decent thing I've got left.*
Surgeon   *Now, the chemotherapy of course, now, it reduces the risk of it coming back a little bit. It doesn't completely abolish that risk I'm afraid*

The surgeon then proposes referring the patient to the oncologist to discuss chemotherapy.
In interviews, the patient said that she felt cared for. ''*He was thorough. I liked the fact that he sat quite close to me. It made it more personal. He spoke to me as though I had some intelligence.*'' In explaining his stance, the surgeon explained that ''*These women have let me into the most personal space, physically. They give me very personal space emotionally. You see people at their most vulnerable. I think that should be treated with enormous respect and not trampled over. I want to treat this person with respect and part of that is being honest with them and treat them as sensible human beings, in the same way that I would wish to be treated myself*''.

Experts' ratings of the surgeon's response
The ratings of the surgeon's response (underlined) were: 0, 2, 2, 3, 5, 8, and 8. Experts rating the response poorly said the surgeon should have explored the patient's concerns about hair loss and body image. Those with high ratings said that the surgeon correctly focused on treatment needs and respected the patient, and that the patient liked his communication style.

---

the formal guidance that communication experts offer cancer clinicians rarely identifies the right thing to do because it is often vague, impractical or contradictory. For example, current guidance around information-giving takes two broad approaches: give 'full information' or 'the information that the patient wants' [17]. The former is impractical because information about complex conditions is effectively infinite, can be presented in different ways and cannot be described simply according to quantity. The latter is impractical, because patients cannot know in advance what information exists [17], and it proves uninformative in practice [18]. Moreover, clinicians are expected to maintain hope, which often means constraining information [19–21]. Guidance about decision-making can also be difficult to implement. Clinicians are advised to 'share' decision-making [10,22], but have to be authoritative and expert in taking clinical responsibility. As a third example, while clinicians are urged to develop emotional relationships with their patients [6], they need to keep objective and avoid personal involvement. Communication experts' expectations for practitioners therefore prove ambiguous in practice.

It is often assumed that communication outcome research will deliver more precise principles to guide practitioners. However, an important constraint on outcome research is that there is rarely a single outcome for any utterance, so communication that is inappropriate for one outcome (for example, because it distresses the patient), might be appropriate for another (for example, because it challenges denial) [2]. Therefore outcome research risks over-simplifying consultation, for example by focusing on patients' satisfaction or distress in isolation from clinical outcomes. Given the inherent variability in communication, the processes that outcome research *can* identify are limited to generalisations. Similarly, focusing on relatively objectifiable, and therefore researchable, elements of communication can mean prioritising trivial processes over important, but subjective, ones [23–25].

Portraying communication education and guidance as an enterprise with obvious validity contrasts strikingly with the vigorous contest in academic discourse about clinical communication. In social science, different theoretical standpoints mean contrasting perspectives on doctors' power and authority [26]. Similarly, different methodological perspectives locate what is important about communication in the moment-to-moment details of people's talk and conversational strategies or in the broad content of what they say [27]. In this context, very little should be 'taken for granted', and the validity of education and guidance will arise from debate and contest, not consensus.

3. Regarding communication as 'skills' will stifle development

Claims to the inherent validity of communication education and guidance reflect the influence of the predominant theoretical framework whereby communication is divisible into discrete elements, or 'skills', that can be defined by experts, then taught and assessed alongside other clinical skills [4–6]. According to this view, practitioners can combine and deploy these skills according to principles and guidelines to achieve consultation objectives. The concept of communication skills reflects the reductionism of psychological sciences, whereby a complex phenomenon is broken down into components. It has thereby allowed communication experts to match the analytic approach of the biomedical sciences. Therefore the concept has been very important in facilitating the introduction of communication education into clinical curricula and of communication guidance into clinical practice. In this way, it has been the vehicle for psychology, psychiatry and social sciences to influence clinical education and to seek to 'humanise' clinical practice. In particular, the concept of communication skills has underpinned development of educational technologies that have proved readily assimilable into curricula and practice,

including training programmes that can target 'basic' or 'advanced' skills that can be assessed formally and that are valued institutionally [5,28,29]. The language of 'skills' therefore now routinely characterises accounts of communication, and the concept informs educational models [30] in cancer care. However, applied to communication, this approach is highly contested and has been criticised over three decades from humanistic, linguistic and clinical perspectives as a framework that obstructs conceptual and pedagogic development [25,31–35].

