

# Communication at Times of Transitions: How to Help Patients Cope with Loss and Re-Define Hope

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## ABSTRACT

Patients undergo multiple transitions during the course of their cancer care. Oncologists are uniquely positioned to help patients through these transitions. When patients' situations change, they must cope with loss and associated negative emotions. They then are able to redefine hope. During transitions, patients want their oncologists to provide biomedical information, show that they care about and understand them as individuals, and balance hope and realism. Eliciting concerns and expressing empathy shows patients that their oncologist cares about and understands them and also helps patients to cope with the loss and negative emotions that transitions create. Oncologists can maintain hope by being sensitive to what patients are ready to hear when, and by helping them discover and identify realistic hopes. This is accomplished with the Ask-Tell-Ask and Hope for the Best, Prepare for the Worst techniques, and most importantly by being curious about patients' hopes and fears. (*Cancer J* 2006;12:417-424)

## KEY WORDS

Eliciting concerns, empathy, hope, realism

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Received on May 25, 2006; accepted for publication August 15, 2006.

No benefits in any form have been or will be received from a commercial party related directly or indirectly to the subject of this article.

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Transition is the process of changing from one situation to the next.<sup>1</sup> Cancer, from diagnosis through the course of illness, is marked by multiple transitions. Although many patients are cured from their cancer, and medicine can prolong the lives and improve the quality of life for many others, a cancer diagnosis involves multiple adjustments for patients, whatever the eventual outcome of their disease. The large transitions include hearing news of an initial diagnosis, a progressing cancer, or that no further antineoplastic treatments are possible. At these points, care changes. Chemotherapy may be initiated or changed, palliative care involved, or hospice suggested. The many smaller transitions may also have a large impact on patients. These include losing one's hair, having a Port-a-Cath placed, no longer being able to drive, or needing help with personal care.

All transitions share the experience of change from one state to another, and patients must adjust to successfully negotiate them. When the transition involves the loss of a previously valued state, that loss must be grieved. Uncertainty may leave patients feeling groundless and vulnerable. Further, in the case of cancer, most find the state that must be adjusted to, increased disability and the possibility of death, to be undesirable. Intense anger, sadness, and anxiety are often associated with such loss. Coping involves dealing with these emotions and being able to reconceptualize and rebuild one's life in a new form. In this new form, there is often hope for other goods or outcomes that are meaningful to the patient.

Oncologists are uniquely positioned to support patients through these transitions. Although no one can save patients from experiencing the distress associated with cancer, there is good evidence that patients' relationships with their oncologists and the way oncologists communicate with them can significantly reduce emotional distress, helping them cope with disease and reframe hope. The goal of this paper is to guide oncologists in how to communicate with

patients at times of transitions in ways that help them to cope with losses and redefine hope. We review the literature on patient preferences for oncologist communication during times of transitions and illustrate how oncologists can accomplish two important goals: (1) eliciting concerns and expressing empathy, and (2) balancing realism and hope.

### **EMPIRICAL EVIDENCE: WHAT PATIENTS WANT THEIR ONCOLOGISTS TO DO DURING TRANSITIONS**

In research studies about communication over transitions, patients consistently state that they are confident in and comforted by physicians who give them biomedical information about their disease and treatment, show that they care about them as individuals, and balance hope and realism.

#### **Giving Biomedical Information**

In visits with their oncologists, the great majority of cancer patients want to hear biomedical information about their cancer and its treatment.<sup>2</sup> Hearing such information is important to patients for multiple reasons. First, patients are better able to understand their disease and treatment and what is happening to them. Second, patients need information to participate in decisions about their treatment. However, patients want information about their disease and treatment, regardless of whether they want to participate in treatment decisions.<sup>3,4</sup> Third, and most important for many patients, hearing biomedical information from their oncologist allows patients to see that their oncologists are technically competent.<sup>5</sup> Technical expertise is rated by patients as the most important quality in their oncologists when compared with other qualities, such as talking about emotions, providing comfort, and providing community resources.<sup>6</sup> Currently, most oncologist-patient communication focuses on relaying biomedical information. Most of the time in oncology visits is spent discussing biomedical topics,<sup>7,8</sup> and most oncologists discuss with their patients the goals of treatment and their state of disease.<sup>3,7</sup> For example, in a study of patients with metastatic cancer, 85% were told the goal of their treatment, and 75% were told that their disease was incurable.<sup>5</sup>

