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## Doctors' communication of trust, care, and respect in breast cancer: qualitative study

Emma Burkitt Wright, Christopher Holcombe, Peter Salmon

### Abstract

**Objective** To determine how patients with breast cancer want their doctors to communicate with them.

**Design** Qualitative study.

**Setting** Breast unit and patients' homes.

**Participants** 39 women with breast cancer.

**Main outcome measure** Patients' reports of doctors' characteristics or behaviour that they valued or deprecated.

**Results** Patients were not primarily concerned with doctors' communication skills. Instead they emphasised doctors' enduring characteristics. Specifically, they valued doctors whom they believed were technically expert, had formed individual relationships with them, and respected them. They therefore valued forms of communication that are currently not emphasised in training and research and did not intrinsically value others that are currently thought important, including provision of information and choice.

**Conclusions** Women with breast cancer seek to regard their doctors as attachment figures who will care for them. They seek communication that does not compromise this view and that enhances confidence that they are cared for. Testing and elaborating our analysis will help to focus communication research and teaching on what patients need rather than on what professionals think they need.

### Introduction

Doctors often communicate poorly with patients who have cancer, and patients do not receive the help they need to understand treatment options.<sup>1 2</sup> Communication skills can be enhanced by training, which improves patients' satisfaction and wellbeing.<sup>3 4</sup> Enhanced communication skills do not always, however, improve patients' experience.<sup>5</sup>

Clinicians are encouraged to provide as much information as possible, to offer choice, and to discuss emotional issues, and extensive research assesses how well they do.<sup>6</sup> Yet professionals' and patients' views as to what is good communication about cancer can diverge, and patients' satisfaction with a consultation is not always related to observer ratings of the formal quality of clinicians' communication.<sup>5 7 8</sup> We examined clinicians' communication according to how patients experienced it.

### Methods

We selected women with primary breast cancer consecutively from surgery and oncology clinics to include a range of stages in treatment.

The researcher asked eligible patients for consent to a study of what is important to them about doctors' communication. By grounding interviews in recent

Royal Liverpool University Hospital, Liverpool L7 8XP  
Emma Burkitt Wright  
senior house officer in medicine

Linda McCartney Centre, Royal Liverpool University Hospital  
Christopher Holcombe  
consultant surgeon

Department of Clinical Psychology, University of Liverpool, Liverpool L69 3GB  
Peter Salmon  
professor of clinical psychology

Correspondence to: P Salmon  
psalmon@liv.ac.uk

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**Box 1: Ways in which doctors could communicate expertise**

Demonstrate a tangible skill

"She [oncologist] really does give you a good examination" (patient 22)

Display confidence and efficiency and make things happen

"He seems to move pretty quickly, get everything organised... and that's the general feeling that things are going OK" (patient 8)

Answer all questions without hesitation

"She answers questions with no hesitation... so quickly you felt she was telling you the truth" (patient 9)

Do not mislead

"He lied, or fibbed, or spared your feelings, about me mum [who died from breast cancer previously]. I lost all faith in what everybody was telling me then" (patient 9)

Tell the patient you will be open

"He did say to me before the operation... what we know you will know, there's nothing we'll keep from you... I just think he was absolutely fantastic" (patient 10)

Avoid telling patients things they do not want to know about

"I don't want to know whether I'm cured or not" (patient 21)

Explain ways in which patient's disease is not as bad as it might have been

"He explained how lucky I was" (patient 10)

consultation, we sought to minimise generalised or idealised accounts. We audiotaped clinical consultations and semistructured interviews in the patient's home. Informed by the transcript of consultation, EB prompted patients to describe aspects of communication that they valued or deprecated in the consultation and with doctors involved in their care.

Transcripts were read by EB and PS to identify sections or features to inform the interview. We focused on aspects that could test the developing analysis; in particular where doctors' communication deviated from current expectations and where patients' accounts seemed discrepant with the consultation.

Using a constant comparison approach, anonymised interview transcripts were analysed inductively, in parallel with the interviews. Recurrent patterns were identified and tested by cycling between data and analysis and discussion among authors.

**Results**

Four patients declined to participate; 39 consented and were recorded in consultation with 12 doctors (see [bmj.com](http://bmj.com)).

Patients did not focus on doctors' communication but emphasised their attributes or personality. We therefore organised the analysis around three perceived attributes of doctors that structured the patients' accounts: expertise; caring; and respecting the patient (boxes 1-3).

**Expertise**

The dominant concern was the need to trust doctors' expertise: "If you asked me what the most important thing was, it's confidence in their ability" (patient 9).