In the strict sense, a skill is an ability that can be precisely defined and assessed – either through observing behaviours, such as in suturing a wound, or through the consequence of the skill, such as successfully intubating a patient. Yet, few communication behaviours can be called skills in this sense. In practice, as Skelton has pointed out, the term 'skill' is more commonly applied to behaviour that is not amenable to objective definition such as 'understanding patients' perspective' [36] or 'providing supportive communication' [4]. Where behaviours, such as maintaining eye contact, are denoted as skills, definitions are often qualified by the term 'appropriate', thereby removing objectivity. The reason that objectivity remains elusive is that, for most elements of communication, meaning does not lie in the objective character-istics of what is said or done, but is largely subjectively shaped [31,32,34,35]. What listeners hear does not depend just on what speakers say but also on listeners' perspective; different patients can experience the same communication as caring or uncaring [37].

Calling some behaviour 'skills' masks this subjectivity and implies, instead, that behaviours have a constant value [31]. Therein lie the dangers of the concept of skills [31,34]. First, it leads naturally to evaluating communication from expert perspectives, for example through expert-designed coding schemes. However, what patients value can diverge from what experts value [38,39], communication that displays improved expert-defined 'skills' does not necessarily help patients [40,41], and communication gov-erned by expert rules can frustrate patients' needs [42,43]. Secondly, the danger in identifying some communication elements as 'skills' is that they become valued intrinsically and define 'good communication' even where there is no evidence of patient benefit. The result is that education is claimed to be successful simply where learners reproduce behaviours they have been taught, such as acknowledging patients' emotional cues or uttering empathic statements, without evidence of the impact on patients. Similarly, although there has been extensive research into how to teach communication skills for 'breaking bad news', very little has asked whether patients benefit [44]. A parallel can be drawn with clinical trials, particularly pharmaceutical industry trials, which evaluate medicines against 'surrogate outcomes' that are easy to attain but of little clinical consequence [45].

Valuing skills in their own right risks leading educational research into untenable positions. For example, the frequent claim that communication training succeeded because it increased practitioners' empathy implies that the more empathy, the better, despite evidence that patients sometimes dislike emotional talk from oncologists [39,46,47], and that practitioners' empathy is not generally associated with patients' satisfaction when it is assessed by coding practitioners' communication [48]. Moreover, in the absence of any specification of exactly how much empathy is appropriate, and at what places in consultation, there can be no end-point to the mission to increase empathy. It therefore becomes, in essence, a moral rather than empirically informed enterprise [49].

Paradoxically, the moral authority that the concept of skill gives educators is at the expense of regarding practitioners' communi-cation as morally directed. Educational theory explains why [50]. Being able to regard learners' communication as reflecting their own choice is necessary for regarding it as authentic. However, pre-determining objectives for learners, as the concept of communication skills implies, means that learners' behavioural change cannot be regarded as self-determined. For instance, consider a study in which cancer patients watched video vignettes of physicians breaking bad news and which showed that the patients preferred physicians to sit, regarding them as more compassionate than those who stood [51]. The problem with translating this into practice is that patients might be less convinced that a physician whom they knew had been *told* to sit was more compassionate. Unimpressed with a nurse's enquiries about her emotional feelings, a patient with cancer explained that the nurse had probably 'just been on a course' [34]. The concept of communication skills and, potentially, the practice of communi-cation skills education, assessment and guidance is therefore intrinsically inimical to the authenticity that patients seek [33,52,53] and constrains understanding of how authentic clinical relationships can be formed.

Therefore, while 'communication skills' has provided valuable language with which to project communication education and guidance into cancer care and other clinical areas, it is limited as a theoretical framework because it disregards the subjectivity of communication. The common view that 'communication skills build relationships' therefore exposes a theoretical lacuna that should be filled by theory that *does* address how relationships are formed. Several theories have been applied to clinical relation-ships, but one in particular – attachment theory – explicitly incorporates the vulnerability and dependency that defines clinical relationships in cancer care [26,49,54–56]. Where patients are mortally vulnerable, and feel that clinicians have the authority and expertise to look after them, clinical relationships resemble attachment relationships [54,55,57–59]. That is, patients' sense of relationship can reflect their own dependency needs rather than clinicians' communication. Even after patients with breast cancer had seen their surgeon only for a brief consultation focused on diagnosis and treatment planning, their sense of relationship was intense, and differed little between patients seeing different surgeons [60]. Variability in relationships reflected differences between patients, including their experience of previous close relationships and their own attachment style [60–62].

