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Communication in Context

New Directions in Cancer Communication Research

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Communication research is sometimes described as analyzing the black box of the doctor's healing power (Bensing, 2000; White, 1988), but, every now and then you get a flash which shows communication researchers analyzing this black box as if it was found in the bush after a plane crash: as an object in itself, completely devoid of the broader context of the medical dialogue. Most communication research has been exclusively focused on the dialogue between patient and doctor or nurse in itself, without taking account of its context. However, such a dialogue does not take place in a vacuum. There is a whole world surrounding it. Researchers too often seem to ignore both the context of the patient system and the context of the health care system which have so much to offer for understanding and interpreting the value of the medical dialogue. We strongly believe that this narrow focus blinds communication researchers to many relevant issues and hampers the progress of knowledge as well as the implementation of knowledge in clinical practice. Thus, the central statement in this chapter is: *We have acquired enough knowledge in general of the value of communication skills. Now it is time to focus our attention to the study of specific contextual conditions that may broaden our knowledge and may help, hinder, or complicate the application of this knowledge in everyday practice.*

FOCUS ON CANCER COMMUNICATION

Although we believe that this central statement is valid for all or most communication research, we elaborate on it specifically for the domain of cancer care. After all, apart from general practice, there is no medical setting with a stronger tradition in communication research than the oncological setting. The reasons are obvious. For one thing, cancer care is always laden with emotions. Although in many cases the prognosis is better than it used to be, the diagnosis of cancer still tends to disrupt patients' lives in an extremely painful and powerful way, meaning that patients need emotional support in addition to the best of biomedical care. Moreover, patients are often confronted with difficult choices that put high demands on informed consent procedures and information-giving. The recent emphasis in communication research on patient-centered care and the relevance of shared decision making also has firm roots in cancer care. Oncologists and oncology nurses, who see so much suffering among their patients, have always shown an interest in communication as an essential part of high-quality care. Probably because of its uncontested relevance in cancer care, communication researchers have always been attracted to this field, and they have provided the field with good empirical descriptions of prevalent and/or adequate communication behaviors. In general, there is much agreement—among teachers as well as researchers—on the basics of good communication in cancer care. Open-ended questions (Maguire, Booth, Elliot, & Jones, 1996), empathy (Razavi et al., 2002), truth-telling (Fallowfield, Jenkins, & Beveridge, 2002), and room for emotional disclosure and psychosocial counselling (Maguire, 1999; Rutter, Iconomou, & Quine, 1996), all are unchallenged elements of good communication. Additionally, much effort has been put into finding empirical evidence for good communication in specific situations, such as bad-news delivery (Fallowfield, Lipkin, & Hall, 1998; Ford, Fallowfield, & Lewis, 1995), palliative care (Detmar et al., 2001), and genetic counselling (Sarangi, 2002). Communication research seems to be firmly rooted within the domain of cancer care.

However, notwithstanding the steady flow of publications, we believe that we should be modest about the real progress that has been made in the development of real evidence-based knowledge about the essentials of high-quality communication in oncology. Much of what is published seems to be a bit more of the same. The problem is this may help "believers" to feel warmly united and committed to a common pursuable aim, but it certainly does not convince "nonbelievers" or more cynical people of the central place communication should have in clinical practice, as well as in medical education and research programs. The community of communication researchers should feel challenged to look for new roads to win the central position in the health care arena that they so often claim.

FUTURE CHALLENGES

A running thread in this chapter is the call for attention to the context of communication. We are convinced that communication has to be studied in its context, the context of aims and targets, the context of persons and organizations, the context of place and time. By doing so we hope to bridge the gap between evidence-based medicine and patient-centered medicine

(Bensing, 2000). Only in this way research can help us find empirical evidence for the mechanisms that foster or hinder patients' well-being, apart from the direct effects of the medical intervention itself. These mechanisms are known to be part of the much-discussed but little-researched placebo- and nocebo-effects in health care (van Dulmen & Bensing, 2001).

There is, however, yet another challenge to meet, the challenge of theory-driven research. Much communication research is still descriptive in nature, more dictated by available methodology than by rigorous application of dedicated theories. Descriptive research is useful in the earlier stages of knowledge-production, when the domain-under-study still has to be charted. Real breakthroughs in knowledge are, however, only possible by systematic testing of theory-guided hypotheses on the presumed mechanisms behind the (positive and negative) effects of communication with cancer patients. We believe that in cancer care the phase of exploratory and descriptive research should and could be over.

