Review Article

Communication skill frameworks: applications in radiation oncology

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Abstract: Communication is an important part of high-quality care at every step. Communication skills can be learned, practiced, and improved. In this review, we outline the basic frameworks for communication skills training, describe their components, and demonstrate their utility in the context of vignettes. We discuss specific evidence-based roadmaps for approaching the various communication tasks a radiation oncologist might encounter. Each is summarized with an easy to remember mnemonic. These include responding to emotion using NURSE statements, delivering serious news using SPIKES, discussing prognosis using ADAPT, and discussing goals of care using REMAP. To tie it all together, we offer a simplified general approach to all communication tasks with the mnemonic ACE (Assess, Communicate, Empathize).

Keywords: Communication; radiation oncology; palliative radiation; skills; education

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Introduction

Skillful communication is essential in the delivery of high-quality, patient-centered cancer care. In addition to strengthening the patient-physician relationship and promoting a model of informed and shared decision-making, patient-centered communication is associated with improved health-related quality of life, mood, symptom control, adherence to therapeutic treatments, and overall satisfaction (1-7). Effective communication also benefits providers, facilitating increased resilience and a greater sense of personal accomplishment (1).

Despite the growing appreciation for the critical role of skilled communication in oncology, breakdowns in communication are common (8-9). Cancer patients may leave oncology visits with confusion regarding the plan of care and treatment options; inaccurate or incomplete prognostic awareness; and unaddressed emotional, psychological, and physical concerns (10-12). Further, most of the efforts to address the need for communication skill training in oncology have been limited to the field of medical oncology with significantly less emphasis placed on developing communication skills among surgical or radiation oncologists.

A rationale for formal communication skills training in radiation oncology

A large proportion of patients referred to radiation oncology are treated with palliative intent (13). As such, radiation oncologists regularly have opportunities to participate in various complex communication tasks associated with an advanced cancer diagnosis, detailed in *Table 1*.

Since formal communication training has not been a

Table 1 Communication tasks frequently encountered by radiation oncologists

Communication Task	Common scenarios
Delivering serious news	• A patient presents for follow-up and is noted to have disease progression or recurrence on interval imaging
	• A patient with metastatic disease is unaware that radiotherapy will not be curative
	• A patient presenting with severe neurologic deficits including non-ambulatory status for the past several weeks due to malignant spinal cord compression asks when he will be able to walk again
Clarifying goals of care	• A patient with aggressive metastatic disease expresses her hope for a cure
	• A patient with advanced cancer is anxious about enduring subsequent chemotherapy after her current course of palliative radiotherapy
	• A patient presents to clinic with an estimated prognosis of 3 months without documented discussion regarding advance care planning
Exploring prognostic awareness	• A patient is referred to your clinic with diffuse bone metastases is unaware of his prognosis
	• A patient's son requests his mother's prognosis not be shared with her
	• A patient expresses anxiety and uncertainty around cancer progression
Obtaining informed consent	• During an initial consultation for palliative radiotherapy you become concerned that the patient may not have decisional capacity
Managing expectations	• A patient and his family members have discrepant expectations regarding the plan of care and anticipated outcomes
	• A patient with diffuse bone metastases requests that you escalate his opioid regimen until he has "no pain"
Disclosing a medical error	• Treatment delivery deviated from that which was intended (e.g., incorrect site, incorrect dose, incorrect side)

consistent part of radiation oncology training programs, the majority of radiation oncologists in practice today have not received education specifically focused in this area. For this and other reasons, radiation oncologists may be less likely to engage patients and family members in challenging patient-centered conversations around prognosis (14-16). In a study by Keating *et al.*, radiation oncologists were the least likely of all oncology specialists to discuss prognosis with their advanced cancer patients (17). Similarly, in a study comparing communication during initial oncology consultation visits, compared to medical oncologists, radiation oncologists were less likely to discuss prognosis, to initiate a social exchange, or to ask patients open-ended questions (3). Radiation oncologists spent a greater percentage of the visit interrupting and their communication style was rated as less patient-centered, more hurried, and less clear. In addition, radiation oncologists spent an average of 9 seconds checking patient understanding and 25 seconds building rapport (partnership building and active support) during initial consultation (3).

