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Clinical Update: Literature Abstracts

MEASURES

Using Five Questions to Screen for Five Common Mental Disorders in Primary Care: Diagnostic Accuracy of the Anxiety and Depression Detector

Means-Christensen, A.J., Sherbourne, C.D., Roy-Byrne, P.P., Craske, M.G., and Stein, M.B.

General Hospital Psychiatry, *28* (2006), 108–118

Primary care providers are increasingly taking on the role of ad hoc mental health provider. However, before patients in primary care can be treated, they must be identified. This study set out to validate a very brief screening instrument for identifying primary care patients with anxiety and depression. Eight hundred one primary care patients completed a questionnaire screening for (1) panic disorder, posttraumatic stress disorder (PTSD), and social phobia or (2) panic disorder, generalized anxiety disorder (GAD), and major depression. Screening was followed by a diagnostic interview. The properties of the questionnaires were examined to identify a small set of items that effectively and efficiently screened for panic disorder, PTSD, social phobia, GAD, and depression. Five items were selected across the two versions of the questionnaire, comprising the Anxiety and Depression Detector (the ADD). The sensitivities for the items ranged from 0.62 to 1.00, and the specificity values ranged from 0.56 to 0.83. When a "yes" answer to any of the screening questions was used to predict the presence of any diagnosis, sensitivity values were 0.92 to 0.96 and specificity The five items of the ADD appear to comprise a useful screening device for anxiety and depressive disorders in primary care settings.

Measuring the Psychosocial Characteristics of Family Caregivers of Palliative Care Patients: Psychometric Properties of Nine Self-Report Instruments

Hudson, P.L. and Hayman-White, K.

Journal of Pain and Symptom Management, *31* (2006), 215–228

Researchers and clinicians have experienced substantial difficulties locating measures that are suitable for use within palliative care settings. This article details the psychometric properties of nine instruments designed to assess the following psychosocial characteristics of family caregivers: competence, mastery, self-efficacy, burden, optimism, preparedness, social support, rewards, and mutuality. Results are based on the responses of 106 primary family caregivers caring for relatives dying of cancer. Principal components extraction with varimax rotation was used to explore the underlying structure of each measure. Following the exclusion of complex variables, suggested components for most measures comprised relatively homogenous items, which were good to excellent measures of each component. Some components comprised only two items; however, Cronbach's alphas typically indicated moderate to high levels of internal consistency. Overall, the results of this study suggest that most of the measures analyzed, excepting the mastery and mutuality scales, can be recommended to examine the family caregiver experience and test supportive interventions.

Validation of the Cancer Care Monitor Items for Physical Symptoms and Treatment Side Effects Using Expert Oncology Nurse Evaluation

Fortner, B., Baldwin, S., Schwartzberg, L., and Houts, A.C.

Journal of Pain and Symptom Management, *31* (2006), 207–214

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The Cancer Care Monitor (CCM) is a tablet computer-based multidimensional measure of symptom burden and quality of life. This study examined individual item validity for 42 items measuring general physical symptoms and treatment side effects. Patients (40 females and 20 males) completed the CCM and a blinded nurse interview. In general, patient self-reported symptoms on the CCM corresponded well to nurse-verified evaluations. There was excellent agreement between the patient-reported CCM items and nurses' ratings on whether the symptom was present or absent and on the severity of a given symptom. Additionally, the results suggested that the majority of items had high sensitivity, specificity, positive predictive value, negative predictive value, and Youden's Index score. Taken together, the results suggest that the CCM can provide an efficient method for collecting information about symptom presence and symptom burden at the point of care.

Validity of the Brief Patient Health Questionnaire Mood Scale (PHQ-9) in the General Population

Martin, A., Rief, W., Klaiberg, A., and Braehler, E.