#### **Show Care and Understanding for Patients as Individuals**

In addition to getting biomedical information from their oncologist, patients want to feel that their oncologist understands and cares about them as an individual. This feeling engenders confidence that

treatment recommendations will be tailored to their specific situation and needs.<sup>5</sup> For patients who prefer, as many do, that their oncologists make treatment decisions for them, it is especially important to trust their oncologist's understanding of them as a person and their commitment to the patients' well-being.<sup>4,5</sup>

Oncologists demonstrate that they understand and care about patients as individuals by spending enough time with them, allowing them to ask questions,<sup>6,9</sup> and listening to their concerns.<sup>4,9</sup> Patients' concerns often have social and emotional components. Although discussion of social and emotional issues with their doctors is rated as less important than the giving of biomedical information, most patients value being able to discuss these issues with their oncologist. In one study, 80% of patients wanted to discuss their family and social lives with their doctor.<sup>10</sup> However, psychosocial and emotional issues are discussed less frequently than biomedical issues in oncology visits. In one study, psychosocial and emotional issues were discussed 2.5 times less frequently than biomedical topics.<sup>7</sup> Aside from asking patients whether they want to discuss psychosocial and end-of-life concerns, there is no good way to predict when patients will want to discuss these issues. Physicians do not adequately predict patient concerns,<sup>11</sup> and disease severity does not predict whether patients want to talk about end-of-life issues.<sup>12</sup>

The personal aspects of the relationship with the oncologist become more important than technical abilities as the patient's illness progresses. At the initial consultation, patients primarily want cognitive information about their illness, but as early as the first follow-up visit, their preference shifts toward wanting support and reassurance and discussing their fears and worries.<sup>13</sup> Especially for patients whose disease progresses, the principle of nonabandonment, the open-ended commitment to face the future together, becomes more important, as the future becomes less certain.<sup>14</sup> Patients want to know that their oncologist will be there with them, even if life-prolonging treatment is not available.

#### **Balancing Realism and Hope**

The great majority of patients want their oncologist to be honest and realistic.<sup>4,6,9</sup> However, they want truth telling to be balanced with hope.<sup>9,15,16</sup> Patients say that this balance of truth telling and hope can be accomplished by oncologists': (1) being sensitive to what information patients are ready to hear and how the information is affecting them, and (2) emphasizing what can be done.

Patients vary with respect to the topics about which they want specific information. In one sample

of patients with metastatic cancer, more than 95% of patients wanted to hear information about treatment options, side effects, and symptoms. Most (85%) wanted to know the longest expected survival with treatment, and 80% wanted to know 5-year survival rates.<sup>2</sup> Patients want their doctor to negotiate with them about when and how the information is presented. When information is relayed, patients want their oncologists to be honest, but not to be too blunt in information giving and not to give a greater amount of detail than the patient wants to hear.<sup>15</sup> Patients want their oncologists to be honest and willing to talk about dying, but to be sensitive to whether the patient is ready.<sup>9</sup>

Patients feel that it is possible to foster coping and nurture hope while discussing prognosis and end-of-life issues.<sup>15</sup> This is accomplished by emphasizing what *can* be done: symptom control, emotional support, preservation of dignity, and practical support. Patients and health care providers have identified a spectrum of hope that includes cure as well as such hopes as dying a peaceful death and being with family. Physicians can foster these other hopes by exploring achievable goals and discussing day-to-day living.

In summary, hearing biomedical information from their oncologists is very important to patients, and oncologists already spend most of their time presenting biomedical information. Yet patients also desire that oncologists understand and care about them as individuals and are able to balance hope and realism. These latter tasks can be more challenging than providing biomedical information and are less likely to be incorporated into training. Thus, for the remainder of this paper, we review communication skills that oncologists can use to show care and understanding and balance hope and realism.