While recognising the historical contribution of the technology and language of communication skills, the concept of skills will constrain conceptual advance in communication education and guidance for cancer care. Changing the theoretical framework is not a merely academic matter. It can change what practitioners are taught or advised to do. For example, rather than teach cancer practitioners that their relationships are built gradually from deploying skills, an attachment perspective points to the need for them to appreciate the intensity of the sense of relationship that patients can have as soon as they meet the practitioners in whom they entrust their care. The challenge is then to understand how practitioners can work with and within this asymmetric relationship.

4. The importance of practice-based evidence

Educators in practice do go beyond the teaching of specific skills and encourage learners to choose and deploy skills appropriately and imaginatively. However, the conceptual framework of skills does not help them do this. Therefore, as long as these activities are cast in the language of skills, this level of education will remain beyond the reach of formal teaching and professional scrutiny. It will be a 'craft' activity, with local solutions by groups of educators, rather than an academically informed one. Similarly, as long as communication guidance is cast in the language of skills and over-simplified generalisations it will leave practitioners uninformed.

Where, however, are the new ideas to come from for the next generation of communication education and guidance?

Researchers have drawn from frameworks other than skills in developing new approaches to education, including mindfulness and self-awareness [1]. However, these approaches start with the view that expertise to guide communication education arises outside clinical practice. Educators do value learners' own knowledge and routinely incorporate it when delivering training. However, the concept of skills means privileging, as building blocks for communication, properties of communication that experts identify, rather than learners or their patients. The privileging of external expertise is clearly necessary for creative areas of human behaviour that rely on component skills which are unfamiliar to learners at the outset; for example, musicians need to be taught to play notes and scales before concertos. However, this view does not readily fit communication, because learners have acquired sophisticated knowledge of communication since birth. Moreover, learners who have been practitioners have learned solutions to specific communication demands in their clinical settings, and it should not be assumed that these are always poor. Epstein and Street pointed out that most communication research in cancer has focused on specific practitioner behaviours, whereas the more complex mutual influence that aligns practitioner and patient goals has been neglected [1]. Arguably, some practitioners' tacit knowledge might in some respects be more sophisticated than that of educators who are unfamiliar with delivering the practitioners' clinical role. Therefore, arguably, the first place for research to look for new ideas to inform communication education and guidance is the interactions that practitioners have with their patients [34,63]. There is already evidence of the value of this approach in researching the dilemmas, outlined above, that current expert principles do not resolve.

4.1. Providing full information, while maintaining hope

Although practitioners are criticised for giving incomplete information [11–14,64], expert guidance that they should simultaneously provide full information and maintain patients' hope leaves practitioners to work out how to reconcile this apparent contradiction. Qualitative research across a range of oncology settings indicates several ways in which they achieve this. Leydon [65] found that oncologists paired positive and negative information so that threatening news was followed by more positive information, for example 'your (tumour) is potentially serious but most of these are cured'. Mendick et al. [66] found the same pattern in breast cancer patients' consultations with surgeons. By also interviewing the surgeons and patients, they showed that surgeons' juxtaposition of good and bad information was a deliberate strategy to end exchanges on the 'positive note' that patients sought. Similarly, Mukjerjee described how one oncologist, through nuanced shaping of information, helped to 'resuscitate' a patient who had been helpless with fear [67]. Previous studies have shown that clinicians commonly also constrain information [38,68–70], and that patients and family rely on them to do this [18,59,66,71,72]. Normative statements from patients that they want to be told 'everything', and from clinicians that they 'hide nothing', thus belie a more nuanced process whereby patients rely on clinicians to manage information [66,72].

One reason why expert guidance about information-giving is limited in practice is that it has focused on *amount* of information. By contrast, study of breast cancer surgeons' practice indicates that they simultaneously gave several *kinds* of information to serve patients' competing needs [73]. They gave explicit biomedical details on which expert guidance focuses, but also gave progressively less explicit kinds of information including information about treatment implications, information with prognostic implications (e.g. that the tumour was completely removed) and evaluative comments (e.g. that information is 'good news'). In this 'spectrum' of information, surgeons used the biomedically less explicit 'wavelengths' to communicate hope; where prognosis is poorer, communication is more likely to be confined to biomedical 'wavelengths' [72,73].

