Interaction with Cancer Patients: Psychological Impact of Doctors’ Communication Behaviour

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ABSTRACT
Psychiatric morbidity can be regarded as closely related to health status and quality of life among cancer patients. Communication between oncologists and cancer patients seems to play an important role in psychological difficulties that can arise during the diagnosis and treatment phase of cancer, such as uncertainty, anxiety, depression and problems with coping. Qualitative researches done earlier, confirms that how cancer patients perceive their relationship with physician, generally affects their psychological well being which ultimately influences their short term and long term health outcomes. This paper presented an extensive review on the significance of physicians’ communication behaviour which revealed the complex relationship of doctor-patient communication and reinforces the practice implications of the former reviews. It was concluded that instead of focusing on different types of communication behaviours as separate entities, future researches should adopt an integrated approach toward the understanding of the doctor patient communication to get a clearer picture of psychological and health outcome in cancer patients.

Keywords: Instrumental Behaviour, Socio Emotional Behaviour, Affective Behaviour, Psychiatric Morbidity.

Cancer is a chronic stressor that places diseased persons as well as their immediate and extended families at risk for psychological distress and psychiatric disorders which can be regarded as closely related to health status and quality of life. There are many factors that determine the intensity of these psychiatric morbidities. Effective and sustained doctor patient communication is one such factor.

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The significance of doctor–patient communication and their potential influence on patients’ health outcome and well-being has been widely recognized (Stewart MA., 1984; Roter DL, Hall JA, Katz NR, 1987; Kaplan SH, Greenfield S, Ware JE., 1989; Henbest RJ, Stewart MA., 1990).

Communication skills have proved their palliative efficacy and a wide therapeutic index when compared with most medications as poor communication skills have been shown to be a predictor of medico-legal vulnerability and also of burnout. In case of life threatening diseases like cancer, the importance of communication process between oncologists and cancer survivors can’t be neglected. This fact is verified by Siminoff, Ravdin, Colabinachi & Sauders-Sturm (2000). They observed that while the communication process between physicians and cancer patients shares most of the general features of standard patient–physician interactions, the stigma and fear associated with a cancer diagnosis, the complexity of medical information, uncertainty regarding the course of the disease, treatment benefits and fear of recurrence adds a greater emotional dimension to the interaction.

Conversation about end of life with patients and families are never easy, however physician need to have such discussions in order to benefit the patient (Lo & Snyder, 1999). The words by the physician at the time of diagnosis like “you have cancer” almost always cause devastation in the lives of cancer patients and lead to Feelings of uncertainty about and loss of control over one’s life are common reactions (McWilliam, Brown, & Stewart, 2000; Molleman, Krabbendam, & Annyas, 1984).

In order to study the outcomes of such emotionally distressing interactions, Beckman et al (1989) distinguished between: (a) short term outcomes (patients’ satisfaction and intention to comply), (b) intermediate outcomes (actual adherence to treatment, anxiety reduction) and (c) long term outcomes (quality of life or health status and recovery).

Earlier researches have primarily focused on patients health outcomes associated with physicians’ communication behaviour by focusing mainly on short term outcomes, while present day studies in this area are attracting the attention of cancer researchers and motivating them to move toward integrated approach of focusing on intermediate outcomes along with short term and long term outcomes in order to have a better global understanding of physicians’ communication behaviour including both physical (health related) as well as psychological outcomes in cancer survivors.

Over the past two decades, psycho-oncological studies have reported that poor physician communication could lead to uncertainty and denial (Maguire et al, 1988), anxiety and depression (Fallowfield et al, 1990), non-compliance (Pruyn et al, 1985), and problematic
psychological adjustment to cancer (Butow et al, 1995; Molleman et al, 1984; Rainey L, 1985).

Although there are many sources of potential influence on cancer survivors’ physical and psychological outcomes, physicians’ communication style is the main area of interest of cancer researchers. In this way, Ong et al. (1995) describes two types of physicians’ behaviour whilst communicating with patient: Instrumental and Affective.