Taken together, these two challenges can help to define a research agenda for the next decade. Within the field of communication in context, three four lines of investigation should be distinguished:

1. The context of *goals* or *targets* that are aimed at by both parties in the medical encounter (patient and physician or nurse), referring to the use of communication as a tool.
2. The context of *time* in relation to continuity of care, which necessitates the investigation of not only one single visit but consideration of the role and influence of previous and future consultations, as well as the patient's medical history.
3. The broader *organizational* context in which the dialogue takes place, colored by policies regarding teamwork, time constraints, and implicit and explicit priorities within the medical staff.
4. The context determined by what both *multifaceted parties*—on the one hand, the patient and accompanying spouse or child, and on the other, the physician and/or the nurse—bring to the health care visit: needs, expectations, knowledge and attitudes, and experience and skills, respectively.

Each of these points is elaborated and put in the proper theoretical perspective.

From General to Specific

There is now ample evidence that communication should be considered as perhaps the most powerful tool in medicine, not only in establishing a workable relationship with the patient, but also in both the diagnostic and therapeutic process (Bensing, 1991; Crow et al., 1999; Lipkin, Putnam, & Lazare, 1995; Roter & Hall, 1992; White, 1988). It also works the other way around: Good technical quality care, provided in an unsatisfactory environment and with unsatisfactory interactions, will not produce healthier patients (Koehler, Fottler, & Swan, 1992), and negative expectancies increase the frequency with which patients report all kind of symptoms (Crow et al., 1999). Consciously or unconsciously, communication plays a crucial role in medicine. Sometimes this role is positive and leads to better understanding and coping, to better therapeutic decisions, and more compliance; sometimes, however, the

role of communication is negative and leads to misunderstanding, dissatisfaction, wrong decisions, and sometimes even malpractice suits (Levinson, Roter, Mullooly, Dull, & Frankel, 1997; Roter & Hall, 1992). The success or lack of success can often be ascribed to communication processes.

It is important that doctors, nurses, and other health care professionals be aware of the effects of their communication behavior and learn to use it as the powerful tool it can be. At least as important is that communication researchers explore, unravel, and test specific communication behaviors in relation to set medical and nursing goals to provide health care professionals with empirical evidence for the singular items of their tool-box in relation to the problems at hand. Communication is a powerful tool, but only when it is used as a tool, or rather, a set of tools, as consciously planned and targeted interventions.

Aside from its well-known and widely trained generic characteristics (creating a good interpersonal relationship, exchange of information), concrete communication strategies and behaviors can be used to reach specified goals within medical and nursing care. As was shown by many researchers, there is a multitude of different specific goals and subgoals within health care (Lazare, Putnam, & Lipkin, 1995; Lipkin et al., 1995; Ong, de Haes, Hoos, & Lammes, 1995; Roter & Hall, 1992). Depending on phase of treatment and/or patient needs, medical encounters may vary in what both participants aim at: getting or giving reassurance; finding and giving the right diagnostic label; establishing a common agenda; weighing diagnostic and/or risk information; valuing preferred therapeutic options and alternative solutions; making patient preferences more explicit; reaching a medical decision (shared or not); strengthening self-efficacy in maintaining difficult therapeutic regimens; acknowledging, fighting, or relieving anxiety and depression; and giving moral support, comfort, and strength in accepting the unacceptable. Even within one medical visit, different targets can be distinguished. It is essential that researchers be aware of these multiple goals in health care encounters and realize that different goals ask for varied communication strategies that are based on a variety of theoretical frameworks.

Let us give one example: how to create a good interpersonal relationship can best be predicted from psychotherapeutic theories with their heavy accent on affective communication behaviors: friendliness, social courtesies, empathy, showing respect and understanding, and "unconditional positive regard" (Rogers, 1961). However, these theories might be worthless and their accompanying behaviors sometimes even contraproductive when trying to tackle noncompliance, the best hidden taboo in medical encounters. Based on self-regulatory theories (Leventhal, Safer, & Panagis, 1983), it can be predicted that enhancing compliance asks for active problem-solving behaviors, combined with active stress reduction: motivating patients to take responsibility, helping to set realistic and tailor-made personal goals and to list possible barriers, showing understanding for incidental events of noncompliance, and showing partnership in creative problem solving. A good example of what this might mean for communication research is shown by Roter and Hall (1994).

