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# COMMUNICATION ISSUES IN THE ONCOLOGY

Vladimir POROCH<sup>1</sup>, Mihaela BOANĂ<sup>2</sup>,  
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## Abstract

Society has undergone many changes in the last decades with a direct and profound impact on the physician-patient relationship. This paper aims to analyze different communication models existing in the literature, as described up to now in different empirical studies. The issue of the communication in the oncological practice is dominated by two aspects: to tell or not to tell the diagnostic to the patient and if the answer is affirmative, the manner in which the diagnostic must be communicated. A large number of patients asserted that they prefer the physician to take their opinions into account when making a decision, reminding therefore the controversial nature of what is best for a patient. It is considered that the information offered to the patients as well as patients' autonomy were key variables in the communication models, having a powerful impact on the patient-physician interaction. The physicians manifesting an authentic interest in the patient as person, who transmit an authentic empathy, who provide adequate and advisable information represent a source of social support for the patients. By giving the patient the opportunity to choose between his own preferences and those of his physician, the circumstances for exercising his autonomy are ensured.

*Keywords:* communication; hospital oncology services; personal autonomy; family relationship, professional

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## Introduction

In the last years, the society has undergone many changes that directly impact the physician-patient relationship. The expectations of the society, the medical improvement, the technological progresses, the wide availability of the medical information and the social diversity increase have affected the new medical world. (Klein, 2012) This paper aims to analyze different communication models existing in the literature, as described up to now in different empirical studies. The research on the communication in oncology proved the association between communication and patient satisfaction, the treatment compliance, a better transition from the curative treatment to the palliative one and a diminution of physician's stress and implicitly of the burnout syndrome incidence. (Ong et al., 2000) In the physician-patient relationship models drafted by Emanuel and Emanuel, the preliminary supply of information to the patient, the autonomy degree and the supplied quantity of medical information are described for each model separately. The issue of the communication in the oncological practice is dominated by two aspects: to tell or not to tell the diagnostic to the patient and if the answer is affirmative, the manner in which the diagnostic must be communicated. Probably one of the most difficult tasks of the physicians is to communicate to the patient/family the diagnostic of cancer and an unfavorable prognostic. In a large study performed in 1961 in the USA, 90% of the oncologists declared that they do not communicate to the patients the diagnostic of cancer. The study carried out again in 1977 highlighted a total change of attitudes: 98% of the physicians communicated the diagnostic. The modification in their behavior is interpreted as a form of democratization of the medical system and of the physician-patient relationship as a consequence of the awareness of the need and right of the patient to know the truth.

## Communication in cancer

In cancer, the discomfort felt during the diagnostic can reduce the deliberative capacity of the patient, a possible explanation of the reason why patients often do not succeed to process the given information, immediately after hearing the words designating the diagnostic. (Parker et al., 2001) Patients' need to be informed has increased and they see their attending physician as the main source of psycho-emotional support. On the other hand, a lot of physicians are not professionally prepared for communication and for the interpersonal dimensions of the oncological patient care (Tattersall, Butow and Clayton, 2002; National Cancer Institute, 2008; Oprea *et al.*, 2013). Buckman (1992) shows that once with the diagnostic of a disease such as cancer, the patient is confronted to difficult and unusual demands, which sometimes exceed his possibilities, his emotional resources. The individual reaction can be efficient, leading to a psychological and inefficient adaptation, producing troubles in his psychic condition. Weisman and Worden (Weisman and Worden, 1992) asserted that the most efficient strategies

to cope with such a disease concern the acceptance of the diagnostic of cancer, followed by attempts to solve the problem, reason why the patient wishes to find out further information on the disease, treatments and their consequences, asks for other opinions of the specialists in the field, agrees to participate to the treatments. The less productive strategies were the retreat, avoidance, passivity and decline ones. (Fallowfield and Jenkins, 2004)