After reviewing a lot of studies in this regard, the present work extracted 3 main communication behaviours/styles i.e. Instrumental behaviour, socio-emotional behaviour and affective (non verbal) behaviour, and an attempt was made to critically evaluate the existing literature on relationship between oncologist-patient communication and its psychological impact on cancer patients, in the light of above mentioned communication behaviours.

While the cancer context is emphasized throughout this paper, the limitation of existing studies, the discussions on recommendations for future research and applicability of this study to other illness settings was done as well.

**Instrumental Behaviour**

Instrumental behaviour describes “task oriented” behaviour. It refers to “cure oriented interactions” where the doctor and patient discuss the health concerns or reasons for appointment and share information that is directly related to the patients’ physical health (Ong et al. 1995).

It involves information giving and question asking by both patient and physician with the primary goal of treating the patient’s illness and health concerns (Roberts C, Arugute M, 2000; Street R, 1992). The content of instrumental communication often includes the physician asking about symptoms, recording information in the patient’s chart, explaining tests or illness and prescribing and explaining medications.

Studies have consistently reported a majority of cancer patients to desire detailed information on a variety of topics such as prognosis, treatment options, associated side effects, risks, benefits, etc. (Blanchard Labrecque, Ruckdeschel, & Blanchard, 1988; Cassileth, Zupkis, Sutton-Smith, & March, 1980; Jenkins, Fallowfield, & Saul, 2001). At the same time, studies have also reported limitations in physicians’ information giving behaviour that often result in cancer patients leaving the medical visit confused and unsure about several aspects of their disease and its treatment (Fallowfield & Jenkins, 1999). Table 1 clearly shows psychological influences of physicians’ instrumental behaviour in cancer patients and also summarizes how Health care providers’ communicative behaviours help regulate patients’ emotions, facilitate comprehension of medical information, and allow for better identification of patients’ needs, perceptions, and expectations.
### Table 1: Psychological outcomes of physicians’ Instrumental communication behaviour

<table>
<thead>
<tr>
<th>References</th>
<th>Sample</th>
<th>Physicians’ Instrumental Behaviour</th>
<th>Psychological Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rainey L (1985)(^23)</td>
<td>Cancer Patients</td>
<td>High Information Giving</td>
<td>Less Emotional Distress</td>
</tr>
<tr>
<td>McHugh P, Lewis S, Ford S et al (1995)(^24)</td>
<td>Cancer Patients</td>
<td>High Information</td>
<td>Less Improvement in Psychological distress even at 6 months follow up</td>
</tr>
<tr>
<td>Ong LML, Visser MRM, Lammes FB, de Haes JCJM (1999)(^25)</td>
<td>Cancer Patients</td>
<td>Cure Oriented Behaviour</td>
<td>No relation with patients’ quality of life</td>
</tr>
<tr>
<td>Butow PN, Maclean M, Dunn SM et al (1997)(^26)</td>
<td>Cancer Patients</td>
<td>Fulfilment of informational needs</td>
<td>No relations with Patients’ satisfaction</td>
</tr>
<tr>
<td>Kaplan SH, Greenfield S, Ware JE (1989)(^20)</td>
<td>Cronically Ill (cancer) patients</td>
<td>Cure oriented behaviour</td>
<td>Better functional status and overall health status</td>
</tr>
<tr>
<td>Fallow Field LJ, Hall A, Maguire GP et al (1990)(^21)</td>
<td>Stage I or II Breast Cancer Patients</td>
<td>Treatment Choice by the patient</td>
<td>More anxiety and depression symptoms at post operative level when compared with no treatment choice group. Anxiety symptoms reduced at 3 as well as 12 month follow up while depressive symptoms reduced at 3 month follow up but improved to a lesser extent at 12 month follow up</td>
</tr>
<tr>
<td>Castejo’n J, Lo’pez-Roig S, Pastor MA et al (1993)(^7)</td>
<td>Cancer Patients</td>
<td>Comprehensive Health information given</td>
<td>Improved quality of life</td>
</tr>
<tr>
<td>Hall JA, Roter DL, Catz NR (1988)(^22)</td>
<td>Cancer Patients</td>
<td>Information giving</td>
<td>Positive effect on Patient satisfaction</td>
</tr>
</tbody>
</table>