Expertise was communicated by being a doctor, and by being efficient, acclaimed, or frank. Being a doctor was often sufficient. Confidence was enhanced by knowing the doctor's reputation. This could be communicated by other patients or staff: "From what [nurse] tells me this morning, he'll do everything he can" (patient 22). Tangible evidence of skill inspired more confidence.

Patients linked trust to feeling that they had been "given the facts" (patient 8). They welcomed doctors telling them that they would be open. Other comments indicated that patients did not want to be given too much information. Desire for information was also shaped by wanting to be left "on a positive note" (patient 1). Doctors often achieved this by explaining how the cancer was not as bad as it might have been.

**Relationship with patient**

Patients wanted "a relationship" with the doctor—that is, to see each other as individuals.

The perception of being regarded as an individual was communicated in several ways. Non-verbal cues included eye contact, smiling, and touching. The simplest verbal strategy was for the patient to be told she was special (see box 2). The most common strategy was brief conversation unrelated to disease.

Several patients liked their doctor "as a person" (patient 3). Female doctors were valued because "a female doctor'll enjoy the consultation more than a man will... it's a sisterhood" (patient 22). No patient criticised doctors' humour, and several valued it.

The most striking way a doctor could be seen as an individual was by doing something that "he didn't have to do" (patient 28). The value of perceived departure from role was magnified by the doctor's status.

**Respecting the patient**

Patients sought to feel respected as "part of the team, fighting the same battle" (patient 22) and to be afforded the dignity and rights associated with being "a human being, somebody who has an opinion" (patient 15). This was clearest when patients described fearing "being a bother" (patient 26).

**Box 2: Ways in which doctors could communicate relationship with patients**

Help patients feel special

"This is about you... because he said to me the first time we went, he said there's a guardian angel sitting on your shoulder" (patient 10)

Talk briefly about something other than cancer

"Being prepared to take that couple of minutes out, you know to talk about something else, it just makes you feel more like a person" (patient 8)

Display natural idiosyncrasies

"He said 'listen, for all our technology, we don't know everything.'... He said 'Do you believe in God?' So I said 'Yes,' and he said 'Well then, leave things in the hands of God.' " (patient 21)

Do something for patient that seems not to be dictated by role

"When I got to the ward for 8 o'clock on the Friday he was there waiting to speak to me again... Now he didn't have to do this... He took the time out, and I just think, out of a schedule like his... I just think it was what I needed" (patient 15)

**Box 3: Ways in which doctors could communicate respect for patients**

Consult at eye level, when patient is fully dressed  
 “They should interview you in an office... fully dressed... like you were going for a job” (patient 21)  
 Match language to patient’s expectations  
 “She was very ordinary, you know. She didn’t like blind you with science” (patient 26)  
 Give patient the “option” to agree to decisions  
 “I didn’t have to have it [chemotherapy]. It was up to me” (patient 26)

The simplest way doctors communicated respect was by sitting down “at eye level” (patient 24). Patients also wanted doctors’ language to be on a level with their intelligence (see box 3).

Patients consistently valued being “given the option” (patient 6). However, no patient described a process of decision making. They had concurred with clinicians’ recommendations. Several rejected responsibility for decisions, giving two reasons. Firstly, “we’ve not got the education, that’s their job” (patient 11). Secondly, responsibility was incompatible with trust: “When I went with the lump, they said to me, do you want to go to the hospital... I could have turned round and said no... didn’t have a lot of faith in them after that” (patient 26).

**Responses to poor communication**

Trust in doctor’s expertise was irretrievable if patients thought they had been misled (see box 1). When patients disliked communication, they interpreted it in ways that did not challenge their confidence in the doctor’s characteristics (see [bmj.com](http://bmj.com)).

**Discussion**

Patients with breast cancer did not think about their doctors according to whether they communicated well. Instead they were concerned with whether their doctors had expertise they could trust, had a personal relationship with them, and respected their autonomy.

When individuals feel vulnerable, they seek attachment figures to help them feel safe.<sup>9–11</sup> Only doctors who were believed to be expert, to value patients as equals, and to be committed to their patients in a unique relationship could fulfil this role. The starting point for study and training of clinical communication should therefore be patients’ vulnerability and dependence on doctors. From this perspective, patients’ perception of the relationship with their clinicians arises from their attachment needs and is not, as widely assumed, solely built by communication.<sup>7</sup> Our patients often discounted poor communication in ways that preserved their confidence in doctors’ attributes. They also showed that they were not well served by some forms of communication currently thought important, and sought some types of communication that are mainly neglected by teaching and research (see boxes 1–3).<sup>6 12 13</sup>

**Expertise**

Trust in doctors’ expertise was our patients’ main concern, yet this is not emphasised by communication research and teaching.<sup>6 12–14</sup> Being a doctor was enough

to communicate expertise for many patients, but confidence was increased when doctors displayed efficiency and technical skill or were acclaimed by others.