Radiation oncologists, however, are uniquely positioned to engage patients and families in discussions regarding prognosis, advance care planning, treatment preferences, and goals of end of life care. Evidence suggests that prognostic accuracy decreases with increased duration of the patient-physician relationship (18). Radiation oncologists can often provide a "fresh perspective" in evaluating a patient's prognosis, especially when patients are receiving daily treatments, and thus may bring to light a greater sense of urgency regarding advance care planning and end-of-life talks. Further, studies indicate that cancer patients may actually prefer to discuss advance care planning with physicians who can function as "disinterested parties" due to fears of upsetting their medical oncologist with whom they may have had the longest relationship (19,20).

The structure of radiation oncology clinic also lends itself to these common yet complex communication tasks. Patients on treatment are seen at least weekly, which allows for sequential and frequent visits that facilitate the forward progression of these conversations. Topics for discussion such as prognosis and end of life planning are especially likely to evolve over multiple discussions, as patients and families are able to process information and emotional

Table 2 NURSE framework for responding to emotion

Name the emotion
Understand the emotion
Respect/praise the patient/family
Support the patient/family
Explore/"tell me more"

reactions over time. In particular, the possibility of hospice care may be initially introduced in a general way at a consultation visit with more detailed information provided during on-treatment visits. Patients may also choose to bring in family members at these later visits to partner in information-sharing and decision-making.

Basic frameworks for communication skills training

Communication frameworks serve as roadmaps that anchor and guide clinicians through challenging conversations. They offer a systematic, teachable, skill-driven approach to moving discussions forward while eliciting patients' priorities, goals, and values and formulating patient-centered management decisions (20,21). Several approaches to communication frameworks exist, although those developed by VitalTalk and the Serious Illness Care Program are thought to be the most accessible and effective. Both have been well-studied and are in operation internationally.

VitalTalk was formed by several U.S.-based palliative care physicians in 2012. Initially funded by the National Institutes of Health, VitalTalk is now a 501c3 nonprofit organization whose purpose is to disseminate communication research into clinical practice (22).

The Serious Illness Conversation Guide is a set of structured questions designed from best practices in generalist-level palliative care. It serves as a framework for clinicians to explore what is most important to patients and their families. "The Guide" (available online: https://www.ariadnelabs.org/wp-content/uploads/sites/2/2015/08/Serious-Illness-Conversation-Guide-5.22.15.pdf) is one element of a larger six-part program called the Serious Illness Care Program developed at Ariadne Labs in Boston, MA, USA that functions at a systems level to provide support for clinicians carrying out important conversations with patients and caregivers/family members (23).

Fundamental communication skills

Recognizing and responding to emotion

Recognizing expressions of emotion and responding with empathy are fundamental communication skills. They can facilitate further disclosure and have been shown to result in improved patient understanding of illness and quality of life outcomes (24,25). A cancer diagnosis is often accompanied by emotional distress, which can directly interfere with a patient's ability to process medical information and cope with his or her illness (26,27). The NURSE framework (*Table 2*) is an established way of conceptualizing various types of empathic statements (28).

Anxiety, anger, guilt, panic, vulnerability, isolation, depression, frustration, hopelessness, fear, and other strong negative emotions are commonly present at the time of an initial cancer diagnosis and may occur throughout the disease course, especially at times of disease progression or complications from either the disease or its treatments (29-31). These emotional reactions can range from normal adjustment reactions to disabling disorders requiring medical treatment. At any level of severity, this emotional noise has a significant impact on an individual's ability to understand or process medical information and must be addressed before moving forward in the conversation.

Cancer patients may also feel reluctant to disclose their emotional distress to their providers due to fear of being burdensome, judged, or even being denied treatment (32-37). A patient's emotional state, however is often communicated through the use of indirect verbal and non-verbal cues (38-41). For example, "*I keep wondering if the cancer has spread*" may actually be an expression of pervasive anxiety or guilt for having not sought medical evaluation or treatments earlier. Indirect cues offer an opportunity for providers to offer emotional support without lending false hope (42-44).