General Hospital Psychiatry, *28* (2006), 71–77

The aim of this study was to assess the validity of the Patient Health Questionnaire depression module (PHQ-9). It has been subject to studies in medical settings, but its validity as a screening for depression in the general population is unknown. A representative population sample (2,066 subjects, 14–93 years) filled in the PHQ-9 for diagnosis (major depressive disorder, other depressive disorder, depression screen-positive [DS+] and depression screen-negative [DS−]) and other measures for distress (GHQ-12), depression (Brief-BDI), and subjective health perception (EuroQOL; SF-36). A prevalence rate of 9.2% of a current PHQ depressive disorder (major depression 3.8%, subthreshold other depressive disorder 5.4%) was identified. The two depression groups had higher Brief-BDI and GHQ-12 scores and reported lower health status (EuroQOL) and health-related quality of life (SF-36) than did the DS-group (ps < 0.001). Strong associations between PHQ-9 depression severity and convergent variables were found (with BDI $r = 0.73$, with GHQ-12 $r = 0.59$). The results support the construct validity of the PHQ depression scale, which seems to be a useful tool to recognize not only major depression but also subthreshold depressive disorder in the general population.

Giving Meaning to Measure: Linking Self-Reported Fatigue and Function to Performance of Everyday Activities

Mallinson, T., Cella, D., Cashy, J., and Holzner, B.

Journal of Pain and Symptom Management, *31* (2006), 229–241

Fatigue, a common symptom of cancer patients, particularly those on active treatment, is generally evaluated using self-report methods, yet it remains unclear how self-reported fatigue scores relate to performance of daily activities. This study examines the relationships among self-reported and performance-based measures of function in patients receiving chemotherapy (CT) to link self-reported fatigue measures to self-report and performance-based measures of function. Self-reported fatigue using the Functional Assessment of Chronic Illness Therapy-Fatigue (FACIT-F) and self-reported physical function using the physical function 10 subscale of the Short Form 36 (SF-36) (PF-10) were measured in 64 patients within 2 weeks of beginning CT ($n = 64$) and after three cycles of CT ($n = 48$). Motor and cognitive functions were captured using five self-reported and seven observed-performance measures at each time point. Significant correlations between self-reported and observed measures ranged from 0.30 to 0.71. Self-reported fatigue correlated (0.30–0.45) with performance-based function. FACIT-F scores in the range of 30 and below and PF-10 scores in the range of 50 and below were related to an increased difficulty performing everyday activities. Observed measures of physical performance correlate moderately with self-reported fatigue and self-reported physical function. These relationships enable one to begin linking fatigue scores directly to a person's ability to perform everyday activities.

Development and Validation of the Functional Assessment of Cancer Therapy–Kidney Symptom Index (FKSI)

Cella, D., Yount, S., Du, H., Dhanda, R., Gondek, K., Langefeld, K., George, J., Bro, W.P., Kelly, C., and Bukowski, R.

Journal of Supportive Oncology, *4* (2006), 191–199

The Functional Assessment of Cancer Therapy (FACT)–Kidney Symptom Index (FKSI) was developed and validated to enhance treatment decision making, practice guidelines, symptom management, and treatment efficacy for kidney cancer patients. Thirty-four symptoms related to the disease

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were identified and tested. An equal weighting of patient and clinician ratings of the relative importance of each of these items led to production of a 15-item index (FKSI-15) and a 10-item abbreviated option (FKSI-10). To assess psychometric properties, patients completed the FKSI, Functional Assessment of Cancer Therapy-General (FACT-G), Eastern Cooperative Oncology Group-Performance Status Rating (ECOG-PSR), and a Global Rating of Change Scale (GRCS). Patient responses to the FKSI were analyzed for internal consistency, test–retest reliability, convergent and discriminant validity, and responsiveness to change in clinical status. The FKSI-10 showed high internal consistency; correlations between both FKSI-10 and the physical and functional well-being domains of the FACT-G were high. The FKSI-10 differentiated patients grouped by ECOG-PSR (all $p < 0.001$) and discriminated patients based on their GRCS rating. The minimally important difference (MID) range estimate for the FKSI-10 was 2–4 points; the psychometric properties of the FKSI-15 were very similar (MID range, 3–5 points). Thus, the FKSI-15 and FKSI-10 are reliable and valid symptom indices for evaluating kidney cancer patients.