4.2. Ensuring patient involvement while taking clinical responsibility

Underlying expert guidance for practitioners to 'share' decisions lies the assumption that responsibility for decision-making is an objective quantity that can be apportioned between parties in a 'zero-sum' model. Therefore, evidence that few patients with cancer are told of treatment options is regarded as indicating practitioners' failure to share decisions [74]. However, patients who seek cure from mortal disease often want doctors to take responsibility [75–77]. Moreover their experience of decision-making does not fit a zero-sum model [77]. In the absence of feeling that they had any *choice*, women with breast or other cancers could still feel *involved* in treatment decisions [38,76]. Recent study of breast and eye cancer consultations indicated how surgeons can achieve this [75,78]. In taking responsibility for decisions, surgeons helped most patients to feel involved by conveying authority and expertise and providing justifying reasons. That is, within the context of a caring relationship, patients' sense of involvement reflected surgeons' authority, not their own.

4.3. Being emotionally connected but emotionally detached

Here, the conundrum for practitioners is how to form emotional connections with patients, and provide emotional support, while keeping the distance that allows the relationship to fulfil its clinical purpose. Guidance and curricula emphasise that practitioners should exploit 'empathic opportunities' by using patients' psychological cues as prompts to psychosocial discussion [6]. This reflects a view of relationships as objective phenomena which exist similarly in the minds of both practitioner and patient and are visible to observers in the transactions between them. Research that examines relationships simultaneously from patient, practitioner and observer perspectives is inconsistent with this view. For example, when a child has leukaemia, parents' relationship with the child's oncologist can feel intensely emotional to parents in the absence of overtly emotional communication or any sense of emotional connection in the oncologist [79]. Oncologists mostly focused on clinical care rather than on explicit emotional support, and parents felt emotionally comforted by this. Likewise, consultations between breast cancer patients and their surgeons included little explicit psychosocial talk [47]. However, rather than *failing* to detect patients' psychosocial needs, surgeons and oncologists described *deciding*, based on what they discerned from patients or parents, that psychosocial talk was inappropriate at that time [47,80]. Similarly, patients described not wanting to explore psychosocial needs with the surgeons, preferring to talk with family or specialist nurses [47]. An explanation for this desire not to talk emotionally with cancer clinicians lies in understanding the intersection of professional roles with patients' (or parents') sense of vulnerability. Given surgeons' and oncologists' expert clinical role in these studies, they could provide emotional comfort by demonstrating that they were conscientiously executing their clinical role [47,80]. For nurses, by contrast, who did not have the same instrumental role in children's leukaemia care, explicitly emotional talk was more likely to provide comfort to parents [80].

5. Discussion and conclusion

5.1. Discussion

Clinical communication in cancer is too important to be left to personal habits and prejudices, so practitioners need to continue to learn from communication experts. However, we have illustrated above how detailed study of practitioners' clinical communication in the light of how patients experience it has begun to indicate forms of psychological care that are 'new' to the science of clinical communication. This should not be surprising if we assume that many practitioners – particularly those who are willing to cooperate with communication research – are committed and resourceful in promoting their patients' wellbeing.

Arguably the most valuable insights from studying communication in practice have arisen from qualitative research; that is from inductive research which tries to minimise the influence of researchers' preconceptions. For example, when patients endorse questionnaire items to say they want 'as much information as possible' [81], quantitative research tends to take this at face value. For qualitative researchers, the response is to examine what patients mean by saying this and to ask questions that can go beyond recycling such culturally normative statements [21,66,82]. Qualitative research that simultaneously examines communication from each participant's perspective as well as by analysing communication between them can be particularly informative [47,83], even to the extent of suggesting that communication that might, according to current guidance, be criticised as unethical resolves ethical dilemmas that the guidance disregards [75,84].

There are implications for research topics, as well as methods, because the areas in which communication skills have been most studied do not converge with the aspects of care or outcomes that patients prioritise [85]. Although researchers prioritise skills for information-giving and sharing decisions, patients do not generally distinguish instances of information-giving or decision-making from the flux of the clinical relationship [58,78,86–88]. Similarly, extensive guidance focuses on skills for 'breaking bad news', but this has been criticised for being too idealised in assuming that practitioners can anticipate and plan for such instances, and that consultations focus on single pieces of bad news in practitioner–patient dyads [89]. In practice, receiving bad news is often not a discrete event but an unpredictable and unfolding process whose meaning for patients lies in clinical relationships including them and their companions [58,89]. Accounts of communication skills in cancer give high priority to explicit discussion of patients' psychosocial concerns [6], but in studies of breast cancer and childhood leukaemia we have seen that patients and those close to them can gain more comfort from clinicians who respected boundaries and confined their talk to clinical care. If research is to be 'patient-centred', it needs to prioritise the aspects of clinical communication that patients prioritise, including trust in practitioners' expertise, commitment and care [38,47,59,86,90].