Common pitfall responses to indirect cues include avoidance and redirection (41-43). In the above example, a radiation oncologist might instinctively provide additional medical information, instead of attending to the question's emotional origin (e.g., anxiety) first. An immediate cognitive response is "*there is no evidence of metastatic disease on your recent staging CT*." This type of "terminator statement" does not acknowledge the underlying anxiety which may have prompted the patient's statement. A response to the question's emotional underpinning, on the other hand, may instead be, "*I can't imagine how terrifying it must be to think about this*" (41,44). This is an example of an "understand"

Table 3 Example dialogue—responding to emotion using NURSE

Clinician/patient	Example dialogue	NURSE statements
Radiation Oncologist	"*I see how frustrated you are, Jerry. I wonder if you're feeling angry too."*	Name the emotion
Jerry	"*Of course I'm feeling angry! I'm in pain all the time. And it's not like I don't know what this means.*"	
Radiation Oncologist	"*I can understand why you'd feel angry. It sounds like you've been suffering through intolerable pain for some time. I'd like to understand, what does your pain mean to you?*"	Understand the emotion
Jerry	"*It's another sign that my cancer is out of control. It's taking everything away from me. I can barely walk. Soon I probably won't even be able to get outside. I'll be stuck in bed all day.*"	
Radiation Oncologist	"*That must feel scary.*"	Name the emotion
Jerry	Pauses. "*Yeah, I'm terrified…and overwhelmed.*"	
Radiation Oncologist	"*I'm so impressed that despite how much pain you're in and how overwhelmed you feel, you still made it to this appointment today.*	Respect/praise the patient
Jerry	Sighs and relaxes in his chair.	
Radiation Oncologist	"*I'm really glad you came. I am going to do everything I can to help treat your pain and make this whole experience less overwhelming for you.*"	Support the patient
Jerry	"*I'm sorry I snapped at you.*"	
Radiation Oncologist	"*I understand your frustration. Pain impacts different people in different ways and in order to make sure that I treat your pain in the best possible way, it's important that I understand the specific ways in which your pain is impacting you. You mentioned that you've had difficulty walking and sleeping. Can you tell me more about how your pain has been impacting your life?*"	Explore the emotion

statement from NURSE. A response to the question's emotional origin (I) assures that the patient feels heard and (II) allows the patient to respond in a way that provides important data to the provider regarding whether it is necessary to continue addressing the patient's underlying emotion or whether it is okay to move on (45-48). Empathic responses have been also associated with increased patient satisfaction, quality of life, treatment adherence, mood, coping ability, and stronger patient-provider alliance (42,49-51).

Case 1

Jerry is a 52-year-old man with diffusely metastatic prostate cancer who presents to radiation oncology clinic for an initial consultation. He has severe, progressive right hip pain with evidence of a new bone metastasis in his proximal right femur. While eliciting Jerry's understanding of his illness, the radiation oncologist notices that Jerry becomes tense and leans away. In a loud voice, he interrupts: "*just treat my pain, already! I can barely walk. I can't sleep. Enough with the questions!*"

The radiation oncologist notices and responds to verbal and non-verbal cues of Jerry's distress (*Table 3*). By attending to Jerry's frustration, she allows him space to defuse his emotions and feel heard. Once she validates that his emotional responses are entirely normal and expected, Jerry calms down and she is able to continue investigating his pain (28).

Delivering serious news

Delivering serious news is one of the most challenging communication tasks in medicine. A patient's experience during this type of encounter is critically important and should be considered at all times. SPIKES (*Table 4*) is a roadmap that outlines the key parts of a conversation involving serious news delivery (28). Information should be provided in a private, quiet setting whenever possible and with limited interruptions or distractions. Sitting down for

Table 4 SPIKES framework for delivering serious news

Setting
Perception
Invitation
Knowledge
Empathy/emotion
Strategy/summary

this process is an important non-verbal signal of presence and respect for the patient and conversation. It may be helpful to have key team members available (e.g., nurse or social worker) to jump into the conversation at appropriate points.