#### **SHOWING CARE AND UNDERSTANDING FOR PATIENTS AS INDIVIDUALS: ELICITING CONCERNS AND EXPRESSING EMPATHY**

Showing care and understanding for patients as individuals can help them through times of transition. Physicians are often reluctant to elicit patient concerns for fear that they will not know how to deal with the problems or emotions they elicit.<sup>17</sup> Medical education emphasizes fixing problems as the way to help patients,<sup>18</sup> and from this perspective, it is counterintuitive to elicit concerns that cannot be fixed. Yet empirical evidence shows that patients benefit from disclosing concerns and feeling that their oncologist cares about them, regardless of whether their concerns can be solved. In one study, patients who wanted more emotional support from their

oncologists at the time of diagnosis had poorer psychological adjustment later.<sup>19</sup> Patients whose physicians respond to their emotions and discuss their psychological problems have lower levels of emotional distress.<sup>20</sup>

Oncologists can help patients to cope with loss and difficult emotions by promoting disclosure of concerns and responding empathically to emotion. Although we discuss them separately here, these two skills are interrelated in patients who feel that their doctor is empathic are more likely to disclose concerns.

#### **Eliciting Concerns**

Because so much is changing during times of transition, cancer patients often have many concerns about medical, psychological, and social issues.<sup>21</sup> Disclosing these concerns to their oncologists can ease the patient's experience of transition, regardless of whether the oncologist is able to "fix" the concerns. Transitions often involve uncertainty regarding the future. Uncertainty typically provokes anxiety and worries regarding the worst possible options. Information about these areas, even bad news, often promotes coping because it decreases uncertainty. Empiric data show that patient's degree of psychological distress is correlated with the number of concerns that they have,<sup>21</sup> and patients who have a high degree of anxiety about their disease are more likely to develop affective disorders.<sup>22</sup> The utility for patients of discussing concerns is twofold. First, simply talking about concerns can defuse them, and this defusing process has been shown to improve symptom control.<sup>23</sup> Second, when physicians inquire about their concerns, it shows patients that their physician cares.

Both physician behavior and patient factors influence disclosure of concerns. Although physicians often feel that they can predict patients' concerns and distress, their actual ability to predict correctly is poor.<sup>11,24,25</sup> When patients were asked to rate their distress before oncology visits and their physicians were asked to estimate the patient's distress, physician detection of distress was actually lowest in those patients with the highest self-rated distress.<sup>24</sup> Patients often want to talk about psychosocial concerns but rarely disclose them if not directly asked.<sup>10,26</sup> Patients are least likely to disclose concerns about the future and their loss of independence, and they are less likely to disclose concerns if they are anxious or depressed.<sup>26</sup>

Because physicians are unable to predict patients' concerns, they must enquire about concerns using communication skills shown to increase disclosure. These specific communication skills are as follows: asking open-ended questions, allowing more time for

patients to speak, and being empathic.<sup>24,27</sup> Of these skills, empathy is especially important. Often, patients disclose concerns, but physicians do not respond in a way that recognizes the concern and its effect on the patient.<sup>28,29</sup> When physicians repeatedly do not recognize concerns, patients stop disclosing them.<sup>29</sup> However, when physicians respond empathically, patient disclosure increases.<sup>24,29</sup>

### Expressing Empathy

Empathy is the explicit acknowledgement by the physician of a patient's expression of emotion.<sup>28,29</sup> Empathic communication reduces a patient's level of anxiety.<sup>20,30</sup> Empathy makes patients feel heard and that their doctor cares about them.<sup>29</sup> Empathy can be both verbal and nonverbal. The goal of verbal and nonverbal empathy is for patients to feel that their oncologist cares about them, wants to understand what they have been going through and are feeling, and will be there to support them. Expressing empathy does not involve the physician promising to fix the emotion the patient is feeling, or the cause of it; that is usually not possible.