5.2. Conclusion

Historically, the concept of communication skills has helped to shape the education and guidance that encourages practitioners in cancer and other clinical areas to treat the patient holistically. However, communication experts, and the researchers who inform their teaching or guidance, will need to set aside the assumption that communication problems necessarily signify skill deficits. Instead, they can draw from recent research about communication in practice, along with theoretical frameworks through which these can be interpreted, to shape future curricula and guidance. The growth of communication education and guidance in cancer care has depended on its ability to demonstrate an evidence base. Our approach will help to ensure the empirical and theoretical base for the next generation of communication education and guidance.

5.3. Practice implications

In research where patient or family perspectives have been studied simultaneously with practitioners', the two have aligned more closely with each other than with expert guidance [47,66,73,79]. This is not to argue that all practitioners communicate well and have no need of guidance or training. Instead, it means that solutions to communication failures are, arguably, more likely to arise from detailed study of what goes wrong in practice than from experts' current general principles. For example, where some breast cancer patients lacked confidence in treatment decisions, the surgeons could have prevented these problems by simply checking whether patients were happy with their recommendations, or by endorsing decisions that patients had made [75]. Where parents could not entirely trust their child's oncologist, oncologists needed to be prepared to change their strategy and explain their actions and expectations to a degree that most parents wanted to be protected from [71]. In such ways, future communication education and guidance might have more to learn from patients and practitioners than is often appreciated [63].

References

[1] Epstein RM, Street RLJ. Patient-centered communication in cancer care: promoting healing and reducing suffering. Bethesda, MD: National Cancer Institute, NIH; 2007.

[2] Street Jr RL, Makoul G, Arora NK, Epstein RM. How does communication heal? Pathways linking clinician-patient communication to health outcomes. Patient Educ Couns 2009;74:295–301.

[3] Thorne SE, Hislop TG, Armstrong EA, Oglov V. Cancer care communication: the power to harm and the power to heal? Patient Educ Couns 2008;71:34–40.

[4] Rodin G, Zimmermann C, Mayer C, Howell D, Katz M, Sussman J, et al. Clinician-patient communication: evidence-based recommendations to guide practice in cancer. Curr Oncol 2009;16:42–9.

[5] Bylund CL, Brown R, Gueguen JA, Diamond C, Bianculli J, Kissane DW. The implementation and assessment of a comprehensive communication skills training curriculum for oncologists. Psychooncology 2010;19:583–93.

[6] Stiefel F, Barth J, Bensing J, Fallowfield L, Jost L, Razavi D, et al. Communication skills training in oncology: a position paper based on a consensus meeting among European experts in 2009. Ann Oncol 2010;21:204–7.

[7] Uitterhoeve RJ, Bensing JM, Grol RP, Demulder PH, Van Achterberg T. The effect of communication skills training on patient outcomes in cancer care: a systematic review of the literature. Eur J Cancer Care (Engl) 2010;19:442–57.

[8] Owen R, Jeffrey D. Communication: common challenging scenarios in cancer care. Eur J Cancer 2008;44:1163–8.

[9] Fallowfield L. The challenge of interacting with patients in oncology. Eur J Cancer 2009;45:445–6.

[10] National Institute for Clinical Excellence. Supportive and palliative care: improving supportive and palliative care for adults with cancer; 2004.

[11] Lamont EB, Christakis NA. Prognostic disclosure to patients with cancer near the end of life. Ann Intern Med 2001;134:1096–105.

[12] Fallowfield L, Jenkins V. Effective communication skills are the key to good cancer care. Eur J Cancer 1999;35:1592–7.

[13] Fallowfield L, Jenkins V. Communicating sad, bad, and difficult news in medicine. Lancet 2004;363:312–9.

[14] Arora NK, Johnson P, Gustafson DH, McTavish F, Hawkins RP, Pingree S. Barriers to information access, perceived health competence, and psychosocial health outcomes: test of a mediation model in a breast cancer sample. Patient Educ Couns 2002;47:37–46.

[15] Fallowfield L, Jenkins V. Current concepts of communication skills training in oncology. Recent Results Cancer Res 2006;168:105–12.

[16] Huntley CD, Salmon P, Fisher PL, Fletcher I, Young B. LUCAS: a theoretically informed instrument to assess clinical communication in OSCEs. Med Educ 2012;46:267–76.

[17] Downie R, Randall F. Truth-telling and consent. In: Doyle D, Hanks G, Cherny NI, editors. Oxford textbook of palliative medicine. 3rd ed., Oxford: Oxford University Press; 2005. p. 61–5.

