Introduction

• Communication in oncology practice (including medical, radiation, and surgical oncology) presents numerous challenges.

• Clinicians often must share devastating news with patients and families.

• Cancers are frightening diseases and patients may react to diagnostic and treatment information with fear, grief, denial, or anger.

• Clinicians must learn to support patients and to help them cope, and must efficiently build rapport, convey adequate information, and address patient and family concerns within the time constraints of clinical practice.

• The guideline presents a framework of specific practices that improve communication.

• Challenging conversations in oncology are in many ways akin to complex interventional procedures or operations in that they require careful planning and execution, using well developed strategies to facilitate optimal communication.
ASCO Guideline Development Methodology

The ASCO Clinical Practice Guidelines Committee guideline process includes:

• multidisciplinary Expert Panel convened to consider the evidence and formulate the recommendations
• Based upon the consideration of the evidence, clinical experience, and a formal consensus process, the authors were asked to contribute to the development of the guideline, provide critical review, and finalize the guideline recommendations.
• final guideline approval by ASCO CPGC

The full ASCO Guideline methodology supplement can be found at:
www.asco.org/supportive-care-guidelines
Clinical Question

This clinical practice guideline addresses nine overarching clinical questions:

1) What core communication skills and tasks apply at every visit, across the cancer continuum?

2) What communication skills and tasks may clinicians use when discussing goals of care and prognosis?

3) What communication skills and tasks may clinicians use when discussing treatment options (including best supportive care) and clinical trials?

4) What communication skills and tasks may clinicians use when discussing end-of-life care?
Clinical Question

5) What communication skills and tasks may clinicians use to facilitate family involvement in care?

6) What communication skills and tasks may clinicians use when there are barriers to communication such as language differences and/or low literacy or numeracy?

7) Should clinicians discuss cost of care with patients?

8) What communication skills and tasks may clinicians use to help meet the needs of underserved populations, racial and ethnic minority patients, and other patients from groups that have experienced discrimination historically?

9) What are the most effective ways for clinicians to acquire communication skills?
Summary of Recommendations

CLINICAL QUESTION 1
What core communication skills and tasks apply at every visit, across the cancer continuum?

Recommendation 1.1
Before each conversation, clinicians should review the patient’s medical information, establish goals for the conversation, and anticipate the needs and responses of the patient and family. (Type: formal consensus; Strength of recommendation: strong)

Strategies for 1.1
• Arrange for an appropriate location for the conversation and enough time to give the information and answer questions.
• Have all the information necessary to conduct an effective encounter.
• Know who should be present for the conversation.
• Have 1-3 goals or take-home messages in mind for the conversation.
• Anticipate the emotional responses of patients and family members.
• Anticipate questions that might be asked.
• Inquire if there are family members who are not able to attend meetings in person and ask whether they are informed about clinician/patient conversations. Consider offering a teleconference for people who are important to the patient but cannot be physically present.
• Explore whether there are financial constraints.

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Summary of Recommendations

Recommendation 1.2
At the beginning of conversations with patients, clinicians should explore the patient’s understanding of their disease, and collaboratively set an agenda with the patient after inquiring what the patient and family wish to address and explaining what the clinician wishes to address. (Type: formal consensus; Strength of recommendation: strong)

Strategies for 1.2
• Use open-ended questions to encourage patients to share what is important to them.
• Consider the use of pre-visit patient-reported outcomes, pre-visit coaching interventions, and question prompt lists.1-3
Summary of Recommendations

**Recommendation 1.3**
During patient visits, clinicians should engage in behaviors that actively foster trust, confidence in the clinician, and collaboration. (Type: formal consensus; Strength of recommendation: strong)

**Strategies for 1.3**
- Introduce oneself and one’s role in the patient’s care.
- Sit down.
- Be friendly but not overly casual.
- Engage in reflective listening.
- Make eye contact.
- Maintain a calm demeanor.
- Get to know the patient as a person, finding out about what their life was like before their cancer diagnosis, and how the cancer has changed their life.
- Inquire about how the patient and family are coping and feeling.
- Be honest, genuine, and respectful.
Summary of Recommendations