Validity and Reliability of the Hospital Anxiety and Depression Scale in a Hypertrophic Cardiomyopathy Clinic: The HADS in a Cardiomyopathy Population

Poole, N.A. and Morgan, J.F.

General Hospital Psychiatry, *55* (2006), 55–58

The purpose of this study is the validation of the Hospital Anxiety and Depression Scale (HADS) in patients suffering from hypertrophic cardiomyopathy in an inner-city teaching hospital. The secondary objective was to establish whether the use of the total HADS score to detect "caseness" is justified. One hundred fifteen patients in a cardiac outpatient clinic completed the HADS, which was compared against the gold standard Structured Clinical Interview for DSM-III-R nonpatient version (SCID-np). Receiver operating characteristic (ROC) curves were created for the anxiety and depression subscales, as well as the total score, then sensitivity, specificity, likelihood ratios, and positive and negative predictive values were calculated. Retest correlation was assessed at 2 weeks in 31 patients. The depression subscale was highly sensitive (100%) when the cutoff score 8 was used; however, the corresponding specificity was poor (79%). Raising the cutoff to 10 improved specificity but compromised sensitivity. The anxiety subscale was performed similarly though with less accuracy. The total HADS score produced a poor ROC curve and performed best when the cutoff was 14. The HADS performs well as a screening instrument for anxiety and depression in this population at the designed cutoff score 8. However, its use as a research instrument and the practice of using the total score to detect caseness are not supported by this study.

Measuring the Maintenance of Daily Life Activities Using the Functional Living Index-Emesis (FLIE) in Patients Receiving Moderately Emetogenic Chemotherapy

Decker, G.M., DeMeyer, E.S., and Kisko, D.L.

Journal of Supportive Oncology, *4* (2006), 35–41

Health care providers believe they have a positive impact on controlling chemotherapy-induced nausea and vomiting (CINV), yet patients still consider CINV to be one of the most distressing side effects of chemotherapy. The effect of CINV on daily activities has been measured using the Functional Living Index-Emesis (FLIE) scale, a validated, nausea- and vomiting-specific, patient-reported outcome instrument comprising nine items in each of two domains. This research explores the potential correlation between reducing CINV and improved quality of life. In clinical trials, patients completed the FLIE questionnaires 24 and 96 h after receiving moderately emetogenic chemotherapy and antiemetic therapy using a serotonin receptor antagonist (ondansetron, dolasetron, or palonosetron). Significantly more patients given palonosetron had FLIE scores that reflected lessened impact of nausea on daily life during the acute period (0–24 h) and of nausea/vomiting during both the acute and delayed periods (days 2–4).These findings strongly suggest that better antiemetic prevention allows patients to maintain their functional status for up to 5 days after chemotherapy.

SYMPTOM CONTROL

Symptom Priority and Course of Symptomatology in Specialized Palliative Care

Stromgren, A.S., Sjogren, P., Goldschmidt, D., Petersen, M.A., Pedersen, L., and Groenvold, M.

Journal of Pain Symptom Management, *31* (2006), 199–206

The study aim was to explore which symptoms/problems cancer patients in palliative care consider most distressing and to investigate how prioritiza-

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tion at first contact was associated with patient-assessed symptom intensity and change in intensity over time. Initially, 175 patients named and prioritized their five most distressing symptoms. Weekly, they completed the following self-assessment questionnaires: European Organization for Research and Treatment of Cancer Quality of Life Questionnaire-C30, Edmonton Symptom Assessment System, and the Hospital Anxiety and Depression Scale. Initial symptom intensity scores and weekly changes were calculated and compared with prioritization of the same symptom. Pain, fatigue, physical function, appetite, nausea/vomiting, dyspnea, and depression were the symptoms most often prioritized. Priority was associated with initial scoring of pain, appetite, nausea/vomiting, dyspnea, constipation, depression, and anxiety, but not with fatigue, physical function, role function, or inactivity. Priority was associated with change in symptom intensity for pain, reduced appetite, nausea/vomiting, and constipation. Symptom prioritization may be a useful guide to choice of treatment as well as to longitudinal symptom evaluation.