[18] Curtis JR, Engelberg R, Young JP, Vig LK, Reinke LF, Wenrich MD, et al. An approach to understanding the interaction of hope and desire for explicit prognostic information among individuals with severe chronic obstructive pulmonary disease or advanced cancer. J Palliat Med 2008;11:610–20.

[19] Clayton JM, Hancock K, Parker S, Butow PN, Walder S, Carrick S, et al. Sustaining hope when communicating with terminally ill patients and their families: a systematic review. Psychooncology 2008;17:641–59.
[20] Thorne S, Oglov V, Armstrong EA, Hislop TG. Prognosticating futures and the human experience of hope. Palliat Support Care 2007;5:227–39.
[21] Butow PN, Dowsett S, Hagerty R, Tattersall MH. Communicating prognosis to patients with metastatic disease: what do they really want to know? Support Care Cancer 2002;10:161–8.
[22] Jefford M, Tattersall MH. Informing and involving cancer patients in their own care. Lancet Oncol 2002;3:629–37.
[23] Norman GR, Van der Vleuten CP, De Graaff E. Pitfalls in the pursuit of objectivity: issues of validity, efficiency and acceptability. Med Educ 1991;25:119–26.
[24] Stiles WB. Evaluating medical interview process components. Null correlations with outcomes may be misleading. Med Care 1989;27:212–20.
[25] Skelton JR. Language and clinical communication: this bright Babylon. Abingdon: Radcliffe Publishing Ltd; 2008.
[26] Pilnick A, Dingwall R. On the remarkable persistence of asymmetry in doctor/patient interaction: a critical review. Soc Sci Med 2011;72:1374–82.
[27] Gwyn R. Communicating health and illness. London: Sage; 2002.
[28] Bylund CL, Brown RF, Bialer PA, Levin TT, Lubrano di Ciccone B, Kissane DW. Developing and implementing an advanced communication training program in oncology at a comprehensive cancer center. J Cancer Educ 2011;26:604–11.
[29] National Cancer Action Team. Connected: national communication skills training; 2011.
[30] Brown RF, Bylund CL. Communication skills training: describing a new conceptual model. Acad Med 2008;83:37–44.
[31] Plum A. Communication as skill – a critique and alternative proposal. J Humanist Psychol 1981;21:3–19.
[32] Egener B, Cole-Kelly K. Satisfying the patient, but failing the test. Acad Med 2004;79:508–10.
[33] Zoppi K, Epstein RM. Is communication a skill? Communication behaviors and being in relation. Fam Med 2002;34:319–24.
[34] Salmon P, Young B. Creativity in clinical communication: from communication skills to skilled communication. Med Educ 2011;45:217–26.
[35] Langewitz W. Beyond content analysis and non-verbal behaviour: what about atmosphere? A phenomenological approach. Patient Educ Couns 2007;67:319–23.
[36] Rider EA, Keefer CH. Communication skills competencies: definitions and a teaching toolbox. Med Educ 2006;40:624–9.
[37] Quirk M, Mazor K, Haley HL, Philbin M, Fischer M, Sullivan K, et al. How patients perceive a doctor's caring attitude. Patient Educ Couns 2008;72:359–66.
[38] Wright EB, Holcombe C, Salmon P. Doctors communication of trust, care, and respect in breast cancer: qualitative study. Brit Med J 2004;328:864–7.
[39] Eide H, Graugaard P, Holgersen K, Finset A. Physician communication in different phases of a consultation at an oncology outpatient clinic related to patient satisfaction. Patient Educ Couns 2003;51:259–66.
[40] Hulsman RL, Ros WJ, Winnubst JA, Bensing JM. The effectiveness of a computer-assisted instruction programme on communication skills of medical specialists in oncology. Med Educ 2002;36:125–34.
[41] Carvalho IP, Pais VG, Almeida SS, Ribeiro-Silva R, Figueiredo-Braga M, Teles A, et al. Learning clinical communication skills: outcomes of a program for professional practitioners. Patient Educ Couns 2011;84:84–9.
[42] Ingelfinger F, Arrogance J. N Engl J Med 1980;303:1507–11.
[43] Thomsen DK, Pedersen AF, Johansen MB, Jensen AB, Zachariae R. Breast cancer patients' narratives about positive and negative communication experiences. Acta Oncol 2007;46:900–8.
[44] Paul CL, Clinton-McHarg T, Sanson-Fisher RW, Douglas H, Webb G. Are we there yet? The state of the evidence base for guidelines on breaking bad news to cancer patients. Eur J Cancer 2009;45:2960–6.