Recommendation 1.4
Clinicians should provide information that is timely and oriented to the patient’s concerns and preferences for information. After providing information, clinicians should check for patient understanding and document important discussions in the medical record. (Type: formal consensus; Strength of recommendation: strong)

Strategies for 1.4
• Avoid unnecessary delays in providing information.
• Communicate with consultants and others involved in the patient’s care so that the patient receives coherent recommendations and information. Different providers may legitimately disagree with each other but differences of opinion should be explained and providers should actively help patients process and interpret differing recommendations.
• Consider whether the information is appropriate to provide by phone or mail/email or if an in-person meeting is needed.
• Orient the patient, if necessary, to make sure they understand what is going to be discussed and why (e.g. “I have the results of the CT scans you had done yesterday and I wanted to go over the results with you if that’s ok.”).
Summary of Recommendations

- Orient yourself to the patient’s understanding and concerns: Ask the patient what they know and what they want to know (e.g. “Please tell me what you understand (or what you have been told) about why you are in the hospital and what we are doing to help you get better?”; “What have the other clinicians told you about your cancer?”; “What are the things that you want to make sure we discuss today?”).

- Use simple language tailored to the patient’s educational level. A patient may be intelligent and well educated but still have low health care literacy.

- Avoid jargon (e.g. “response rate” or “positive test result”) and explain in lay language when you must use medical terminology.

- Provide information that is relevant to what the patient wants to know and to the patient’s goals.

- Avoid information overload by providing information in small doses, stopping frequently, and checking for comprehension.

- Check for understanding by using a “teach back” or “talk back” method, with a statement such as, “In your own words, what does this mean to you?” or “What will you tell your family about what we discussed?”

- Assure the patient that you are available to answer questions in the future.
Summary of Recommendations

**Recommendation 1.5**
When patients display emotion through verbal or nonverbal behavior, clinicians should respond empathically. (Type: formal consensus; Strength of recommendation: strong)

**Strategies for 1.5**
- Acknowledge and name the emotions (e.g. “You seem sad today.” “Help me understand how you’re feeling about what we discussed.” “This has been a very tough six months for you.” “I know you had a bad time when you were on chemotherapy previously and that you’ve been worried about starting it again.” “It’s stressful coming in for these scans and having to worry about whether there will be bad news.”)
- Use partnership and supporting statements. (e.g. “I want to make sure we do everything we can to get you the best outcome.” “I know this has been a rough time and I want to do what I can to help you feel better.” “I’m distressed to hear that you’ve been suffering so much, and I’m hoping we can work together to improve your quality of life.”)
- Be cautious about providing information when patients are emotional. When in a strongly emotional state, patients often have difficulty absorbing and processing information.
- Ask patients what they are most concerned about, and explore what’s behind strong emotions. (e.g. “Tell me what you are worried about.” “What has been the hardest part of all this for you?” “Help me understand what you are feeling right now”).

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CLINICAL QUESTION 2
What communication skills and tasks may clinicians use when discussing goals of care and prognosis?

Recommendation 2.1
Clinicians should provide diagnostic and prognostic information that is tailored to the patient’s needs and that provides hope and reassurance without misleading the patient. (Type: formal consensus; Strength of recommendation: strong)

Strategies for 2.1
• When discussing the patient’s disease status and treatment history, assess the patient’s understanding of his/her disease status, prognosis, and the effects of any treatments to date; the patient’s goals of care and treatment preferences; and how the patient’s goals of care relate to life goals, activities of daily living, and quality of life.
• Determine whether the patient: is prepared for explicit information; is ambivalent; or doesn’t want information. For ambivalent patients, discuss the pros and cons of knowing. For patients who don’t want to know, negotiate (with the patient’s permission) a future discussion or discussion with family members.
• Determine if family members are involved, in agreement, and supportive.
• An example of providing hope might be assuring the patient that I as their clinician will do everything I can to help them get the best possible outcome. Communication behaviors that facilitate hope include reframing (“Is there something in particular that you are hoping for now?”), and non-abandonment (“I will do everything I can to support you.”).