## Physician-patient relationship

Both before and during the XX-th century, the physician-patient relationship has been typically paternalist. (Livengood, 2004) The society recognized that the physicians held exclusively medical knowledge and a particular experience with health values, being therefore in the best position to make a medical decision on behalf of the patient. Consequently, the physician played mostly a dominant role during the consultations and the patients observed his decisions, repressing at times their own thoughts. Nevertheless, once with the remodeling of the ideals within the society, the patients have become more and more dissatisfied with this stereotype interaction and a large number of patients started looking for a higher involvement during the consultation. As a consequence, instruments have been developed so as to support the young physicians understand the dynamic nature of the patient-physician interaction and these undertakings determined a range of clinical models aiming at formalize the meeting between the physician and the patient. (Emanuel and Emanuel, 1992) The most well-known is the classification system drafted by Emanuel and Emanuel, which describes the physician-patient interaction as being one of the four types of possible relationship: paternalist, deliberative, interpretative, informative – which can be differentiated according to the awareness of patient's values, the allocation of the decisional responsibilities (autonomy) and the divulgation by the physician of the medical information.

## Communication models

The *paternalist* model is a “traditional” approach and describes the situation in which the patient has little information regarding his medical condition. Only the physician decides which medical act must be performed and usually the patient receives minimal information. Undeniably, there are cases in which the paternalist care is still necessary, mostly in emergencies, in acute troubles or trauma where the immediate treatment has to be performed and one cannot apply another approach model.

The legislative modifications regarding patient information have determined the physicians to change their behavior with regard to the “complete information on all the viable alternative treatments from a medical point of view”. (Mazur, 2003) A large number of patients asserted that they prefer the physician to take

their opinions into account when making a decision, reminding therefore the controversial nature of what is best for a patient. Limits have been established with regard to the paternalist actions; the physicians cannot initiate the treatment without the informed consent of the patient. (Hall, Prochazka and Fink, 2012) At the other end of the paternalist model is the informative model, also called engineering or consumerism model, where the patient has control and is responsible for the medical decisions. Physician's responsibilities are limited to the supply of concrete information regarding the medical interventions and the patient must choose the intervention which fits the best with his values and interests. Physician's role is that of being a source of relevant medical information, not being allowed to make recommendations to the patient, as this would mean imposing values. The autonomy concept on which this model is based consists in patient's control on the medical decision. It supposes that patients have very stable values and know the best their interests and this model offer them concrete information with regard to the medical interventions which shall allow them to pursue their interests. (Emanuel and Emanuel, 1992)

Continuing in the direction of a higher involvement of the patient, the interpretative model is described, the aim of the physician-patient interaction being that of elucidating the clinical situation of the patient, who detains incipient information and helping him select the available medical interventions. A consistent dialogue comprises information regarding the disease and the interventions which are about to be performed. Within this communication model, the physician must involve the patient in a common understanding process. Physician provides all relevant information and after that the patient decides what interventions will follow, always being supported by the physician's advise. Thus, patient's autonomy is higher, as he gets to better know himself and to understand how the medical decisions may affect his identity. (Egnew and Wilson, 2011)

The deliberative model involves a high degree of patient's involvement. In this situation, the patient has minimum information, but the physician discusses with the patient so as to discover and develop the information. At the medical contact level, the physicians act as teachers or friends. In this approach, the physicians deliver to the patients all the relevant information regarding the existing therapeutic options; they help the patients discover the values hiding beyond the available medical interventions; and they suggest why certain health condition values are advisable, but also the reason why they must be chosen. Within the deliberative model, the only purpose of the physicians is that of deferentially persuading their patients with regard to certain medical interventions that they should attend. Ultimately, the patients decide on the medical care that they deem appropriate for their desires. (Gillotti, Thompson and McNeilis, 2002)