Prior to disclosing serious news, radiation oncologists should assess patients' understanding of the clinical situation and the type of information they want to know. It is important that assumptions are not made regarding patients' understanding or desired extent of disclosure. Radiation oncologists should specifically ask patients for permission prior to sharing the new information and adhere to patients' expressed communication preferences. A "warning shot" or verbal statement preparing a patient for the news about to be delivered can be an effective tool when there is concern that the news will come as a surprise.

Next, radiation oncologists should state the news clearly and concisely. Often a single, unequivocal statement is sufficient. Attention should be made to avoid medical jargon and to pause while patients process the information. Radiation oncologists should be sure to assess patients' understanding of what was communicated and to be attentive to verbal and non-verbal expressions of emotion (e.g., "*How is this information sitting with you?*"). Patients may respond with varying degrees and types of emotion, including relief, dread, anger, or acceptance. Radiation oncologist should provide empathetic support of any emotion expressed, to ensure that patients feel supported. It is critical that they have time to process information and evaluate their feelings prior to trying to make any further decisions about treatment. It is also critical to make sure that patients do not feel abandoned. If the plan is unlikely to include additional follow-up visits with the radiation oncologist, a statement should be made to explain that the patient is welcome to schedule additional visits with the radiation oncologist if desired. Patients may want to meet with their established practitioners again, if only to ensure that the relationship is maintained. An example dialogue for delivering serious news is shown in *Table 5*.

Case 2

Dana is a 49-year-old woman diagnosed with invasive ductal carcinoma of the right breast found to have invasion of the chest wall on radical mastectomy who presents to radiation oncology clinic for post-mastectomy irradiation. The referral was initially placed after her mastectomy 3 months ago, but due to changes in her employment with a temporary lack of insurance coverage, she has had delayed follow-up. In anticipation of this visit, her medical oncologist ordered CT chest/abdomen/pelvis for re-staging, performed yesterday. She has not yet been informed of the results. Upon reviewing her imaging, the radiation oncologist notes progression of disease with multiple hepatic and pulmonary lesions.

Discussing prognosis

The majority of cancer patients prefer to have a clear understanding of their illness and expected disease trajectory yet the extent to which these conversations are carried out in a way that facilitates understanding is variable (51-55). The ADAPT framework for communicating prognosis is described in *Table 6* (28).

Conversations regarding prognosis are frequently deferred until very late in the disease trajectory when there may be insufficient time to align end of life care with a patients' preferences (56). Oncologists may communicate an overly optimistic prognosis for several reasons, including the worry that sharing information about a poor prognosis may result in loss of hope (56). The prevalence of prognostic non-disclosure was highlighted in a study of over 1,000 patients by Weeks *et al.* in which 69% of patients with metastatic lung cancer and 81% of patients with metastatic colorectal cancer were unaware that chemotherapy was not at all likely to cure their disease (57). Similarly, 64% of the lung cancer patients treated with radiotherapy in this patient population lacked understanding that radiotherapy was not at all likely to be curative (58).

It is important for radiation oncologists to gauge patients' prognostic awareness and desire for information regarding anticipated disease trajectory and life expectancy, This is especially true when further radiation treatment may involve acute toxicities or when trade-offs regarding symptom burden may deserve special consideration. A conversation with the referring provider about a patient's