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Summary of Recommendations

**Recommendation 2.2**
Clinicians should reassess a patient’s goals, priorities, and desire for information whenever a significant change in the patient’s care is being considered. (Type: formal consensus; Strength of recommendation: strong)

**Strategies for 2.2**
- Triggers for such a discussion include initial diagnosis, relapse or progression, change in treatment approach, change in goals of care, and at patient/family request.
- In order to establish a starting point for the conversation, ask the patient to explain what they understand about their illness, including the status of their disease and the treatment plan.
- After providing patients with test results, it may be helpful to ask them “Would you like to talk about what this means?”

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Summary of Recommendations

**Recommendation 2.3**
Clinicians should provide information in simple and direct terms. (Type: formal consensus; Strength of recommendation: strong)

**Strategies for 2.3**
- Use mixed framing (e.g. chance of a cure and chance of a relapse, or best/worst/most likely outcome).
- Provide information in multiple formats (words, numbers, ranges)
- Provide information in “chunks” (small discrete units), and check regularly for understanding.

**Recommendation 2.4**
When providing bad news, clinicians should take additional steps to address the needs and responses of patients. (Type: formal consensus; Strength of recommendation: strong)
Summary of Recommendations

Strategies for 2.4

• Ensure that the timing and setting are as appropriate and private as possible.
• Express solidarity (e.g. “I wish I had better news”).
• Give the bad news clearly and succinctly in plain, non-technical language (e.g. “Your cancer unfortunately has spread to your liver”).
• Pause after delivering the bad news in order for the patient to absorb what has been said (“supportive silence”).
• Wait for the patient to respond before saying anything more. If the patient says nothing, clinicians can ask questions such as “what’s going through your mind?” or respond empathically (e.g. “You look like you feel overwhelmed”).
• Respond empathically to patient emotion.
• Avoid trying to reduce patient distress by minimizing the bad news or changing the subject.
• Titrate the amount of information to the patient’s emotional state.
• Encourage patients to ask questions (“What questions do you have?”), and use silence to create space for patients to express their concerns.
• Discuss the meaning of the findings and next steps before ending the conversation.
• Affirm commitment to supporting the patient (e.g. “It’s my job to help you get the best care possible,” or “I’ll continue to take care of you whatever happens.”) and, if appropriate, help the patient find additional sources of support (e.g. family, friends, church, support groups, therapist, or social worker).

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Summary of Recommendations

CLINICAL QUESTION 3
What communication skills and tasks may clinicians use when discussing treatment options (including best supportive care) and clinical trials?

Recommendation 3.1
Before discussing specific treatment options with the patient, clinicians should clarify the goals of treatment (cure versus prolongation of survival versus improved quality of life) so that the patient understands likely outcomes and can relate the goals of treatment to their goals of care. (Type: formal consensus; strength of recommendation: strong)

Strategies for 3.1
• Revisit any previous conversations regarding the patient’s values, goals of care and treatment preferences.
• Ask whether and how these values and preferences have changed. (e.g. “In the past you expressed a desire to continue cancer treatment, but I can see this last round of therapy has been hard on you. I’m wondering if your thoughts about treatment have changed?”)
• Include the family or caregiver when possible and acceptable to the patient.

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Recommendation 3.2
When reviewing treatment options with patients, clinicians should provide information about the potential benefits and burdens of any treatment (proportionality) and check the patient's understanding of these benefits and burdens. (Type: formal consensus; Strength of recommendation: strong)

Strategies for 3.2
• Include a discussion of the frequency and nature of clinic visits and/or hospital stays and side effects of treatment.
• Frame treatment options in the context of the patient’s goals and priorities.
• If appropriate, given goals of care and treatment preferences, include the option of a sole focus on palliative care or hospice.