Different problems ask for specific tools and, thus, for specific communication strategies and behaviors. This positions communication researchers for methodological as well as theoretical challenges. Methodological challenges are to be found in subdividing medical encounters in meaningful elements, and in innovative ways of analyzing communication data (sequential analysis, pattern analysis, critical incident analysis, cue responding, etc.). Theoretical challenges are to be found in applying theories that have been developed in clinical psychology, social psychology, and health psychology to the field of communication research and vice versa. As an additional advantage, this could help to explain under which

conditions theoretically based behavioral intervention programs are more or less successful when implemented in everyday practice. For, as stated earlier, good technical quality care, provided in an unsatisfactory environment and with unsatisfactory interactions, will not produce healthier patients.

The issue is further complicated by the fact that there are often individual differences in the targets patients may have. Again an example using the recent paradigm on shared decision making might be illustrative. There is ample evidence that patients diagnosed with cancer want to be adequately informed of their diagnosis and prognosis, but that many (but not all) relinquish decisional control (Coulter, 1997; Fallowfield et al., 2002; Stiggelbout & Kiebert, 1997). Patients may feel burdened by the significance and consequences of making treatment decisions and prefer the physician to be accountable for the choices made. Therefore, advocating increased patient involvement for every patient in every situation may well endanger rather than safeguard patient autonomy (Gattellari, Voigt, Butow, & Tattersall, 2002).

Towards a Time Perspective

In most research literature, there is hardly any recognition of past or future. Continuity of care (with the same or other health care providers) is a central issue in health care—especially in complex care settings such as cancer care—but it is hardly an issue in communication research (van Dulmen, Verhaak, & Bilo, 1997). Most dialogues are studied as if previous consultations did not leave the patient with specific uncertainties, hopes, and expectancies, and as if everything has to take place during the consultation under study. From the patient's perspective, receiving bad news may reflect the process of being diseased by cancer, whereas research on breaking bad news primarily focuses on how to provide information in the course of a single diagnostic consultation (Salander, 2002). In addition, previous contacts set the agenda for future contacts and should be taken into consideration when examining the content, process, and effects of a single encounter.

Theories from research into the placebo effect of the provider-patient encounter (Crow et al., 1999; Di Blasi et al., 2001; van Dulmen & Bensing, 2002) could well complement the theoretical and methodological insights gathered so far in studies into communication in oncology. Investigating the role of conditioning and expectancies in ongoing oncological encounters could bring forward a new field of study not yet explored within the field of communication in oncology. The theory of classical conditioning can, for instance, be used to explain why one patient suffers from serious side-effects from chemotherapy and another one does not, or why patients with serious complaints respond positively to a treatment and others with the same complaints do not. Apparently, previous experiences with certain treatments, hospitals, or doctors influence the way patients respond to future experiences. In view of conditioning theory, a current treatment may be associated with an earlier experience that resulted in a reduction in negative symptoms. This earlier experience is said to be positively conditioned as far as recovery and anxiety reduction is concerned. This makes it extremely important to not only look at patients' medical history but also what actually happened in former visits and at the way physicians have attended to patients' experiences with health care. Eliciting patients' past experiences with the health care system, including these subjective experiences, can help the clinician to understand patients' reactions to treatment proposals, personal preferences, and unspoken resistances.

The role of expectancies, the other central placebo theory, has more to do with explaining why experiences in the present influence future treatment outcome (Crow et al., 1999). Response expectations appear to be triggered by the information a person receives (Thomas, 1987). Research shows that physicians—by their communication behavior—are able to influence patients' expectations in a positive as well as a negative direction.

From the neurocognitive sciences it is known that the brain can be blocked from acquiring new information when persons are under stress (Bremner, 1999; Newcomer et al., 1999). This means that in stressful situations information-giving must be carefully dosed, repeated, and spread over more visits. It can be experimentally tested what delay is necessary to allow for new information to be given to the patient. The role of stress-reducing communication techniques in this process is another topic of research. It is worthwhile to look for opportunities to combine this line of research with neuro-imaging techniques, such as PET or MRI scans.