The first step in expressing empathy is recognizing when patients are expressing emotion. Patients express emotion directly<sup>29</sup> by saying words that describe an emotion: *scared, worried, sad, depressed, discouraged*, for example: "I'm quite discouraged about my trouble swallowing and losing weight." They may also allude<sup>29</sup> to their emotional state without using a word that describes the emotion, for example: "I don't know if I can handle this any more." They may sigh or cry, or show other nonverbal signs of emotion: appearing down or depressed, fidgeting, or avoiding eye contact.

Once physicians recognize an emotion, they can then decide to whether to pursue it. Although not all expressions of emotion need to be explored, responding empathically to emotions does not increase visit time,<sup>20</sup> and as described earlier, can be very useful to the patient. Patients often repeat emotional cues if their physician does not respond to the first.<sup>29</sup> Another time that responding to emotion can be particularly helpful is in patients who refuse to recognize cognitive information about their disease. In this case, switching to from a cognitive channel, where information is being given, to an emotional channel can help get the physician and patient on the same page:

Doctor: "I'm sorry to say it, but you're too weak to get more chemotherapy, I think it's time we change our approach."

Patient: "I'm not weak! Ask my wife. I need that chemotherapy."

Doctor: "This must be really hard news to hear."

Patient: "Yes, it is, I haven't let myself think about what I would do if I couldn't get treatment anymore."

The acronyms SOLER<sup>31</sup> and NURSE<sup>32,33</sup> can be used to represent the aspects of nonverbal and verbal empathy respectively (Tables 1 and 2). The elements of nonverbal empathy (Table 1) involve using one's body posture to convey interest in the patient and relaxation. We discuss verbal empathy in more detail here. The key factor in responding to the emotion verbally is not so much being correct in determining the type of emotion being expressed but in recognizing that emotion is present. In **NAMING** the emotion, if the patient did not name their specific emotion, the physician can guess it, phrasing as a question: "Are you feeling sad?" Patients usually care not that their doctor guess their emotion correctly, but that he or she is interested in how they are feeling. If the doctor guesses incorrectly, they will say how they are actually feeling. The goal of **UNDERSTANDING** the emotion is to normalize it and shows that the physician understands the emotion: "I can't fully imagine how you have been feeling, but it seems like this has been really difficult." **RESPECT** affirms how well the patient has been doing in the face of difficult obstacles: "I see so many patients, and from my experience, you are coping with this so well, given the circumstances." **SUPPORT** conveys to the patient nonabandonment; you are there for them and will be there for them: "I know this pain has been hard to control. I want you to know that we'll keep working on it together." Finally, **EXPLORE** statements encourage patients share a fuller view of their experience: "You said you were worried about difficulty breathing, can you tell me more about that?"

"I wish" statements are also a powerful way to convey empathy when patients receive difficult news or seem unable to accept their clinical situation.<sup>16</sup> When the physician is giving biomedical information that the patient cannot accept, the patient and physician

**TABLE 1** Nonverbal Expressions of Empathy

- S** Face the patient **SQUARELY** to indicate interest in her story.
- O** Adopt an **OPEN** body posture as a sign that you are open to the patient.
- L** **LEAN** toward the patient to show intimacy and flexibility toward the patient's position.
- E** Use **EYE CONTACT** to show you are paying attention.
- R** Maintain a **RELAXED** body posture to decrease patient anxiety.

From Egan G.<sup>31</sup>

**TABLE 2** Verbal Expressions of Empathy

Patient emotional statement:	<i>"These headaches are killing me!"</i>
Empathetic physician responses:	
<b>N NAME</b> the emotion:	<i>"You seem frustrated."</i>
<b>U UNDERSTAND</b> the emotion:	<i>"It must be so hard to be in pain like that."</i>
<b>R RESPECT</b> (praise) the patient:	<i>"I'm so impressed that you've been able to keep up with your treatment and the rest of your life while having these headaches."</i>
<b>S SUPPORT</b> the patient:	<i>"I and my team will be here to help you with the headaches."</i>
<b>E EXPLORE</b> the emotion:	<i>"Tell me more about how these headaches are affecting you."</i>