Drugs Used to Alleviate Symptoms with Life Shortening as a Possible Side Effect: End-of-Life Care in Six European Countries

Bilsen, J., Norup, M., Deliens, L., Miccinesi, G., van der Wal, G., Lofmark, R., Faisst, K., and van der Heide, A.

Journal of Pain and Symptom Management, *31* (2006), 111–121

We investigated the drugs used in the alleviation of pain and symptoms (APS) with a possible life-shortening side effect in six European countries' end-of-life care. We sent mail questionnaires to physicians who signed a representative sample of death certificates in each country. APS with a possible life-shortening effect occurred from 19% of all deaths in Italy to 26% in Denmark. Physicians usually administered opioids (from 76% of APS cases in Italy to 96% in The Netherlands), but the type of opioids and administration practice differed markedly between countries. The doses of opioids given in the last 24 h also varied significantly and were usually lower than 300 mg oral morphine equivalent (from 83% of cases in Belgium to 93% in Sweden). The highly variable results bring into question whether existing guidelines for pain relief were applied appropriately and to what extent unfounded concerns about the possible life-shortening effect of opioids resulted in less than optimal symptom management in end-of-life care.

Continuous Deep Sedation: Physicians' Experiences in Six European Countries

Miccinesi, G., Rietjens, J.A., Deliens, L., Paci, E., Bosshard, G., Nilstun, T., Norup, M., and van der Wal, G.

Journal of Pain and Symptom Management, *31*, (2006), 122–129

Continuous deep sedation (CDS) is sometimes used to treat refractory symptoms in terminally ill patients. The aim of this paper was to estimate the frequency and characteristics of CDS in six European countries: Belgium, Denmark, Italy, The Netherlands, Sweden, and Switzerland. Deaths reported to death registries were sampled and the reporting doctors received a mailed questionnaire about the medical decision making that preceded the death of the patient. The total number of deaths studied was 20,480. The response rate ranged between 44% (Italy) and 75% (The Netherlands). Of all deaths, CDS was applied in 2.5% in Denmark and up to 8.5% in Italy. Of all patients receiving CDS, 35% (Italy) and up to 64% (Denmark and The Netherlands) did not receive artificial nutrition or hydration. Patients who received CDS were more often male, younger than 80 years old, more likely to have had cancer, and died more often in a hospital compared to nonsudden deaths without CDS. The high variability of frequency and characteristics of CDS in the studied European countries points out the importance of medical education and scientific debate on this issue.

Artificial Hydration Therapy, Laboratory Findings, and Fluid Balance in Terminally Ill Patients with Abdominal Malignancies

Morita, T., Hyodo, I., Yoshimi, T., Ikenaga, M., Tamura, Y., Yoshizawa, A., Shimada, A., Akechi, T., Miyashita, M., Adachi, I., and for the Japan Palliative Oncology Study Group

Journal of Pain and Symptom Management, *31* (2006), 130–139

To explore the association between hydration volume and laboratory findings and between calculated fluid balance and changes in clinical signs of dehydration and fluid retention in terminally ill cancer patients, a secondary analysis of a large multicenter, prospective, observational study was performed. The study enrolled 125 abdominal cancer patients who received laboratory examinations in the last week before death. Patients were classified into two groups: the hydration group (n = 44),