Recommendation 3.3
Clinicians should discuss treatment options in a way that preserves patient hope, promotes autonomy, and facilitates understanding. (Type: formal consensus; Strength of recommendation: strong)
Summary of Recommendations

Strategies for 3.3

• Focus on what can be done.
• Reinforce that the patient will not be abandoned, regardless of treatment choice.
• Acknowledge uncertainty.
• Normalize patient requests for a second opinion.
• Present information in small chunks and check-in frequently to assess understanding.
• When available, use published decision aids to prepare patients and to enhance communication and shared decision-making during consultations between patients and providers.
• Whenever possible, include an involved clinic or bedside nurse in discussions. They often have valuable contributions to make and will often be present for patients when questions and emotions arise after the physician has left the room.
• Document discussions in the medical record.
Summary of Recommendations

**Recommendation 3.4**
Clinicians should make patients aware of all treatment options, including clinical trials and a sole focus on palliative care. When appropriate clinicians should discuss the option of initiating palliative care simultaneously with other treatment modalities. If clinical trials are available, clinicians should start treatment discussions with standard treatments available off trial, and then move to a discussion of applicable clinical trials if the patient is interested. (Type: formal consensus; Strength of recommendation: strong)

**Strategies for 3.4**
- Explain what clinical trials are and why they are conducted.
- Clearly delineate treatment choices, including available standard treatments and investigational treatments.
- Explain what is known about the safety and efficacy data of the study treatment(s).
- Affirm that care will not be compromised if the patient decides not to participate in a clinical trial.
- Allow patient time to give their reaction to clinical trials in general and the clinical trial presented.
- Include discussion of symptom- or quality-of-life-directed care, such as palliative care or hospice, in conjunction with or as an alternative to anticancer treatment if consistent with patient’s goals or clinical scenario.
CLINICAL QUESTION 4
What communication skills and tasks may clinicians use when discussing end-of-life care?

Recommendation 4.1
Clinicians should use an organized framework to guide the bidirectional communication about end-of-life care with patients and families. (Type: formal consensus; Strength of recommendation: strong)

Strategies for 4.1
• Published frameworks include: SPIKES, PREPARED, and the Serious Illness Conversation Guide.
Summary of Recommendations

• Important steps to consider:
  – Mental preparation: Prepare for discussions by anticipating patient and family member emotions as well as questions about topics such as prognosis.
  – Review medical chart for documentation of previous end-of-life discussions.
  – Provide information to patient and, with patient’s permission, families regarding previous end-of-life discussions.
  – Develop rapport with the patient and family or caregivers.
  – Information preferences: Ask patients and families about their preferences for information sharing.
  – Assess understanding: Ask patients and families what they understand about their medical situation.
Summary of Recommendations

- Ask permission: Before sharing new medical information, including difficult news, prognostic information, or significant changes in treatment plan, ask permission.
- Provide information: Provide information in small amounts, using language appropriate to the patient’s level of education and health literacy, and check understanding frequently.
- Address emotions: Acknowledge and address emotions throughout the conversation.
- Define goals: Ask patients and families to define their goals in light of the medical situation. What is most important to them? What are their priorities?
- Align patient goals, values and care preferences with treatments and services offered.
- Inquire if all appropriate family members are aware of patient’s goals.
- Summarize: Summarize the conversation and establish a plan for the future.
- Document: Document EOL conversations in the medical record.
- Consider spreading out the conversation over two or more visits.
Summary of Recommendations

Recommendation 4.2
Clinicians should initiate conversations about patients’ end-of-life preferences early in the course of incurable illness, and readdress this topic periodically based on clinical events or patient preferences. (Type: formal consensus; Strength of recommendation: strong)

Strategies for 4.2
• Early in terminal illness, within a month of diagnosis of terminal cancer:
  – Discuss prognosis and advance care planning.
  – Document a surrogate decision maker and encourage patients to complete an advance directive early in the course of disease, as many advanced cancer patients experience altered mental status during the course of their cancer that may limit their ability to designate decision makers or to make healthcare decisions.
  – Explain why advance care planning is important and why patients should discuss their goals, values and care preferences with their appointed health care agent.
  – Explore patient goals and values.
  – Anticipate that patient goals and preferences may change over time in response to disease and treatment-related factors as well as physical and emotional changes.
Summary of Recommendations