Between Knowing and Doing

Cancer care goes hand in hand with strong emotions and much uncertainty. Doctors and nurses may feel barriers in emotion-laden communication because it produces stress. From stress-coping theories it can be hypothesized that experienced stress in doctors and nurses will lead to blocking behaviors as a coping strategy while facilitating communicative behaviors are needed from the patients' point of view (de Valck, Bruynooghe, Hulsman, Kerssens, & Bensing, 2001; Kruijver, Kerkstra, Bensing, & van de Wiel, 2000). This could explain the discrepancy between doctors attitudes, which tend to be rather patient-centered in general, and patients' assessments of the quality of care, which stresses problems in information-giving and personal care (de Valck, 2002).

Doctors and nurses may not only feel stressed as a result of not being able to relieve the burden of the disease from their patients' shoulders, but also as a result of organizational demands. Time constraints and schedules, treatment protocols, and institutional norms and values may all distract attention from a patient's needs for individualized care. Time constraints, for instance, force many physicians to interrupt their patients' flow of speech at the beginning of the consultation (Marvel, Epstein, Flowers, & Beckman, 1999). Providers, convinced that they know patients' reasons for the encounters, may incorrectly focus on an issue that is not the patient's main concern. This may engender the risk of making incorrect diagnoses and giving inappropriate advice on the part of the physician, and dissatisfaction, non-compliance, and second opinion-seeking on the part of the patient. A recent study showed that cancer patients indeed often seek a second opinion because they are dissatisfied with the way they have been treated by the first physician (Mellink et al., 2003). Although the issue of time has frequently been attended to in communication research, it has, so far, mostly been examined in a retrospective way, that is, by examining the communication process in relation to consultation length (DeVeugele, Derese, van den Brink-Muinen, Bensing, & De Maeseneer, 2002). Less attention has been given to the influence of time pressure experienced by a health care provider at the beginning of the visit on the actual communication process.

In addition, treatment protocols and guidelines developed to improve and standardize the information exchange may also hinder a patient-centered process. Institutionalized norms and values, reflected in a supervisor's attitude toward good health care, is also likely to color

the actual communication process. A supervisor may play a fairly prominent role in explaining why communication skills thoroughly acquired in training are not observed in real-life nursing care (Kruijver, 2001). The extent to which a supervisor supports the nurse's communication style appears to have a large impact on the actual communication process. Especially affective communication, highly needed in cancer care, suffers from such contextual constraints.

From the theory of cognitive dissonance it can be hypothesized that doctors and nurses who are highly dependent on organizational norms and values will tend to conform to them at the cost of care tailored to the patient, whereas doctors (and to a lesser degree nurses) who prioritize patient care above institutional demands probably show more patient-centered communication behavior.

Beyond the Dialogue

Traditionally, research on provider-patient communication has focused on the doctor-patient dyad. Yet, in daily medical practice, physicians often find themselves forced to communicate with an elaborate and complicated patient system. Many health care visits, especially those with a strong emotional component such as oncological visits, involve more than two participants—an elderly patient accompanied by a spouse or adult child, couples visiting a doctor, parents consulting a doctor for their child, or, in case of non-native speakers, interpreters supporting a patient.

Due to the myopic dyadic perspective there has been little empirical exploration on the role and influence of a third (or fourth) person's presence on the process, content, and outcome of the medical visit. The scarce research on multiparty medical interactions within the setting of pediatrics (Aronsson, 1991; van Dulmen, 1998; Wissow et al., 1998), geriatrics (Greene, Majerovitz, Adelman, & Rizzo, 1994), dietary counseling (Pyörälä, 2000), and the general practitioner's surgery (Tates, Meeuwesen, Elbers, & Bensing, 2002), showed that merely the presence of a third person changes the dynamics of the medical interaction, no matter how small the third person's conversational contribution to the actual visit. After all, in attending a health care provider, patients have their agenda (needs and expectations) as do the people accompanying the patient. In order to communicate effectively, the health care provider should not only consider the patients' viewpoints but those of their relatives as well.

In the emotionally laden context of communication with cancer patients, caregivers or relatives are likely to make themselves especially felt. Therefore, an appropriate avenue for future communication research in oncology would be to explore the implications regarding participant roles and responsibilities beyond the scope of the medical dialogue. In light of social support theory, the relative's presence should not be ignored but rather encouraged for its positive impact on the patient's quality of life (Kamarck, Peterman, & Raynor, 1998).