Table 5 Example dialogue for delivering serious news using SPIKES

Clinician/patient	Example dialogue	SPIKES framework
Radiation Oncologist	Reviews the chart, speaks with patient's medical oncologist. Ensures a private setting and that there is no one else that Dana would like to have present for this visit. Silences his cell phone	Setting—ensure an appropriate environment
Radiation Oncologist	"*I've reviewed your chart and have been updated by your medical oncologist, but it would be helpful for me to hear what your understanding of your health is. That way, if there are any gaps or questions that you have, we can make sure to address them.*"	Perception—elicit the patient's understanding
Dana	"*Well, I was diagnosed with breast cancer a few months ago. Supposedly it was the good kind of breast cancer, if there is such a thing. The kind that doesn't tend to spread or kill you. But I guess because it was all over my breast, they recommended I get a mastectomy. No chemo or anything. So I did. They wanted me to see you since I guess they thought radiation might help keep the cancer away? Anyway, I ended up losing my job because I missed so much work and then I didn't have insurance…it's been a huge mess. I have a new job now, and insurance. So I'm finally able to be here.*"	
Radiation Oncologist	"*It sounds like you've been through a lot in the past few months.*"	
Dana	"*Yeah. I'm just ready to move forward and finally feel like this whole cancer thing is behind me. I guess radiation is the last step? And getting CT scans every few months for a while, my oncologist told me that's pretty routine. I went ahead and got them out of the way yesterday. Haven't heard anything. I guess no news is good news!*"	
Radiation Oncologist	"*Would it be okay if we talked about the results of your scans and where we are overall in terms of your cancer?*"	Invitation—ask for permission before disclosing serious news
Dana	"*Yeah, sure, that's why I'm here.*"	
Radiation Oncologist	"*Unfortunately, the CT scans did not show what we were hoping for.*"	Knowledge—provide a warning shot
Dana	"*What do you mean? What did they show?*"	
Radiation Oncologist	"*Your cancer has spread to your liver and lungs.*"	Knowledge—disclose the information concisely and avoiding medical jargon
Dana	Pushes her chair back. "*What? That's not possible.*" Looks down at the floor and starts to cry	
Radiation Oncologist	Silence	Empathy/emotion—allows for therapeutic silence
Dana	After a short time, looks up, signaling that she is ready to proceed	
Radiation Oncologist	"*This must be such a shock to hear. I know this is not what you were expecting.*"	Empathy/emotion—respond to emotion with NURSE
Dana	"*No, it never even crossed my mind. I can't even think right now. I don't even know what to ask.*"	
Radiation Oncologist	"*That's okay. Most people would feel the same way. I can't imagine how difficult it must be to hear this news but I want you to know that you are not alone. We will come up with a plan together.*"	Empathy/emotion—validate feelings; respond to emotion with NURSE
Dana	"*Okay.*"	
Radiation Oncologist	"*If you'd like, I can get you some water and give you some time to process this news before we talk about next steps. I want to make sure that I answer your questions and that we have a clear plan of what to do next.*"	Strategy/summary—make a plan; discuss next steps; have patient summarize what was discussed
Dana	"*Yes, I think that would help. Thank you.*"	

prognosis may be warranted to ensure that all providers are on the same page and present the same information to the patient. Radiation oncologists should be prepared with responses for patients who express ambivalence about discussing their prognosis. This should be thoughtfully explored. Efforts to understand the type of prognostic information that would be most helpful and underlying concerns that might accompany this type of information should be made. For instance, some patients may desire detailed, numerical information while others may ask about whether they will be able to attend specific, important future events. It is essential for the radiation oncologist to be able to provide honest prognostic estimates and to avoid the tendency toward unrealistic optimism. Prognostic estimates are often best described in terms of a time interval, for example hours to days, days to weeks, or weeks to months. Uncertainty in prognostication should be acknowledged. Framing uncertainty in terms of best case/worst case scenarios can be helpful. Underlying the prognosis discussion, paying attention to patients' emotional reactions and responding with statements of empathy (*Table 2*) is key. An example dialogue for discussing prognosis is shown in *Table 7*.

Table 6 ADAPT framework for discussing prognosis

Ask what the patient knows and wants to know
Discover what information for the future would be helpful
Anticipate ambivalence
Provide information
Track emotion

Case 3

Salima is a 62-year-old woman with metastatic esophageal cancer who is referred to radiation oncology for palliative management of progressive dysphagia.