- Recognize triggers or sentinel events that may prompt end-of-life care conversations with patients in the setting of advanced disease, including:
  - Cancer progression
  - Decline in functional status.
  - Increased high intensity healthcare utilization, including multiple emergency department visits, admissions to the hospital, ICU stays, or transition to a nursing facility if previously independent.
  - Consideration of a new line of cancer-directed therapies in the setting of progression on or poor tolerance of previous treatments
  - Consideration of high-risk or high-burden medical or surgical interventions (e.g. hemodialysis, palliative surgery, feeding tube placement).
  - Requests for care that don’t make sense in the patient’s clinical scenario.
  - Patient or family request for end-of-life care planning conversation
Summary of Recommendations

**Recommendation 4.3**
Clinicians should explore how a patient’s culture, religion, or spiritual belief system impacts their end-of-life decision making or care preferences. (Type: formal consensus; Strength of recommendation: strong)

**Strategies for 4.3**
- Avoid assumptions about a patient’s end-of-life care preferences based on stereotypes related to their race, ethnicity, culture, religion or spirituality.
- Ask open-ended questions regarding the impact of a patient’s culture and spirituality on their medical decision-making.
- Consider use of a standardized tool such as FICA (Faith and Belief, Importance, Community, Address in Care)⁸ to assess a patient’s spiritual or religious beliefs.
- When spiritual distress is identified, offer spiritual support from a medically trained chaplain.
Summary of Recommendations

**Recommendation 4.4**
Clinicians should recognize and respond empathically to grief and loss among patients, families, and themselves. Clinicians should refer patients and families to psychosocial team members (e.g., social workers, counselors, psychologists, psychiatrists, and clergy) when appropriate. (Type: formal consensus; Strength of recommendation: strong)

**Strategies for 4.4**
- Recognize different presentations of grief among patients, family members, and colleagues.
- In response to anticipatory grief (e.g. “What do I tell my kids?” “How will my family cope when I’m gone?”), providers should explore patient concerns and refer patients for appropriate psychosocial support.
- In response to patient descriptions of loss (e.g. loss of role, income, identity, etc.), explore meaning with patients, acknowledge the loss through empathy, and refer for appropriate psychosocial support.
- Refer bereaved family members for grief counseling; identify local agencies, programs, and hospices that provide this service.

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Summary of Recommendations

**Recommendation 4.5**
Clinicians should identify and suggest local resources to provide robust support to patients, families, and loved ones transitioning to end-of-life care. (Type: formal consensus; Strength of recommendation: strong)

**Strategies for 4.5**
- Introduce and describe palliative care services, including simultaneous palliative and oncology care, palliative care alone, and hospice care, early in the course of terminal illness.
- When a patient is transitioning to end-of-life care or hospice care, explore the patient and family goals and service needs. Introduce hospice by aligning goals and service needs with services provided via hospice care. For example, “I understand that you don’t want to spend any more time in the hospital, but you are scared about pain control at home. There’s a program called hospice that can help you stay at home and manage your pain and other symptoms.”
- Be aware of cues that the patient might or might not be ready for such a discussion.
- Address family members, whose openness to hospice may differ from the patient’s.
- When possible and with patient’s permission, include key family members by phone if they cannot be present.
Summary of Recommendations

**CLINICAL QUESTION 5**
What communication skills and tasks may clinicians use to facilitate family involvement in care?

**Recommendation 5.1**
Clinicians should suggest family and/or caregiver involvement in discussions (with patient consent) early in the course of the illness for support and discussion about goals of care. (Type: formal consensus; Strength of recommendation: strong)

**Strategies for 5.1**
- Establish rapport and lines of communication within the family. Identify a spokesperson if appropriate.
- If a patient lacks decisional capacity, remind the surrogate that their responsibility is to represent the wishes of the patient.
- Develop proficiency in conducting a family meeting.
- Document goals of care in medical record.