[45] Goldacre B. Bad science. London: Harper-Collins; 2008.
[46] Kvale K. Do cancer patients always want to talk about difficult emotions? A qualitative study of cancer inpatients communication needs. Eur J Oncol Nurs 2007;11:320–7.
[47] Salmon P, Mendick N, Young B. Integrative qualitative communication analysis of consultation and patient and practitioner perspectives: towards a theory of authentic caring in clinical relationships. Patient Educ Couns 2011;82:448–54.
[48] Lelorain S, Brédart A, Dolbeault S, Sultan S. A systematic review of the associations between empathy measures and patient outcomes in cancer care. Psychooncology; http://dx.doi.org/10.1002/pon.2115, in press.
[49] Salmon P, Young B. Core assumptions and research opportunities in clinical communication. Patient Educ Couns 2005;58:225–34.
[50] Alexander HA. Human agency and the curriculum. Theory Res Educ 2005;3:343–69.
[51] Bruera E, Palmer JL, Pace E, Zhang K, Willey J, Strasser F, et al. A randomized, controlled trial of physician postures when breaking bad news to cancer patients. Palliat Med 2007;21:501–5.
[52] Wear D, Varley JD. Rituals of verification: the role of simulation in developing and evaluating empathic communication. Patient Educ Couns 2008;71:153–6.
[53] Steele DJ, Hulsman RL. Empathy, authenticity, assessment and simulation: a conundrum in search of a solution. Patient Educ Couns 2008;71:143–4.
[54] Tan A, Zimmermann C, Rodin G. Interpersonal processes in palliative care: an attachment perspective on the patient–clinician relationship. Palliat Med 2005;19:143–50.
[55] Lilliehorn S, Hamberg K, Kero A, Salander P. 'Admission into a helping plan': a watershed between positive and negative experiences in breast cancer. Psychooncology 2010;19:806–13.
[56] Milberg A, Wåhlberg R, Jakobsson M, Olsson EC, Olsson M, Friedrichsen M. What is a 'secure base' when death is approaching? A study applying attachment theory to adult patients' and family members' experiences of palliative home care. Psychooncology; http://dx.doi.org/10.1002/pon.1982, in press.
[57] Salmon P, Young B. Dependence and caring in clinical communication: the relevance of attachment and other theories. Patient Educ Couns 2009;74:331–8.
[58] Salander P. Bad news from the patient's perspective: an analysis of the written narratives of newly diagnosed cancer patients. Soc Sci Med 2002;55:721–32.
[59] Salander P, Bergenheim T, Henriksson R. The creation of protection and hope in patients with malignant brain tumours. Soc Sci Med 1996;42:985–96.
[60] Pegman S, Beesley H, Holcombe C, Mendick N, Salmon P. Patients' sense of relationship with breast cancer surgeons: the relative importance of surgeon and patient variability and the influence of patients' attachment style. Patient Educ Couns 2011;83:125–8.
[61] Clark L, Beesley H, Holcombe C, Salmon P. The influence of childhood abuse and adult attachment style on clinical relationships in breast cancer care. Gen Hosp Psychiat 2011;33:579–86.
[62] Salmon P, Holcombe C, Clark L, Krespi R, Fisher J, Hill J. Relationships with clinical staff after a diagnosis of breast cancer are associated with patients' experience of care and abuse in childhood. J Psychosom Res 2007;63:255–62.
[63] Kleinman A. Moral experience and ethical reflection: can ethnography reconcile them? A quandary for "the new bioethics" Daedalus 1999;128:69–97.
[64] Rogg L, Loge JH, Aasland OG, Graugaard PK. Physicians' attitudes towards disclosure of prognostic information: a survey among a representative cross-section of 1605 Norwegian physicians. Patient Educ Couns 2009;77:242–7.
[65] Leydon GM. 'Yours is potentially serious but most of these are cured': optimistic communication in UK outpatient oncology consultations. Psychooncology 2008;17:1081–8.
[66] Mendick N, Young B, Holcombe C, Salmon P. Telling 'everything' but not 'too much': the surgeons' dilemma in consultations about breast cancer. World J Surg 2011;35:2187–95.
[67] Mukherjee S. Emperor of all maladies. London: Harper-Collins; 2011.
[68] Leydon GM, Boulton M, Moynihan C, Jones A, Mossman J, Boudioni M, et al. Cancer patients' information needs and information seeking behaviour: in depth interview study. Brit Med J 2000;320:909–13.