From Fischer G, Tulsy J, Arnold R.<sup>33</sup>

feel at odds with one another because they disagree about the cognitive information. The "I wish" statement has the effect of underscoring the truth of the situation, while at the same time telling patients that their doctor is on their side:

Doctor: *"Mr. Jones, unfortunately the cancer has grown."*

Patient: *"That's impossible! I feel fine. The test must be wrong."*

Doctor: *"I wish I had different news."*

Patient: *"So it's really grown then?"*

Doctor: *"Yes."*

### Balancing Hope and Realism

Hope is the desire and search for a future good.<sup>1</sup> Often, hope is defined related to a certain outcome.<sup>34</sup> For cancer patients, a predominant hope is that they will be cured of their disease. Unfortunately, for many, this cure will not happen. Further, patients say that they want their oncologists to be honest with them but at the same time say that they do not want them to take away their hope.<sup>4,6,9,15,16</sup> Oncologists are put in a bind: it seems they cannot tell the truth without taking away hope. However, patients feel that it is possible for oncologists to tell the truth without taking away hope.<sup>15</sup> They have described how oncologists can realistically discuss their disease state with them while fostering hope.<sup>15</sup> They identified two key ways in which oncologists can accomplish this by (1) being sensitive to how much information the patient wants and when he or she is able to hear information, and (2) promoting hopes other than cure.

### Sensitivity When Giving Information

Patients want the giving of information to be tempered with consideration of how the information is affecting them. They want their oncologists to not be too blunt, to give information at a time when patients are ready to hear it, and to not include more detail

than the patient wants to hear. This can be challenging because it is impossible to tell on the surface where patients are and so what they are ready to hear. Two techniques allow oncologists to discuss difficult information at a speed and degree of detail appropriate for the individual patient:

### Ask-Tell-Ask and Hope for the Best, Prepare for the Worst.

**Ask-Tell-Ask** The Ask-Tell-Ask<sup>35</sup> technique ensures that (1) the doctor-patient interaction remains a conversation, and that (2) the information to be given is appropriate for the patient. In this technique, the oncologist telling the patient information is bracketed by his asking questions to check that he or she will give the information that is most helpful to the patient. This example uses Ask-Tell-Ask in a conversation about prognosis:

Patient: *"How long do I have, doctor?"*

**Ask** Doctor: *"That is important for us to talk about. So that I make sure to give you the most helpful answer, can you tell me first why you are asking?"*

Patient: *"My daughter is getting married in July—I really want to be there."*

**Tell** Doctor: *"With the treatment you are getting, I fully expect that you will be able to go to her wedding in July."*

**Ask** Doctor: *"Does that give you the information you were hoping for?"*

Patient: *"Yes, that puts my mind at ease to know that."*

Although the patient brought up a difficult topic (prognosis), because the doctor used the Ask-Tell-Ask technique, the patient got the information that best answered his or her question and was not overloaded with unwanted information. Asking questions ensured that the doctor never got more than one step ahead of the patient in the conversation. It is at the

times when the doctor gets too far ahead of the patient or does not check that the information that he or she is giving is wanted that there is a risk of giving the patient more information than the patient is ready to handle. In this case, although the patient asked about prognosis, he or she only really wanted to know whether he or she would live to see his or her daughter get married; more information might have been harmful.