Emanuel and Emanuel (Emanuel and Emanuel, 1992) support this model as being preferable, based on the same common social values. First of all, the model represents the personal autonomy ideal specific to the pluralist and liberal societies. This model allows the individual to choose the preferred way, without constraint, with the informed consent and with no physical intervention. Secondly, the model promotes the image of the careful physician, which corresponds to the ideal physician-patient relationship of the society. The model allows

the physicians to make recommendations to the patients and to persuade them to accept these. Thirdly, they say that this model does not promote a dissimulated paternalism. The deliberative process rather allows the physicians to learn from suffering and to educate patients. Fourthly, this model allows the physicians and patients to mutually know their values, important aspect for the patients when choosing their physician.

The authors themselves criticized their own model (Emanuel and Emanuel, 1992). First of all, it is not clear if physicians are able to assess the values of their patients. The model supposes that physicians can assess health values better than their patients. More than that, the model can be a means of promoting the values of certain physicians. A physician-patient relationship where the physician, from the technician presented in the informative model becomes an adviser, a counselor and a friend, acquiring a plus of power within the relationship.

In the opinion of Agarwal AK and Murinson BB, patient's autonomy exercise is not in direct relationship with value formation, as there are three types of patients who do not frame in these "classical" models: for instance, a patient with a high degree of autonomy, but with insufficient formation values (eg. financial analyst) or a patient with a low level of autonomy, but with clearly expressed values (eg. patient originating from a traditionalist culture with very clear values related to care).

## Discussions

It is considered that the information offered to the patients as well as patients' autonomy were key variables in the communication models, having a powerful impact on the patient-physician interaction. Nevertheless, while most of the models accurately identify the existence of both variables, they do not succeed to understand and to express patients' values. For instance, Emanuel and Emanuel asserted that if patient's autonomy and involvement in the decision-making process increase, patient's power and value formation increases too. This aspect is obvious when one analyzes the specificity of the model, where a transition from completely non-informed to fully informed and from a reduced autonomy to a high autonomy represents a progress from a paternalist approach to an informative one.

Reach proposes a customized care model specific to the chronic diseases (Reach, 2014), where the medical education process of the person play a key role. Therefore, Reach identifies as the best ethical way a succession of the models regarding the physician-patient relationship, starting from patient's education. The physician offers concrete data (playing an information role), and the patient chooses (recognizes the informative model) or he may offer information and help the patient elucidate his own preferences (interpretation –interpretative model), reaching the situation where he presents his own opinions and the patient deliberates, having therefore the possibility to choose among different options (in fact between his preferences and those of the physician –deliberative

model). These subtle passages among different hypostases are suggestively illustrated by the actual “driving belts” represented by the following values: patient’s education (medical knowledge), patient’s preference, physician’s empathy and involvement.

Therefore, in Reach’s opinion, by offering the opportunity to choose for the patient, the deliberative model ensures the circumstances for the exercise of his autonomy. The patient deliberates both on his own values and on those expressed by the physician (therefore on the differences between his own preferences and those of the physician).

In one of his studies, Tentori and his collaborators highlighted the importance of experience associated to knowledge as a moderator of the age differences in the decision-making and judgment process, the experience being also deemed as a potential compensatory mechanism for the decline from the deliberative processes. Aged adults’ knowledge and experience seem to be beneficial when facing difficult situations. The previous experience of the “senior” adults allow them the avoidance of the errors made by most of the teenagers. (Tentori et al., 2001) To that effect, Meyer and his collaborators studied a group of women diagnosed with breast cancer and noticed that aged women required little information, making decisions faster and finally reaching the decision that young women made more difficultly. (Meyer, Russo and Talbot, 1995)