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who received 1 l or more of artificial hydration per day both 1 and 3 weeks before death, and the nonhydration group ($n = 81$). The mean albumin level 1 week before death was significantly lower in the hydration group than in the nonhydration group, and the interaction between hydration group and decrease in the albumin level was statistically significant after adjusting multiple covariates (from 2.8 ± 0.68 mg/dl 3 weeks before death to 2.4 ± 0.56 mg/dl 24 h before death in the hydration group vs. a decrease of 2.8 ± 0.53 to 2.6 ± 0.45 mg/dL in the nonhydration group, $p = 0.015$). There was no significant difference between the groups in the mean blood urea nitrogen/creatinine, sodium, or potassium levels 1 week before death. Among 53 patients who had oral fluid intake of less than 500 ml/day throughout the last 3 weeks and completed a fluid balance study, the median of calculated fluid balance was −400 ml/day 3 weeks before death, −521 ml/day 1 week before death, and −421 ml/day 24 h before death. Calculated fluid balances did not significantly differ between the patients with deterioration of dehydration signs, edema, ascites, and pleural effusion during the final 3 weeks and those without. These data suggest that active artificial hydration might result in hypoalbuminemia, with no clear beneficial effects on normalizing blood urea nitrogen/creatinine, sodium, or potassium levels. Fluid balance did not significantly correlate with changes in dehydration—and fluid retention—signs. Calculated fluid balance is not an appropriate alternative to direct monitoring of patient symptoms. More studies are needed to determine the clinical efficacy of artificial hydration for terminally ill cancer patients.

Supportive Intervention for Fatigue in Patients Undergoing Chemotherapy: A Randomized Controlled Trial

Ream, E., Richardson, A., and Alexander-Dann, C.

Journal of Pain and Symptom Management, *31* (2006), 148–161

This study evaluated a supportive intervention for fatigue in patients undergoing chemotherapy. One hundred three chemotherapy-naive patients were recruited, stratified by treatment regimen, and randomly allocated to intervention or usual care. The intervention was conducted over 3 months. Recipients were provided with an investigator-designed information pack and Fatigue Diary that they completed during the week following each treatment. Additionally, support nurses visited them monthly at home. They assessed fatigue, provided psychological support, and coached participants in self-care. The intervention group reported significantly less fatigue ($p < 0.05$), lower associated distress ($p < 0.05$), and less impact of fatigue on valued pastimes ($p < 0.05$) than the control group. Further, they reported significantly less anxiety ($p < 0.05$) and depression ($p < 0.05$) and displayed more adaptive coping ($p < 0.05$). The intervention enabled patients to adapt to living with fatigue and contributed to their psychological/emotional well-being and ability to cope with their illness and treatment.

A Pilot Study to Assess the Influence of Tai Chi Chuan on Functional Capacity among Breast Cancer Survivors

Mustian, K.M., Katula, J.A., and Zhao, H.

Journal of Supportive Oncology, *4* (2006), 139–145

Treatment of breast cancer can significantly diminish functional capacity in patients months and even years after the completion of treatments. Tai chi chuan (TCC) is a moderate form of exercise that may be an effective therapy for improving functional capacity among breast cancer survivors. We sought to provide pilot data comparing the efficacy of TCC and psychosocial therapy (PST; physical activity control) for improving functional capacity among breast cancer survivors post treatment. Twenty-one women who had completed treatment of breast cancer were randomized to receive TCC or PST 3 times/week for 12 weeks. Functional capacity was assessed at baseline and at 12 weeks. The TCC group demonstrated significant improvement in functional capacity (specifically aerobic capacity, muscular strength, and flexibility) whereas the PST group showed significant improvement in flexibility only. These data suggest that TCC may be an efficacious intervention for enhancing functional capacity among breast cancer survivors and may support the need for larger randomized, controlled clinical trials to further elucidate these relationships.

Relieving Symptoms in Cancer: Innovative Use of Art Therapy

Nainis, N., Paice, J.A., Ratner, J., Wirth, J.H., Lai, J., and Shott, S.