**Hope for the Best, Prepare for the Worst** It seems that so frequently patients cling to hopes that do not seem possible. An approach called “hope for the best, prepare for the worst”<sup>36</sup> can be used to discuss the possibility of less desirable outcomes with patients who seem to be clinging to unrealistic hopes. This approach is useful in two ways: (1) it allows for practical planning while not seeming to take away hopes for a good outcome, and (2) it allows patients to face scary outcomes, which can be the first step toward finding new hopes. The view of this approach is that hoping for a cure, even if a cure is extraordinarily unlikely, is not in itself a problem. The negative impact of unrealistic hopes occurs when patients are unable to entertain other possibilities and when lack of attention to these possibilities may cause future ills to the patient and their family. Patients make treatment choices based on their prognosis, and if they perceive their life expectancy to be longer, they choose life-prolonging therapies that they would not choose if they knew their prognosis.<sup>37,38</sup> Further, many of the factors that patients rate as defining a good death<sup>39,40</sup> require preparation, and thus advance notice that death is approaching. For example, Von Roenn and von Gunten<sup>18</sup> pointed out that a patient who is hoping to be cured but has completed his or her will and made amends with his or her family is very different from a patient who is hoping to be cured and has not made arrangements for the care of his or her young child.

The hope for the best, prepare for the worst approach allows multiple possibilities to be held at the same time, allowing discussion of difficult possibilities that otherwise could not be considered. This hoping for the best also aligns the patient and physician, and it means that the physician is not put in the position of taking away hope for a good outcome. For example:

Doctor: “Jim, the cancer being in your bones means that though we still have treatments that can lengthen your life, this cancer won’t ever completely go away.”

Patient: “I have to keep my hope that I’ll be cured.”

Doctor: “I share that hope with you then, Jim. I’m wondering whether we could also talk about what will happen if things don’t go as we hope.”

The goal is to establish realistic goals that allow for hopes, even if they seem unrealistic, while planning for the worse-case scenario. It is important to be curious about patients’ hopes and fears but not force them to talk about them. Each person has their own timeline of coping, and if a patient knows that his or her oncologist is available to listen and cares, the patient will talk about their hopes and fears when he or she is ready. Thus, if the patient’s answer to the doctor’s last question above is, “No, I can’t talk about that,” the patient’s wish should be respected.

### Promoting Hopes Other than Cure: The Spectrum of Hope

Von Roenn and von Gunten<sup>18</sup> described hope not as the wish for a certain outcome but as a process by which we expect for something good in the future and make plans toward that goal. From this view, hope is perpetual and is something that all humans do naturally. Further, hope is not limited to one outcome: we are able to hope for multiple things at once. Patients and health care providers have defined this range of things to hope for as a spectrum of hope, including being cured, living longer, finding meaning in life, having special time with loved ones, finding spiritual meaning, and having a peaceful death.<sup>15</sup> Although each patient may not hope for any or all of these specific things, there will always be other things in which he or she can find hope. Hopes are very personal and unique to the individual. Through good communication skills, oncologists can help their patients discover and voice their own unique personal hopes.

Patients tell us that oncologists can foster hope by emphasizing what *can* be done: pain and symptom control, emotional and practical support, having dignity, being in a caring environment. Further, patients want their oncologists to explore and help them to set realistic goals for the future and to discuss the practicalities of day-to-day living. Patients have also identified multiple factors as attributes of a good death: freedom from pain and other symptoms, clear decision making, preparation for death, having a sense of completion, contributing to others, affirmation of the whole person, being at peace with God, being in the presence of family, being kept clean, and trusting one’s physician.<sup>39,40</sup> These are important sources of hope, whether or not a cure is likely.

Oncologists can most help their patients discover

and voice their hopes by providing a supportive environment in which patients feel that their oncologists care about them and are curious about their hopes. This is accomplished through empathy, the ask-tell-ask technique, the hope for the best, prepare for the worst approach if patients have difficulty talking about fears, and most importantly, being curious about patients' hopes and fears. Most goals and hopes are not biomedical but are personal and social, relating to the most valued parts of patients' lives: their families and friends, their sense of self, their spirituality, and practical concerns, such as finances and wills. Thus, in the process of defining goals, the physician, by being curious and caring, facilitates the patient uncovering their hopes and fears and defining goals. The following example illustrates how an oncologist being curious about a patient's fear leads to the patient voicing his hope for the future: to spend time quality time with his family.

Doctor: "What about this cancer is worrying you most?"

Patient: "That I'll die of course."

Doctor: "Yes."

Patient: "And leave my wife and kids alone."

Doctor: "They must be really important to you."