The above discussion gives a comprehensive view of how health care providers’ communicative behaviour help regulate patients’ emotions, facilitate comprehension of medical information and allow for better identification of patients’ needs perceptions and expectations.
**Socio-Emotional Behaviour**

Socio-emotional communication refers to “care oriented interactions” (Bensing J, 1991) that have the primary goal of making the patient feel comfortable, relieving patient anxiety and building a trusting relationship (Ong et al, 1995; Pendleton et al, 2003).

It may involve positive talk where physician expresses friendliness, empathy, sympathy, concern, reassurance, reflection and partnership building. The specific elements of socio-emotional communication may include greeting the patient in a friendly way, addressing the patient by name, engaging in small talk, signs of agreement or disagreement, paraphrasing, being friendly, and listening attentively.

In a study by Desjarlais-deklerk K & Wallace J E, 2013, they identified three specific types of interaction central to the socio-emotional communications:

1. *Informal pleasantries* often occurred at the beginning of the interaction and refer to casual communication that the doctor and patient engage in without any advanced knowledge of each other, such as discussing the weather or a recent sporting event.
2. *Humour during the interaction* was also observed and involves sarcasm, teasing and joking from either the doctor or the patient. Laughing and making jokes has been identified as a necessary ingredient of good inter-personal relationships between doctors and patients.
3. *Active Relationship-building* refers to communication involving any personal talk about the patient’s and/or physician’s life outside the medical office and their roles in it.

Table 2 shows the different components of socio-emotional behaviour and their effect on psychology of cancer patients.

**Table 2: Psychological outcomes of physicians’ socio-emotional communication behaviour**

<table>
<thead>
<tr>
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<th>Sample</th>
<th>Physicians’ Communication Behaviour</th>
<th>Psychological Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chaitchik S., Kreitler S., Shaked S., Schwartz I. and Rosin R. (1992)41</td>
<td>Male and female Cancer Patients</td>
<td>Poor Care Oriented Behaviour of Physician</td>
<td>Feelings of patients were affected negatively, in a quarter of subjects anxiety was reduced and was replaced by anger.</td>
</tr>
<tr>
<td>Buller M. K. and Buller D. B (1987)27</td>
<td>Cancer Patients</td>
<td>Physicians’ expression of affiliative communication style (Friendly, encouraging, open, honest and empathetic)</td>
<td>Positive association with patient satisfaction and health care</td>
</tr>
<tr>
<td>Like R. and Zyzanski S. J. (1987)40</td>
<td>Cancer patients</td>
<td>Patients’ requests were met</td>
<td>Increase in satisfaction with medical encounter</td>
</tr>
</tbody>
</table>
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<th>Sample</th>
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<th>Psychological Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stewart M A (1984)(^{28})</td>
<td>Cancer Patients</td>
<td>Patients’ feelings were being understood; Resolution of patients’ concerns; Doctors have ascertained Patients’ reason of coming</td>
<td>Patients reported more compliance</td>
</tr>
<tr>
<td>Henbest R. J. and Stewart M. A. (1990)(^{29})</td>
<td>Cancer Patients</td>
<td>Doctors’ Patient Centred care</td>
<td>No significant relationship found with patient satisfaction</td>
</tr>
<tr>
<td>Roter D. L. (1989)(^{30})</td>
<td>Cancer Patients</td>
<td>Information Giving and Positive Talk; Doctors’ question asking and negative talks</td>
<td>Positive association with compliance; Negative association with compliance</td>
</tr>
<tr>
<td>Ong LML, Visser MRM, Lammes FB, de Haes JCJM (1999)(^{25})</td>
<td>Cancer Patients</td>
<td>Socio-emotional behaviour and affective tone</td>
<td>More patient satisfaction (Both visit specific and global)</td>
</tr>
<tr>
<td>Hall JA, Dorman MC. (1988)(^{31})</td>
<td>Cancer Patients</td>
<td>Socio-emotional behaviour such as Social talks and Positive and Negative talks</td>
<td>Positive association with patients satisfaction and compliance</td>
</tr>
</tbody>
</table>