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Art therapy has been used in a variety of clinical settings and populations, although few studies have

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explored its use in cancer symptom control. The specific aim of this study was to determine the effect of a 1-h art therapy session on pain and other symptoms common to adult cancer inpatients. A quasi-experimental design was used (n = 50). The Edmonton Symptom Assessment Scale (ESAS) and the Spielberger State-Trait Anxiety Index (STAI-S) were used prior to and after the art therapy to quantify symptoms, and open-ended questions evaluated the subjects' perceptions of the experience. There were statistically significant reductions in eight of nine symptoms measured by the ESAS, including the global distress score, as well as significant differences in most of the domains measured by the STAI-S. Subjects overwhelmingly expressed comfort with the process and desire to continue with therapy. This study provides beginning evidence for the efficacy of art therapy in reducing a broad spectrum of symptoms in cancer inpatients.

Music Thanatology: Prescriptive Harp Music as Palliative Care for the Dying Patient

Freeman, L., Caserta, M., Lund, D., Rossa, S., Dowdy, A., and Partenheimer, A.

American Journal of Hospice and Palliative Medicine, *23* (2006), 100–104

Music thanatology represents an emerging area in which the raw materials of music, usually harp and/or voice, assist and comfort the dying patient. During prescriptive "music vigils," the clinician-musician carefully observes physiological changes, cues, and breathing patterns, thereby synchronizing the music to reflect or support the patient's physiology and overall condition. Using data collected from 65 patients, this study was designed to assess the effectiveness of prescriptive harp music on selected palliative care outcomes using a sample of de-identified data forms from past music vigils. Patients were administered a 25- to 95-min intervention of prescriptive harp music. Data collected included vital signs and observational indicators before (Ti) and after (T2) the vigil. Patients were more likely to experience decreased levels of agitation and wakefulness while also breathing more slowly and deeply with less effort at the conclusion of the music vigil. Results from this study suggest that a prescriptive vigil conducted by a trained music thanatologist could provide an effective form of palliative care for dying patients.

QUALITY OF PALLIATIVE CARE

Palliative Care Program Effectiveness Research: Developing Rigor in Sampling Design, Conduct, and Reporting

Bakitas, M.A., Lyons, K.D., Dixon, J., and Ahles, T.A.

Journal of Pain and Symptom Management, *31* (2006), 270–284

Research on palliative care presents some unique sampling challenges. The purpose of this paper is to articulate the sampling challenges that palliative care researchers face during phases of study design, conduct, and the reporting of results. Challenges include identifying a target population, avoiding selection bias in the face of clinician and patient denial of serious illness, developing eligibility criteria for a seriously ill population, minimizing high patient refusals due to illness, and accurate reporting of all screened and eligible participants. These challenges are explored within the context of a randomized clinical trial testing a palliative care intervention. Suggestions for improving scientific rigor in sampling design include (1) defining a target population that is consistent with research goals; (2) identifying eligibility criteria that are objective and understandable to clinicians to yield the desired sample; and (3) reporting results about the target population, sample eligibility/exclusions, and participation using standardized criteria.

Requests to Forgo Potentially Life-Prolonging Treatment and to Hasten Death in Terminally Ill Cancer Patients: A Prospective Study

Georges, J.J., Onwuteaka-Philipsen, B.D., van der Heide, A., van der Wal, G., and van der Maas, P.J.

Journal of Pain and Symptom Management, *31* (2006), 100–110

This study investigates the background and evolution of requests to forgo treatment and hasten death in terminally ill cancer patients. Physicians participating in a nationwide study on end-of-life decision making were asked whether they were treating a terminally ill cancer patient whose life expectancy was longer than 1 week but no longer than 3 months and who they would continue to treat until the patient's death. Of the 120 physicians who had a patient who met the inclusion criteria, 85 (70.8%) completed a questionnaire each month until the patient's death. The questionnaire provided information on the patient's symptoms, concerns, and requests involving end-of-life decisions. Most patients suffered from cancer of the gastrointestinal

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tract or the respiratory system, and 66% died within 2 months of the initial interview. The prevalence of requests involving end-of-life decisions increased during the last 3 months of a patient's life. The evolution of a request was especially related to an increase in the number of severe symptoms and concerns. Requests to forgo treatment were related to general weakness, whereas loss of dignity was a major reason for requests to hasten death. Physical suffering alone appeared to lead to less drastic requests than suffering blended by concerns and psychological problems leading to requests for hastened death. The results emphasize the importance of gaining insight into the patients' suffering to provide meaningful assistance.