Patient: "They mean the world to me."

Doctor: "So it sounds like quality time with them is a priority for you."

Patient: "Definitely."

## CONCLUSION

Patients undergo multiple large and small transitions during the course of their cancer care. Oncologists are uniquely positioned to help patients through these transitions. When patients' external situation changes, they must cope with the loss of previous hopes and with the negative emotions associated with those losses. They then are able to redefine hope, finding hope in other outcomes. During transitions, patients want their oncologists to provide biomedical information, show that they care about and understand them as individuals, and balance realism and hope. Oncologists are well trained to provide biomedical information. Showing care and understanding for patients as individuals and balancing realism and hope can be challenging as medical training does not emphasize these skills. Eliciting concerns and expressing empathy show patients that their oncologist cares about and understands them. Discussing concerns and showing empathy also helps patients cope with the negative emotions and loss that transitions create. Patients feel that it is possible for oncologists

to be realistic while maintaining hope. Patients say oncologists can maintain hope by being sensitive to what they are ready to hear, and by helping them discover and identify realistic hopes. Being sensitive to what patients are ready to hear can be accomplished by using the ask-tell-ask and hope for the best, prepare for the worst approaches. Oncologists can help patients discover and identify realistic hopes by using all the techniques discussed, and most importantly, by being curious about their patients' hopes and fears.

## REFERENCES

1. The American Heritage Dictionary of the English Language, 4th ed. Boston: Houghton Mifflin Company; 2000.
2. Hagerty RG, Butow PN, Ellis PA et al. Cancer patient preferences for communication of prognosis in the metastatic setting. *J Clin Oncol* 2004;22:1721-1730.
3. Gattellari M, Voigt KJ, Butow PN et al. When the treatment goal is not cure: are cancer patients equipped to make informed decisions? *J Clin Oncol* 2002;20:503-513.
4. Henman MJ, Butow PN, Brown RF et al. Lay constructions of decision-making in cancer. *Psychooncology* 2002;11:295-306.
5. Wright EB, Holcombe C, Salmon P. Doctors' communication of trust, care, and respect in breast cancer: qualitative study. *BMJ* 2004;328:864.
6. Parker PA, Baile WF, de Moor C et al. Breaking bad news about cancer: patients' preferences for communication. *J Clin Oncol* 2001;19:2049-2056.
7. Ford S, Fallowfield L, Lewis S. Doctor-patient interactions in oncology. *Soc Sci Med* 1996;42:1511-1519.
8. Detmar SB, Muller MJ, Wever LD et al. The patient-physician relationship: patient-physician communication during outpatient palliative treatment visits: an observational study. *JAMA* 2001;285:1351-1357.
9. Wenrich MD, Curtis JR, Shannon SE et al. Communicating with dying patients within the spectrum of medical care from terminal diagnosis to death. *Arch Intern Med* 2001;161:868-874.
10. Detmar SB, Aaronson NK, Wever LD et al. How are you feeling? Who wants to know? Patients' and oncologists' preferences for discussing health-related quality-of-life issues. *J Clin Oncol* 2000;18:3295-3301.
11. Goldberg R, Guadagnoli E, Silliman RA et al. Cancer patients' concerns: congruence between patients and primary care physicians. *J Cancer Educ* 1990;5:193-199.
12. Pfeifer MP, Mitchell CK, Chamberlain L. The value of disease severity in predicting patient readiness to address end-of-life issues. *Arch Intern Med* 2003;163:609-612.
13. Butow PN, Maclean M, Dunn SM et al. The dynamics of change: cancer patients' preferences for information, involvement and support. *Ann Oncol* 1997;8:857-863.
14. Quill TE, Cassel CK. Nonabandonment: a central obligation for physicians. *Ann Intern Med* 1995;122:368-374.
15. Clayton JM, Butow PN, Arnold RM et al. Fostering coping and nurturing hope when discussing the future with terminally ill cancer patients and their caregivers. *Cancer* 2005;103:1965-1975.
16. Ptacek JT, Eberhardt TL. Breaking bad news: a review of the literature. *JAMA* 1996;276:496-502.
17. Maguire P. Improving communication with cancer patients. *Eur J Cancer* 1999;35:1415-1422.