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Summary of Recommendations

**Recommendation 5.2**
Determine if a formal family meeting in a hospital or outpatient setting is indicated at important junctures in care. When possible, ensure that patients, their designated surrogates, and desired medical professionals are present. (Type: formal consensus; Strength of recommendation: strong)

**Strategies for 5.2**
- Before the meeting, designate a medical professional to facilitate the meeting.
- Review medical record for previous discussions of goals of care and end-of-life directives.
- Introduce everyone present.
- Explore a family’s agenda for a family meeting and state the provider team’s agenda in order to create a framework for the discussion and to ensure a family’s questions are answered directly.
- Share information about and/or documentation of previous discussions of goals of care and end-of-life directives.
- Elicit perspectives from all meeting attendees.
- Identify key issues, disagreements and perspectives clearly before problem-solving.
- Anticipate that in non-urgent situations, a resolution may not happen in the meeting itself.
- Pay attention to interactions (e.g., who talks, to whom, and who is seen as a decision-maker in the family).
- Set a plan for follow up.
- Offer to include absent family members via telecommunications, if appropriate.

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CLINICAL QUESTION 6
What communication skills and tasks may clinicians use when there are barriers to communication such as language differences and/or low literacy or numeracy?

Recommendation 6.1
For families who do not share a common language with the clinician, use a medical interpreter rather than a family interpreter. (Type: formal consensus; Strength of recommendation: strong)

Strategies for 6.1
– Ask the interpreter if they have any concerns about interpreting a conversation about cancer with the patient.
– Use simple, clear sentences, pausing frequently to allow for interpretation.
– Ask the patient to state his/her understanding after you’ve explained something.
– Be aware of cultural differences, not just language differences.
Summary of Recommendations

**Recommendation 6.2**
For patients with low health literacy, focus on the most important points, use plain language, and check frequently for understanding. (Type: formal consensus; Strength of recommendation: strong)

**Strategies for 6.2**
- Health literacy may be assessed with two questions: 1) How confident are you filling out medical forms by yourself? 2) How often do you have someone help you read hospital materials?
- Consider allowing the family to audio-record discussions or encourage them to take notes.

**Recommendation 6.3**
For patients with low health numeracy, use pictographs or other visual aids when available, and describe absolute risk rather than relative risk. (Type: formal consensus; Strength of recommendation: strong)
CLINICAL QUESTION 7
Should clinicians discuss cost of care with patients?

Recommendation 7
- Clinicians should explore whether cost of care is a concern for cancer patients. (Type: formal consensus; Strength of recommendation: strong)

Strategy for 7
- For patients who are concerned about cost of care, clinicians should clarify the specific concerns and either address the concern directly or refer the patient and their family to a financial counselor or social worker.
CLINICAL QUESTION 8
What communication skills and tasks may clinicians use to help meet the needs of underserved populations, racial and ethnic minority patients, and other patients from groups that have experienced discrimination historically?

Recommendation 8.1
• Enter clinical encounters with a sense of curiosity, aware that any patient and family, regardless of their background, may have beliefs, experiences, understandings, and expectations that are very different from the clinician’s. (Type: formal consensus; Strength of recommendation: strong)

Strategies for 8.1
– Self-awareness about one’s own experiences and biases can be helpful in providing equitable care.
– Focus on listening and observing at the beginning of the encounter.
Summary of Recommendations

**Recommendation 8.2**
Avoid assumptions about sexual orientation and gender identity, and use nonjudgmental language when discussing sexuality and sexual behavior. (Type: formal consensus; Strength of recommendation: strong)

**Strategy for 8.2**
- Take a comprehensive, sensitive sexual history from patients with life-limiting disease, and don’t assume that the disease has diminished their desire or interest in sex.