Though efforts have been made by several researchers to develop theoretical frameworks of different components of socio-emotional behaviour and their psychological influences on cancer patients, because of both the complexity and the limitations of the methods of objective assessment of socio-emotional behaviour, need for scientific studies is still existing.

**Affective Behaviour**
Affective (non verbal) behaviour has been defined as 'ratings of the affect conveyed in voice quality and counts of speech errors indicative of anxiety' (Hall et al, 1987), touching patient (Blanchard et al, 1983), behaviours directed by the doctor toward the patient as a person rather than as a case' (Ben-Sira Z., 1980), or 'behaviours designed to establish and maintain a positive relationship between the doctor and his patient' (Buller & Buller, 1987).

Affective behaviour however, cannot always be verbally perceived. Only 7% of the emotional communication is conveyed verbally; 22% is transferred by voice tone; but 55% is transferred by visual cues, like eye contact, body positioning, etc (Bensing J M, 1991). Non-verbal behaviour
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has been operationalized in different ways. Tone of voice, gaze, posture, laughter, facial expressions, touch and physical distance are thought to convey the emotional tone of interpersonal interaction (Smith C K, 1981; Bensing J M, 1991; Dimatteo et al, 1980; Hall et al, 1981; Stiles & Putnam, 1989).

When empirical studies do involve non-verbal communication in their classification schemes, they often consist of just one or sometimes two or three behaviors, e.g. physical proximity, time spent on chart reviewing (Smith et al, 1981)\textsuperscript{36}, the proportion of time the doctor looks at the patient, shows interest (Bensing J M, 1991)\textsuperscript{37}, sits down while talking to the patient or touches the patient (Blanchard et al, 1986)\textsuperscript{36}. All these non verbal behaviours resulted in less emotional distress (Blanchard et al, 1988)\textsuperscript{42}, more patient satisfaction (Anderson L. A. and Zimmerman M. A., 1993)\textsuperscript{40}, Smith C. K., Polis E. and Hadac R. R., 1981\textsuperscript{36}; Buller M. K. and Buller D. B, 1987)\textsuperscript{30}, better psychological adjustment (Butow PN, Dunn SM, Tattersall MHN et al., 1995)\textsuperscript{26} and improved quality of life (Bensing J. M., 1991)\textsuperscript{37} among cancer patients.

Non-verbal communication 'leaks' messages that are not meant to be transmitted (DiMatteo et al, 1980). Patients are very sensitive to these messages, and to inconsistencies between physicians' verbal and nonverbal communication (Hornsby & Franklin, 1979; Friedman H S, 1979). Despite increased attention in this area, there are not many studies that use a systematic approach to coding non-verbal interaction. Table 3 summarizes the research works done earlier in order to see the influences of non verbal behaviours that physicians show, on the psychological health of cancer patients.

\textbf{Table 3: Psychological outcomes of physicians’ affective (non verbal) communication behaviour}

<table>
<thead>
<tr>
<th>References</th>
<th>Sample</th>
<th>Physicians’ Communication Behaviour</th>
<th>Psychological Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Larsen K. M. and Smith C. K. (1981)\textsuperscript{32}</td>
<td>Cancer Patients</td>
<td>Higher Non Verbal activities like eye contact, touching patients, and body positioning</td>
<td>Higher patients’ satisfaction</td>
</tr>
<tr>
<td>Smith C. K., Polis E. and Hadac R. R. (1981)\textsuperscript{33}</td>
<td>Cancer patients</td>
<td>Physical proximity, time spent on chart reviewing</td>
<td>Higher patient satisfaction and understanding of medical information</td>
</tr>
<tr>
<td>Bensing J. M. (1991)\textsuperscript{34}</td>
<td>Cancer patients</td>
<td>Proportion of time the doctor looks at the patient, and shows interest</td>
<td>Better quality of life</td>
</tr>
</tbody>
</table>
As these qualitative studies have the potential to inform us about the similarities and discrepancies in the conceptualization of participation by physicians and patients. Such discrepancies may very well influence the course of the patient–physician interaction resulting in potentially satisfactory visits and patients’ optimal psychological and health outcomes.