18. Von Roenn JH, von Gunten CF. Setting goals to maintain hope. *J Clin Oncol* 2003;21:570-574.
19. Butow PN, Kazemi JN, Beeney LJ et al. When the diagnosis is cancer: patient communication experiences and preferences. *Cancer* 1996;77:2630-2637.
20. Roter DL, Hall JA, Kern DE et al. Improving physicians' interviewing skills and reducing patients' emotional distress: a randomized clinical trial. *Arch Intern Med* 1995;155:1877-1884.
21. Heaven CM, Maguire P. The relationship between patients' concerns and psychological distress in a hospice setting. *Psychooncology* 1998;7:502-507.
22. Parle M, Jones B, Maguire P. Maladaptive coping and affective disorders among cancer patients. *Psychol Med* 1996;26:735-744.
23. Smyth JM, Stone AA, Hurewitz A et al. Effects of writing about stressful experiences on symptom reduction in patients with asthma or rheumatoid arthritis: a randomized trial. *JAMA* 1999;281:1304-1309.
24. Merckaert I, Libert Y, Delvaux N et al. Factors that influence physicians' detection of distress in patients with cancer: can a communication skills training program improve physicians' detection? *Cancer* 2005;104:411-421.
25. Ford S, Fallowfield L, Lewis S. Can oncologists detect distress in their out-patients and how satisfied are they with their performance during bad news consultations? *Br J Cancer* 1994;70:767-770.
26. Heaven CM, Maguire P. Disclosure of concerns by hospice patients and their identification by nurses. *Palliat Med* 1997;11:283-290.
27. Maguire P, Faulkner A, Booth K et al. Helping cancer patients disclose their concerns. *Eur J Cancer* 1996;32A:78-81.
28. Butow PN, Brown RF, Cogar S et al. Oncologists' reactions to cancer patients' verbal cues. *Psychooncology* 2002;11:47-58.
29. Suchman AL, Markakis K, Beckman HB et al. A model of empathic communication in the medical interview. *JAMA* 1997;277:678-682.
30. Fogarty LA, Curbow BA, Wingard JR et al. Can 40 seconds of compassion reduce patient anxiety? *J Clin Oncol* 1999;17:371-379.
31. Egan G. *The Skilled Helper: A Problem-Management and Opportunity-Development Approach to Helping*, 7th ed. California: Brooks/Cole, 2002.
32. Smith RC, Hoppe RB. The patient's story: integrating the patient- and physician-centered approaches to interviewing. *Ann Intern Med* 1991;115:470-477.
33. Fischer G, Tulsy J, Arnold R. Communicating a poor prognosis. In: Portenoy R, Bruera E, eds. *Topics in Palliative Care*. New York: Oxford University Press, 2000.
34. Tulsy JA. Hope and hubris. *J Palliat Med* 2002;5:339-341.
35. Back AL, Arnold RM, Baile WF et al. Approaching difficult communication tasks in oncology. *CA Cancer J Clin* 2005;55:164-177.
36. Back AL, Arnold RM, Quill TE. Hope for the best, and prepare for the worst. *Ann Intern Med* 2003;138:439-443.
37. Murphy DJ, Burrows D, Santilli S et al. The influence of the probability of survival on patients' preferences regarding cardiopulmonary resuscitation. *N Engl J Med* 1994;330:545-549.
38. Weeks JC, Cook EF, O'Day SJ et al. Relationship between cancer patients' predictions of prognosis and their treatment preferences. *JAMA* 1998;279:1709-1714.
39. Steinhauser KE, Christakis NA, Clipp EC et al. Factors considered important at the end of life by patients, family, physicians, and other care providers. *JAMA* 2000;284:2476-2482.
40. Steinhauser KE, Clipp EC, McNeilly M et al. In search of a good death: observations of patients, families, and providers. *Ann Intern Med* 2000;132:825-832.