With regard to the empathy manifested by the physician for the patient, cancers’ specificity is that according to which the oncologists do not empathically answer to patient’s emotions expression. Anderson remarked (Anderson et al., 2008) the fact that the acknowledgement of the discomfort and of the complex suffering of the patient is low and the solution for the reduction of this suffering is the manifestation of an empathic attitude of the oncologists for their patients. Kirklin in “Truth telling, autonomy and the role of metaphor” (Kirklin, 2007) describes physician-patient communication particularities in advanced cancer stages. He remarked a good protective intent of the physicians, through the usage of certain strong metaphors with a short-term beneficial role, but, on a long term, this practice denies patient’s autonomy at the end of life, creating at the same time confusion and emotional suffering both for the medical staff and for the patient. Metaphors are used for the purpose of partially hiding the painful truth and, therefore, to avoid causing an emotional suffering to the patient, but hiding the truth means depriving the patient of the right of making an informed decision on the manner in which he decides to spend the rest of his life.

Friedrichsen MJ (Friedrichsen, 2000), remarked the fact that the physician can be seen in 6 different hypostases by the patients when the truth regarding the serious disease is revealed: (1) unexperienced messenger, (2) emotionally charged/overwhelmed physician, (3) the tough and prepared expert, (4) the benevolent, but tactless physician, (5) the distant physician, (6) the empathic professional.

McCormick TR (1995) deemed that obtaining information regarding the disease and the care directly from the physician shall lead to patient’s satisfaction increase. The physicians manifesting an authentic interest in the patient as

person, who transmit an authentic empathy, who provide adequate and advisable information represent a source of social support for the patients. (Mercer and Reynolds, 2002) On the contrary, physician's anxiety when discussing about death, the medical jargon, the "intellectualization" in order to avoid the personal contact, the absence of a consistent information source represent gaps in the communication between the physician and the patient in advanced cancer stages.

Some of the *reasons which make difficult the physician-oncological patient communication are* (Angelos and Kapadia, 2008; Kaye, 1996): *The fact that the physician has not full control of his own communication skills* ("What if I aggravate the situation?"); *The fear that he will be incriminated by the patient and by his relatives*; *The fear that he will cause the expression of different emotional reactions* (fury, crying, hostility) *of the patient*; *Guilt caused by physician's inability before cancer*; *The desire of protecting the patient*, so as to avoid the despair of the latter; *The uncomfortable feeling caused by the fact that a medical professional must show compassion*: physicians must master their feelings (panic, sadness), so as to appropriately play their role and for efficiency purposes.; *The feeling of not being able to control suffering*; *The uneasiness* regarding the manner in which he shall behave when someone is very confused and the *uncertainty feeling* whether it is normal or not that a physician comfort the patient in such a situation; *The fact that he has little time* for a patient in such a situation.

According to Wolkenstein, announcing the diagnostic of a disease with an unfavorable prognostic can be a psychological traumatism independently of the entire physical suffering. This traumatism can be characterized by a psychic and somatic suffering at the same time. The psychic suffering is reflected in mood and behavior troubles, deep sadness, inhibiting and suppressing all the interest forms and can touch the somatic register. (Wolkenstein et al., 2002) The following predictors encumber the efficient adaptation of the patient with the oncological disease (Holland and Rowland, 1989): the helplessness/ the hopelessness; the reality refusal or avoidance by the patient; the stoic acceptance and the fatalism; the social isolation; the low socioeconomic status; the harmful use of alcohol or drugs; psychiatric history (anxious/ depressive coping); emotional factors (suppression of feelings); recent losses; the pessimistic life philosophy; the absence of a system of beliefs or values on life and death; multiple obligations. C.Mîrșu-Păun (1999) thinks that the cancer patient must be encouraged to express his feelings, mostly the negative ones. (Mîrșu Păun, 1999)

## Conclusions

By giving the patient the opportunity to choose between his own preferences and those of his physician, the circumstances for exercising his autonomy are ensured. Facilitating the development of new communication strategies, especially focusing on providing a wider context of medical information to the patient, represents the premise of a good physician-patient relation. Also, if the physician



wants a good relationship with his patient he must try to develop the individual health-related values of the patient.

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