[69] Perakyla A. Hope work in the care of seriously ill patients. Qual Health Res 1991;1:407–33.
[70] Rodriguez K, Gambino F, Butow P, Hagerty R, Arnold R. Pushing up daisies: implicit and explicit language in oncologist–patient communication about death. Support Care Cancer 2007;15:153–61.
[71] Salmon P, Hill J, Ward J, Gravenhorst K, Eden T, Young B. Faith and protection: the construction of hope by parents of children with leukemia and their oncologists. Oncologist 2012;17:398–404.
[72] Step MM, Ray EB. Patient perceptions of oncologist-patient communication about prognosis: changes from initial diagnosis to cancer recurrence. Health Commun 2011;26:48–58.
[73] Mendick N, Young B, Holcombe C, Salmon P. The 'information spectrum': how breast cancer surgeons give patients information; submitted for publication.
[74] Gattellari M, Voigt KJ, Butow PN, Tattersall MHN. When the treatment goal is not cure: are cancer patients equipped to make informed decisions? J Clin Oncol 2002;20:503–13.
[75] Mendick N, Young B, Holcombe C, Salmon P. The ethics of responsibility and ownership in decision-making about treatment for breast cancer: triangulation of consultation with patient and surgeon perspectives. Soc Sci Med 2010;70:1904–11.
[76] Henman MJ, Butow PN, Brown RF, Boyle F, Tattersall MH. Lay constructions of decision-making in cancer. Psychooncology 2002;11:295–306.
[77] Sinding C, Hudak P, Wiernikowski J, Aronson J, Miller P, Gould J, et al. I like to be an informed person but negotiating responsibility for treatment decisions in cancer care. Soc Sci Med 2010.
[78] Cook SA, Damato B, Marshall E, Salmon P. Reconciling the principle of patient autonomy with the practice of informed consent: decision-making about prognostication in uveal melanoma. Health Expect 2011.
[79] Young B, Ward J, Forsey M, Gravenhorst K, Salmon P. Examining the validity of the unitary theory of clinical relationships: comparison of observed and experienced parent–doctor interaction. Patient Educ Couns 2011;85:60–7.
[80] Forsey M, Salmon P, Eden T, Young B. Comparing doctors' and nurses' accounts of how they provide emotional care for parents of children with acute lymphoblastic leukaemia. Psychooncology; http://dx.doi.org/10.1002/pon.2084, in press.
[81] Jenkins V, Fallowfield L, Saul J. Information needs of patients with cancer: results from a large study in UK cancer centres. Br J Cancer 2001;84:48–51.
[82] Quill TE, Arnold R, Back AL. Discussing treatment preferences with patients who want "everything". Ann Intern Med 2009;151:345–9.
[83] Kendall M, Murray SA, Carduff E, Worth A, Harris F, Lloyd A, et al. Use of multiperspective qualitative interviews to understand patients' and carers' beliefs, experiences, and needs. Brit Med J 2009;339:6.
[84] Cook SA, Damato B, Marshall E, Salmon P. Reconciling the principle of patient autonomy with the practice of informed consent: decision-making about prognostication in uveal melanoma. Health Expect 2011;14:383–96.

[85] Brown VA, Parker PA, Furber L, Thomas AL. Patient preferences for the delivery of bad news – the experience of a UK Cancer Centre. Eur J Cancer Care (Engl) 2010;20:56–61.

[86] Salander P, Henriksson R. Severely diseased lung cancer patients narrate the importance of being included in a helping relationship. Lung Cancer 2005;50: 155–62.

[87] Perneger TV, Charvet-Berard A, Perrier A. Patient assessments of the most important medical decision during a hospitalization. J Gen Intern Med 2008;23: 1659–65.

[88] Kukla R. Conscientious autonomy – displacing decisions in health care. Hastings Cent Rep 2005;35:34–44.

[89] Eggly S, Penner L, Albrecht TL, Cline RJW, Foster T, Naughton M, et al. Discussing bad news in the outpatient oncology clinic: rethinking current communication guidelines. J Clin Oncol 2006;24:716–9.

[90] Thorne SE, Hislop TG, Stajduhar K, Oglov V. Time-related communication skills from the cancer patient perspective. Psychooncology 2009;18:500–7.

[91] Humphris G. EACH newspages: 6th and 7th February, 2004 Verona Network on sequence analysis. Patient Educ Couns 2004;53:247–50.