Fruitful theoretical frameworks may be derived from social psychology, in particular from social support theories (Cutrona, 1996) and theories on family coping (Coyne & Smith, 1994). Many of these theories lead to explicit assumptions about communication behaviors that are beneficial or detrimental for the patients' well-being.

But patients are only part of a larger system, even within the consultation room. Future research should also pay attention to the multifaceted character of the health care system. Patients diagnosed with cancer are confronted with a broad range of health care providers,

such as oncologists, nurses, and radiologists. These providers are likely to differ in attitudes, experience, and skills. Inadequate communication, due to discordance in information or insufficient fine-tuning of information conveyed by the various providers, can lead to confusion for patients about the diagnosis, the prognosis, and future management plans. Indeed, studies in nononcological settings show that patients often feel overwhelmed by contradictory advice or an overload of information supply emanating from multidisciplinary sources (van Weert, van Dulmen, Bär, & Venus, 2002). Not only may this cause unnecessary stress for patients, but also for health care providers themselves. After all, effective communication has been shown to be important for the efficiency, morale, and work satisfaction of the individual providers (Jenkins, Fallowfield, & Poole, 2001). So far, however, few data are available on how the process of information exchange between provider and patient is influenced by factors such as task distribution and delegation and fine-tuning and checking of the information conveyed. Research into the expectations of team members of their own and each other's roles in providing information to women with breast cancer showed that even the members of these multidisciplinary teams were not completely acquainted with the informational roles and responsibilities of their colleagues (Jenkins et al., 2001). These findings may cause concern, as one of the tenets of multidisciplinary oncological care is the provision of comprehensive and consistent information. Further research is required to capture health care providers' views on what they consider to be their individual task and responsibility in the process of exchanging and tailoring the information supply.

Decontextualized dyadic analyses are bound to fail in fully exposing the dynamics of multiparty medical communication. By acknowledging the multiparty character of medical communication, future research will have to take into account the context of medical communication both on the patient's and on the provider's side. Fruitful areas of research might also be communication studies on small group interactions and organizational theory on interdisciplinary collaboration. New advances must be made in order to capture the impact of these contextual factors on the course and outcome of the medical "dialogue."

CONCLUSION

In this chapter we expand the focus of cancer communication research and incorporate the broader context in which a single health care visit takes place. Such a broader perspective is necessary to find out why health care professionals do not always act in conformity with the generally approved standards of high quality communication—although they are known to have mastered the skills in training, how the factor of time span can be used more effectively in the medical encounter, and what the reasons are why patients do not always disclose their concerns assessed prior to the health care visit. Eventually, a broader context view will bridge the existing gap between theory and practice.

REFERENCES

- Aronsson, K. (1991). Facework and control in multiparty talk: A pediatric case study. In I. Marková & K. Foppa (Eds.), *Asymmetries in dialogue* (pp. 49-74). New York: Harvester.