How Do Surrogate Decision Makers Describe Hospice? Does It Matter?

Vig, E.K., Starks, H., Taylor, J.S., Hopley, E.K., Fryer-Edwards, K., and Pearlman, R.A.

American Journal of Hospice and Palliative Care, *23* (2006), 91–99

We interviewed 71 surrogate decision makers of older, chronically ill veterans to explore their knowledge of hospice and their role in helping loved ones access hospice services. We asked them to describe hospice and any previous hospice experiences. Of the group, 24 percent with hospice experience and 14 percent without hospice experience correctly described three key aspects of hospice: who hospice cares for, where the care is provided, and the goal of the care. Additionally, we found evidence that surrogates who correctly described the three key aspects of hospice were inclined to pursue hospice care for loved ones in the future, and surrogates who provided less complete descriptions of hospice might not access it. Because surrogates often help dying patients access care, incomplete knowledge of hospice may be an important barrier to hospice services. We advocate that clinicians discuss the three key aspects of hospice during routine advance care planning sessions with patients and their future surrogate decision makers.

COMMUNICATION

Is There a Cost to Poor Communication in Cancer Care?: A Critical Review of the Literature

Thorne, S.E., Bultz, B.D., Baile, W.F., and SCRN Communication Team

Psycho-Oncology, *14* (2005), 875–884

In this paper, the authors engage in a critical analysis of the existing empirical literature that addresses the impact of ineffective communication between cancer patients and clinicians. It is increasingly accepted that communication plays a significant role in many aspects of the care experience, and that poor communication can have a significantly negative influence on the patient's psychosocial experience, symptom management, treatment decisions, and quality of life. However, scant attention has been given to the idea that poor communication may also have an economic impact worthy of attention. This area has not been the focus of systematic inquiry or substantive critical consideration. On the basis of critical analysis of the limited empirical evidence that exists across a wide range of studies in related areas, the authors propose that the existential and material costs associated with poor communication in cancer care may well be considerable, and conclude with a call to mobilize a heightened enthusiasm for addressing the research challenges in this field propose that the existential and material costs associated with poor communication in cancer care may well be considerable, and conclude with a call to mobilize a heightened enthusiasm for addressing the research challenges in this field.

Developing Communication Competency in the Context of Cancer: A Critical Interpretive Analysis of Provider Training Programs

Butler, L., Degner, L., Baile, W., Landry, M., and SCRN Communication Team

Psycho-Oncology, *14* (2005), 861–872

We conducted a critical interpretive analysis of 47 studies from the Cochrane Review of the communications training literature to capture the empirical indicators used to judge provider communication competency and to describe how the indicators were characterized in the context of a cancer care system. Of the 47 studies reviewed, few showed any resemblance to recommendations from two international consensus conferences of experts in the communication research field. Some of the challenges in moving forward with cancer-related communication skills involve deciding what we want people to learn, providing learning across various experiences, identifying learning models, and finding alternate ways of motivating people to learn. Once core competencies are clearly articulated, we can determine the best approaches for developing cancer-specific training programs.

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What Do We Know about Facilitating Patient Communication in the Cancer Care Setting?

Parker, P.A., Davison, B.J., Tishelman, C., Brundage, M.D., and SCRN Communication Team

Psycho-Oncology, *14* (2005), 848–858

Throughout the cancer diagnosis and treatment period, patients interact with multiple health care providers. To facilitate these communications, researchers have developed interventions primarily for providers, and, more recently, for patients. The aim of this paper is to conduct a critical examination of a sample of the empirical literature regarding current knowledge about the types of interventions that have been designed to facilitate cancer patients' communication with their health care providers. Overall, the empirical literature suggests that some types of patient-based interventions (e.g. prompt sheets, audiotapes, coaching sessions) may be beneficial in specific areas (e.g., increasing the number of questions asked, increased patient satisfaction). However, there are few consistent findings and the outcome measures that have been examined have varied substantially across studies. More controlled studies using carefully chosen outcome variables are needed. Increasing patients' communication skills so that their goals are met has the potential to positively affect the communication process.