**CONCLUSION**

An essential component of the delivery of health care is the relationship between the patient and the health care provider. Studies exploring the underlying mechanisms by which physicians’ communication behaviour impacts patient outcomes are likely to contribute to improvements in cancer care.

Qualitative research confirms that cancer patients do perceive a greater sense of control when they are satisfied with their physicians’ efforts to inform them and involve them in decision
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making (Bakker et al., 2001; McWilliam et al., 2000). Studies conducted in other chronic illness settings have also established a positive relationship between personal control and patient health outcomes (Affleck, Tennen, Pfeiffer, & Fifield, 1987). Thus, patient perceptions of uncertainty and personal control are likely mediators of the relationship between physicians’ communication behaviour and patient outcomes.

The authors conclude that the doctor-patient relationship can be seen as a primary bond that may act as a form of social support. Physician behaviors that reinforce patients' self-confidence, motivation, and positive view of their health status may therefore indirectly influence patients' health outcomes (Kaplan S. H., Greenfield S. and Ware J. E., 1989).

It is still unclear, however, whether patients can discriminate between instrumental and affective physician behaviors (Roter D. L., Hall J. A. and Katz N. R., 1987; Buller M. K. and Buller D. B., 1987; Hall J. A., Roter D. L. and Katz N. R., 1988; Ben-Sira Z., 1980; Hall J. A., Roter D. L. and Katz N. R., 1987). It could well be that patients do not perceive these two behaviours as distinct aspects of care, in which case it would be illogical for communication researchers to regard them as separate.

This paper presented an extensive review on the significance of physicians’ communication behaviour which revealed the complex relationship of doctor-patient communication and reinforces the practice implications of the former reviews. A preliminary conclusion of this review, would be that instrumental vs affective behaviours may be false dichotomies. Doctors' affective behaviours could indeed be regarded as technical skills. This idea finds support in the fact that medical students can be taught several interviewing techniques focusing on affective behaviours (Squier R. W., 1990).

Findings from such reviews and qualitative studies could also be used to construct better survey measures of patient and physician preferences for patient participation and their perception of physicians’ actual facilitation of patient participation. Recent studies assessing the effectiveness of initiatives to improve the communication between doctors and patients in oncology suggest a positive effect on patient satisfaction. Social scientists agree that psychological outcomes such as satisfaction, compliance, recall and understanding of information are good indicators of the consequences of 'talk'. However, these outcomes are what Beckman et al. (1989) call 'short-term and intermediate outcomes'. The limitation of using short-term outcomes is that the possible long-term consequences are unknown.

It has been suggested by authors of the present review that initiatives to improve psychological health, should target both doctors and patients. Patients should be educated in soliciting information and expressing their preferences, and doctors must recognise the need to acquire appropriate communication skills to better elicit patients’ overall needs, impart information in a sensitive manner, and respond to more assertive patients. Further research should be
implemented to assess the appropriateness of these approaches across socio cultural contexts. It is hoped that such studies will help further our understanding of the dynamics of the patient–physician relationship and lead to improvements in the quality of cancer care and enhanced health outcomes for cancer patients.

Patients’ social behaviours (making personal remarks, laughing, giving approval, making compliments) predicted both their physical distress and their global quality of life. This finding is unanticipated as well as difficult to interpret. New studies are needed to replicate this result. Patients’ negative talk predicted their visit specific as well as their global satisfaction at both follow-up measurements.

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