- Bensing, J.M. (1991). *Doctor-patient communication and the quality of care. An observational study into affective and instrumental behavior*. Utrecht: NIVEL.
- Bensing, J.M. (2000). Bridging the gap. The separate worlds of evidence-based medicine and patient-centered medicine. *Patient Education and Counseling*, 39, 17-25.
- Bremner, J.D. (1999). Does stress damage the brain? *Biological Psychiatry*, 45, 797-805
- Coulter, A. (1997). Partnerships with patients: The pros and cons of shared clinical decision-making. *Journal of Health Service Research Policy*, 2(2), 112-121.
- Coyne, J.C., & Smith, D.A. (1994). Couples coping with a myocardial infarction: Contextual perspective on patient self-efficacy. *Journal of Family Psychology*, 8, 43-54.
- Crow, R., Gage, H., Hampson, S., Hart, J., Kimber, A., & Thomas, H. (1999). The role of expectancies in the placebo effect and their use in the delivery of health care: A systematic review. *Health Technology Assessment*, 3, 1-96.
- Cutrona, C.E. (1996). Social support in couples. In *Marriage as a resource in times of stress*. Thousand Oaks, CA: Sage.
- Detmar, S.B., Muller, M.J., Wever, L.D.V., Schornagel, J.H., & Aaronson, N.K. (2001). Patient-physician communication during outpatients palliative treatment visits. An observational study. *JAMA*, 285, 1351-1357.
- deValck, C. (2002). *Responding to patient cues in a video simulated bad news consultation*. Leuven.
- de Valck, C., Bruynooghe, R., Hulsman, R.L., Kerssens, J.J., & Bensing, J.M. (2001). Cue responding in a simulated bad news situation. *Journal of Health Psychology*, 6(5), 585-596.
- DeVeugele, M., Derese, A., van den Brink-Muinen, A., Bensing, J., & De Maeseneer, J. (2002). Consultation length in general practice: Cross sectional study in six European countries. *BMJ*, 325(7362), 472.
- Di Blasi, Z., Harkness, E., Ernst, E., Georgiou, A., & Kleijnen, J. (2001). Influence of context effects on health outcomes: A systematic review. *Lancet*, 357, 757-762.
- Dulmen, A.M. van. (1998). Children's contribution to pediatric outpatient encounters. *Pediatrics*, 102, 563-568.
- Dulmen, A.M. van, & Bensing, J.M. (2001). *The effect of context in healthcare; a programming study*. RGO, The Hague.
- Dulmen, A.M. van, & Bensing, J.M. (2002). Health promoting effects of the physician-patient encounter. *Psychology, Health, and Medicine*, 7, 289-300.
- Dulmen, A.M. van, Verhaak, P.F.M., & Bilo, H.J.G. (1997). Shifts in doctor-patient communication during a series of outpatient consultations in non-insulin-dependent diabetes mellitus. *Patient Education Counseling*, 30, 227-237.
- Fallowfield, L.J., Jenkins, V.A., & Beveridge, H.A. (2002). Truth may hurt, but deceit hurts more: Communication in palliative care. *Palliative Medicine*, 16, 297-303.
- Fallowfield, L., Lipkin, M., & Hall, A. (1998). Teaching senior oncologists communication skills: Results from phase 1 of a comprehensive longitudinal program in the United Kingdom. *Journal of Clinical Oncology*, 16, 1961-1968.
- Ford, S., Fallowfield, L., & Lewis, S. (1995). Doctor-patient interactions in oncology. *Social Science and Medicine*, 42, 1511-1519.
- Gattellari, M., Voigt, K.J., Butow, P.N., & Tattersall, M.H. (2002). When the treatment goal is not cure: Are cancer patients equipped to make informed decisions? *Journal of Clinical Oncology*, 20, 503-513.
- Greene, M.G., Majerovitz, S.D., Adelman, R.D., & Rizzo, C. (1994). The effects of the presence of a third person on the physician-older patient medical interview. *Journal of the American Geriatric Society*, 42, 413-419.
- Jenkins, V.A., Fallowfield, L.J., & Poole, K. (2001). Are members of multidisciplinary teams in breast cancer aware of each other's informational roles? *Quality in Healthcare*, 10, 70-75.
- Kamarck, T.W., Peterman, A.H., & Raynor, D.A. (1998). The effects of the social environment on stress-related cardiovascular activation: Current findings, prospects, and implications. *Annals of Behavioral Medicine*, 20, 247-256.