Being frank also enhanced trust. Patients trusted doctors who answered their questions without hesitation, but many did not want to be informed about aspects of prognosis and to be “left on a positive note.” Contrary to assumptions, patients do not seek information to be better informed but for other reasons.<sup>10 11</sup> Our patients seemed to seek information primarily to maintain hope and trust, a view that contrasts with the suggestion that the need for hope and trust constrains the desire for information.<sup>15</sup>

**Caring relationship and respect**

Our patients did not seek relationships based on communication about emotional issues—they wanted doctors who were individuals and who regarded them as individuals. The value that patients therefore attached to doctors’ actions that they “didn’t have to do” and to idiosyncratic demonstrations of individuality indicates a challenge for communication training: to reconcile a model of skills that all doctors can use with patients’ wish to experience a unique relationship.

In valuing being given the option rather than choice, patients diverged from the professional emphasis on patient empowerment and shared decision making.<sup>13 16</sup> In wanting the option, patients identified a role for surgeons that equated neither to direction nor choice but meant respecting autonomy. Fallowfield and coworkers found that women with breast cancer treated by surgeons who normally offered choice of treatment became less distressed than those treated by surgeons who denied choice, but that this occurred even in patients who could not be offered choice.<sup>17</sup> Perhaps the offer of choice was one marker that these surgeons had several ways of communicating respect for patients’ autonomy.

**What is already known on this topic**

Good communication is central to clinical care of women with breast cancer

Training in communication can improve clinical care but does not always improve patients’ experience of care

Future development of communication training should be informed by knowledge of what patients seek from clinical communication

**What this study adds**

Patients are more concerned with doctors’ enduring qualities than with their communication skills

Patients want to know that their doctors have expertise, have a unique relationship with them, and respect their autonomy

Forms of communication that convey these qualities differ from those currently emphasised in communication training and research

Convergence with previous evidence shows that our findings are more generally relevant than just to our sample. Where they depart most from current knowledge and assumptions is by showing how clinical communication can deliver or deny trust, care, and respect and by showing that aspects of communication believed to be ends in themselves should be considered from the perspective of the function that they have for patients. Testing and elaborating our analysis will help to focus communication research and teaching on what patients need rather than on what professionals think they need.

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## Inappropriate admission of young people with mental disorder to adult psychiatric wards and paediatric wards: cross sectional study of six months' activity

Adrian Worrall, Anne O'Herlihy, Sube Banerjee, Tony Jaffa, Paul Lelliott, Peter Hill, Angela Scott, Helen Brook

Child and adolescent psychiatric inpatient wards were established because young people with mental illness are often poorly served by admission to general psychiatric wards, owing to needs that differ from those adults, different skills needed by staff, and difficulty ensuring young people's safety.<sup>1</sup> The admission of young people with mental illness to paediatric wards also raises concerns about safety and the skills of staff. We estimated the number of inappropriate admissions of young people with mental disorder to adult psychiatric wards and paediatric wards.

### Participants, methods, and results

We chose nine health authorities representative of England and Wales in terms of location, population size, deprivation, and provision of child and adolescent psychiatric wards (see table on [bmj.com](http://bmj.com)). These health authorities served 1.13 million people aged under 18, representing 9% of the population of England and Wales (1999 projections of 1991 census).

We identified all adult psychiatric wards and paediatric wards. Consultant general psychiatrists and paediatricians completed a questionnaire for each

eligible patient (patients aged under 18 on general psychiatric wards and patients on paediatric wards for treatment of mental illness not solely for medical treatment of self harm) admitted between 1 July and 31 December 1999.


All 31 adult psychiatric wards replied, yielding 43 eligible admissions (23 male). Five were aged 15, and the remainder were 16 or 17. Sixteen of the 21 paediatric wards replied, with 11 eligible admissions (three male, one aged 3 and the others 8-16). The table presents the numbers and projected rates of admissions.

The consultants rated whether each eligible admission was appropriate and, if not, why the patient had not been admitted to a more appropriate unit. Twenty six (60%) adult psychiatric admissions and six (55%) paediatric admissions were deemed "inappropriate." The main reasons for these admissions were

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Royal College of Psychiatrists' Research Unit, 6th Floor, 83 Victoria Street, London SW1H 0HW  
Adrian Worrall senior research worker  
Anne O'Herlihy research worker  
Paul Lelliott director  
Angela Scott research assistant  
Helen Brook research assistant  
continued over

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