The Communication Goals and Needs of Cancer Patients: A Review

Hack, T.F., Degner, L.F., Parker, P.A., and SCRN Communication Team

Psycho-Oncology, *14* (2005), 831–845

The aim of this review paper is to critique the empirical literature pertaining to the communication needs and goals of cancer patients, and to provide direction for research in this area. According to the conceptual framework of Feldman-Stewart et al., patient-physician communication occurs for the fundamental purpose of addressing each participant's goal(s). This review is divided into two categories of goals: (a) optimal medical management of the cancer and (b) optimal attention to the patient's psychosocial response to cancer. Optimal medical management includes discussions about disease status and the treatment plan, and the effectiveness of these discussions is frequently determined by assessing patient understanding, satisfaction, and well-being. The literature suggests that cancer patients continue to have unmet communication needs, and communication outcomes are enhanced when physicians attend to the emotional needs of patients. Research gaps in communication research are highlighted, including the need for additional study of several external factors affecting the patient and provider.

Patient-Professional Communication Research in Cancer: An Integrative Review of Research Methods in the Context of a Conceptual Framework

Carlson, L.E., Feldman-Stewart, D., Tishelman, C., Brundage, M.D., and SCRN Communication Team

Psycho-oncology, *14* (2005), 812–828

This paper uses the conceptual framework of Feldman-Stewart et al. to organize and review the types of research methodologies used to investigate various aspects of patient–health care professional communication in the context of cancer. Research methods employed are classified as either nonexperimental or experimental. Nonexperimental designs include naturalistic observational studies (e.g., participant observation, audio- or videotaping of interactions) and retrospective introspective descriptions (e.g., self-report questionnaires, qualitative interview methods). Experimental designs often involve interventions aimed at improving communication, such as physician or patient training, and the use of technology to enhance communication (e.g., audiotapes, computers). Using the conceptualization of the communication framework description, we argue that the outcome measures used in these studies address either primary goals, enabling goals, or secondary communication outcomes. Outcomes that are related to primary goals of the communication exchange include assessing the level of understanding of information conveyed, aspects of decision making, planning around treatments, or general provision of care. Outcomes related to enabling goals focus on elements that affect the ability to achieve primary goals. Outcomes secondary to the communication do not relate directly to what the communication is attempting to achieve. We conclude by identifying priority areas for further research, such as identifying the goals of both participants, understanding how particular aspects of the communication process affect their ability to achieve their goals, and examining the external environment in which communication takes place.

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A Conceptual Framework for Patient–Professional Communication: An Application to the Cancer Context

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We present a conceptual framework of one-to-one, in-person communication that occurs between a health care professional and a patient. The framework is intended as a tool for organizing and summarizing relevant research, but it can also help guide assessing the communication process and can help guide development of interventions to improve the process. The framework includes four key components, with a focus on elements that can be modified. The first component is the focus of the interaction: each participant's communication goals. The second component consists of the participants themselves, each with five key attributes that determine, in part, how they address their goals. The third component is the communication process: Each person both conveys messages and receives messages, and the messages themselves can be verbal, nonverbal, or silent. The communication process is iterative and extended in time, with one act having an impact on following acts. Finally, the fourth component is the environment in which the communication occurs, both the immediate physical setting and the context beyond. Important aspects of the environment, identified as external factors, affect the communication process through their impact on the participants' attributes. The framework builds on classic communication frameworks to which it adds unique elements. Some of its unique aspects include the prominent role of the participants' goals and its distinct recognition that messages are conveyed through silence. The framework serves as a common conceptualization of factors important to successful communication for the remaining review papers in this series and for future studies of practitioner–patient communication.

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