**Recommendation 8.3**
Remain aware that members of underserved or marginalized populations have an increased likelihood of having had negative past healthcare experiences, including feeling disrespected, alienated, or unsafe. (Type: formal consensus; Strength of recommendation: strong)

**Strategy for 8.3**
- Inquire about patients’ past experience with the health care system and health care providers.
Summary of Recommendations

CLINICAL QUESTION 9
What are the most effective ways for clinicians to acquire communication skills?

Recommendation 9.1
Communication skills training should be based upon sound educational principles and include and emphasize skills practice and experiential learning using role-play scenarios, direct observation of patient encounters, and other validated techniques. (Type: evidence based; Quality of evidence: intermediate; Strength of recommendation: strong)

Strategies for 9.1
- Lectures are an ineffective method of skills training and are not adequate unless paired with supervised skills-practice exercises.
- Skills-practice exercises may include any of the following:
  i. Role-play sessions conducted by trained facilitators.
  ii. Directly-observed or videotaped interviews with real patients or standardized patients.
- Skills-practice exercises should include structured feedback so that clinicians can learn which of their behaviors are effective and what opportunities exist to improve future performance.
- Skills-practice exercises benefit from techniques which enhance empathy for the patient and family such as role-reversal.

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Summary of Recommendations

**Recommendation 9.2**
For communication skills training to be most effective, it should foster practitioner self-awareness and situational awareness related to emotions, attitudes and underlying beliefs that may affect communication, as well as awareness of implicit biases that may affect decision-making.

(Type: evidence based; Quality of evidence: intermediate; Strength of recommendation: strong)

**Strategies for 9.2**

- Exercises to increase practitioner self- and situational awareness may include:
  - Reflection on the types of patient encounters that the clinician finds difficult, challenging, or unpleasant.
  - Reflection on the elements of patient care that bring the clinician satisfaction or a sense of meaning. Asking clinicians why they chose to work in healthcare and what they find meaningful and rewarding in their work is an example.
  - Reflection on personal experiences with the healthcare system as a patient or the loved one of a patient can increase both personal and situational awareness.
  - Assuming the role of the patient or family member in role-play exercises to appreciate their perspective and emotional reactions and gain insight into effective communication responses.
  - Brief mindfulness practices during the workday may help with self-awareness, reactivity and equanimity in the face of suffering.
Summary of Recommendations

**Recommendation 9.3**
Facilitators of communication skills training should have sufficient training and experience to effectively model and teach the desired communication skills and facilitate experiential learning exercises. (Type: evidence based; Quality of evidence: intermediate; Strength of recommendation: strong)

**Strategies for 9.3**
- Facilitators should be familiar with the various modalities that enhance learner communication skills.
- Facilitators should be trained to conduct skills-based learning sessions so that participants:
  - Learn
  - Do not feel humiliated
  - Are adequately prepared to demonstrate the desired skills
  - Receive feedback aimed at improving future performance

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Future Directions

• Many important questions need better answers.
  – What, for example, are the most appropriate measures of the effectiveness of communication?
  – If we give a patient distressing news, is measuring patient distress the right focus?
  – When giving bad news, the easiest way to reduce the patient’s distress in the short term is to be less forthcoming so that the patient doesn’t know the truth.
  – Similarly, if we aim for improving measures of patient satisfaction, will they be more satisfied if we are excessively optimistic about their prognosis?
  – This is not to say that patient satisfaction and distress aren’t important; only that it’s complicated.
Future Directions

• Other key issues include
  i. Refining our understanding of what the most effective education tools and strategies are
  ii. Scaling educational interventions (e.g. using the internet for distance learning) so that more clinicians can benefit within the constraints of available resources
  iii. Refining our understanding of how best to train healthcare communication trainers
  iv. Learning how best to sustain the improvements that derive from communication skills training so that skills do not diminish over time.
Additional Resources

More information, including a Data Supplement, a Methodology Supplement, slide sets, and clinical tools and resources, is available at www.asco.org/supportive-care-guidelines

Patient information is available at www.cancer.net
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