- Koehler, W.F., Fottler, M.D., & Swan, J.E. (1992). Physician-patient satisfaction: Equity in the health services encounter. *Medical Care Review*, 49(4), 455-484.
- Kruijver, I.P.M. (2001). *Communication between nurses and admitted cancer patients: The evaluation of a communication training program* (thesis). Utrecht: Nivel.
- Kruijver, I.P.M., Kerkstra, A., Bensing, J.M., & van de Wiel, H.B.M. (2000). Nurse-patient communication in cancer care. *Cancer Nursing*, 23, 20-31.
- Lazare, A., Putnam, S.M., & Lipkin, M. (1995). Three functions of the medical interview. In M. Lipkin, S.M. Putnam, & A. Lazare (Eds.), *The medical interview. Clinical care, education and research*. New York, Berlin, Heidelberg: Springer Verlag.
- Leventhal, H., Safer, M.A., & Panagis, D.M. (1983). The impact of communications on the self-regulation of health beliefs, decisions, and behavior. *Health Education Quarterly*, 10(1), 3-29.
- Levinson, W., Roter, D.L., Mullooly, J.P., Dull, V., & Frankel, R.M. (1997). Physician-patient communication. The relationship with malpractice claims among primary care physicians and surgeons. *JAMA*, 277, 553-559.
- Lipkin, M., Putnam, S.M., & Lazare, A. (1995). *The medical interview. Clinical care, education and research*. New York, Berlin, Heidelberg: Springer Verlag.
- Maguire, P. (1999). Improving communication with cancer patients. *European Journal of Cancer*, 35, 1415-1422.
- Maguire, P., Booth, K., Elliot, C., & Jones, B. (1996). Helping health professionals involved in cancer care acquire key interviewing skills—the impact of workshops. *European Journal of Cancer*, 32A, 1486-1489.
- Marvel, M.K., Epstein, R.M., Flowers, K., & Beckman, H.B. (1999). Soliciting the patient's agenda: Have we improved? *JAMA*, 281, 283-287.
- Mellink, W.A.M., Dulmen, A.M. van, Wiggers, T., Spreeuwenberg, P.M.M., Eggermont, A.M.M., & Bensing, J.M. (2003). Cancer patients seeking a second opinion: Results of a study on motives, needs and expectations. *Journal of Clinical Oncology*, 21, 1992-1997.
- Newcomer, J.W., Selke, G., Melson, A.K., Hershey, T., Craft, S., Richards, K., & Alderson, A.L. (1999). Decreased memory performance in healthy humans induced by stress-level cortisol treatment. *Archives of General Psychiatry*, 56, 527-533.
- Ong, L.M., de Haes, J.C., Hoos, A.M., & Lammes, F.B. (1995). Doctor-patient communication: A review of the literature. *Social Science and Medicine*, 40(7), 903-918.
- Pyörälä, E. (2000). *Interaction in dietary counselling of diabetic children and adolescents* (thesis). Helsinki: Helsinki University Press.
- Razavi, D., Delvaux, N., Marchal, S., Durieux, J.F., Farvacques, C., Dubus, L., & Hogenraad, R. (2002). Does training increase the use of more emotionally laden words by nurses when talking with cancer patients? A randomised study. *British Journal of Cancer*, 87, 1-7.
- Rogers, C.R. (1961). The characteristics of a helping relationship. In C.R. Rogers (Ed.), *On becoming a person: A therapists' view of psychotherapy*. Boston: Houghton Mifflin.
- Roter, D.L., & Hall, J.A. (1992). *Doctors talking with patients; patients talking with doctors. Improving communication in medical visits*. Westport, CT: Auburn House.
- Roter, D.L., & Hall, J.A. (1994). Strategies for enhancing patient adherence to medical recommendations. Clinical guidelines. *JAMA*, 271(1), 80.
- Rutter, D.R., Iconomou, G., & Quine, L. (1996). Doctor-patient communication and outcome in cancer patients: An intervention. *Psychology and Health*, 12, 57-71.
- Salander, P. (2002). Bad news from the patient's perspective: An analysis of the written narratives of newly diagnosed cancer patients. *Social Science and Medicine*, 55, 721-732.
- Sarangi, S. (2002). The language of likelihood in genetic counseling discourse. *Journal of Language and Social Psychology*, 21, 7-31.
- Stiggelbout, A.M., & Kiebert, G.M. (1997). A role for the sick role. Patient preferences regarding information and participation in clinical decision-making. *CMAJ*, 157(4), 383-389.

- Tates, H., Meeuwesen, L., Elbers, E., & Bensing J. (2002). "I've come for his throat": Roles and identities in doctor-parent-child communication. *Child: Care, Health Development*, 28, 109-116.
- Thomas, K.B. (1987). General practice consultations: Is there any point in being positive? *British Medical Journal*, 294, 1200-1202.
- Weert, J.C.M. van, Dulmen, A.M. van, Bär, P., & Venus, E. (2003). Multidisciplinary preoperative patient education in cardiac surgery. *Patient Education Counseling*, 49, 105-114.
- White, K. (1988). *The task of medicine*. Menlo Park, CA: The Henry J. Kaiser Family Foundation.
- Wissow, L.S., Roter, D., Bauman, L.J., Crain, E., Kerckmar, C., Weiss, K., Mitchell, H., & Mohrs, B. (1998). Patient-provider communication during the emergency department care of children with asthma. *Medical Care*, 36, 1439-1450.