Discussing goals of care

Identifying patients' goals, hopes, worries, values, beliefs,

Table 7 Example dialogue for communicating prognosis using ADAPT

Clinician/patient	Example dialogue	ADAPT framework
Radiation Oncologist	"*Have you had discussions about your prognosis with any of your other doctors?*"	Ask what the patient knows
Salima	"*No.*"	
Radiation Oncologist	"*Some patients find it helpful to discuss what to anticipate in the future with their physician and others would prefer not to. What's your preference?*"	Ask what the patient wants to know
Salima	"*I'd like to have the discussion. Just so I know what to expect. I want to be able to plan.*"	
Radiation Oncologist	"*When you say 'expect'—what do you mean?*"	Discover what information for the future would be helpful
Salima	"*How much time I have, you know, before I die. Am I looking at weeks? Years? I really have no idea. I don't think I've been ready to have this conversation.*"	
Radiation Oncologist	"*It's completely normal to have mixed feelings about having this conversation. Do you feel comfortable discussing this now or would you rather wait to discuss it at another time?*"	Anticipate ambivalence
Salima	"*No, I'm ready to talk about it now.*"	
Radiation Oncologist	"*First, there's no way for me to know exactly how much time you have left. The best answer that I can provide you is an estimate based on your overall clinical situation. I think that we are likely looking at several weeks to a few months.*"	Provide information
Salima	Silence. "*Wow. Alright.*"	
Radiation Oncologist	"*This must be hard to hear.*"	Track emotion
Salima	"*Yes. It is. But I think it's what I was expecting to hear. In fact, it helps to hear you say it.*"	

Table 8 REMAP framework for discussing goals of care

Reframe
Expect emotion
Map out patient's goals, values, worries
Align with patient's values
Propose a plan based on the patient's values

priorities, and preferences is essential to the process of shared decision-making. When possible, these conversations should precede discussions about specific medical interventions and treatment options so that the latter can be framed in an appropriate context and expectations can correlate with anticipated outcomes. Frequently, a patient will have several concurrent goals—such as prolonging life and minimizing suffering—and these goals may at times conflict. Given the dynamic nature of a patient's priorities and preferences, goals of care may need to be, and should be, revisited and revised at multiple points throughout the course of illness. If a patient's goals are not realistically achievable, a radiation oncologist can assist the patient in reframing goals such that hope is maintained and achievable goals are identified.

As yet, data suggest cancer patients' goals of care are not consistently addressed within the context of their values and preferences. In a study by Mack *et al.*, only 27% of nearly 1,500 patients who died from stage IV colorectal or lung cancer had end of life goals of care discussions documented by their oncologists (59). Failure to engage patients and families in discussions about end of life care may result in unreasonable expectations and/or interventions that do not result in treatment benefits. These may also lead to increased caregiver stress during the bereavement period (51,59-65).

An ideal conversation about goals of care is one that (I) begins with an ascertainment of patient's or family's illness understanding; (II) involves sharing of knowledge regarding pertinent clinical findings and results; (III) allows for time to process emotion and responses of empathy; (IV) elicits values, worries, and priorities from patients and family members given new and potentially distressing information; (V) summarizes information shared to reassure the patient and family members that they were heard; and finally (VI) offers a recommendation about treatment couched in empathy and with the communicated priorities in mind. In this way, these conservations should be less treatment-centric and more patient values-centric. An established communication framework for discussing goals of care, REMAP, is described in *Table 8* (66). An example dialogue for discussing goals of care is shown in *Table 9*.

Case 4

Juan is a 68-year-old man with stage IV lung cancer. He was recently found to have diffuse brain metastases and was referred to radiation oncology for possible whole brain radiation. You had previously treated him with palliative radiotherapy for a painful bone metastasis approximately 1 year ago. At that time his functional status was excellent and his expressed goal was "*to beat this cancer and resume life as usual*."

Today he is frail and lethargic with a recent unintentional 15-lb weight loss. He reports spending the majority of time in bed. He has minimal appetite and needs assistance in nearly all activities of daily living. He expresses concern about his progressive weight loss but he is hopeful that brain irradiation will improve his appetite and energy level so that he can "*get strong again.*"

Bottom line

In the broadest sense, skilled communication stems from the ability to listen actively, to speak with intention, and to attend to patients' and/or family members' emotions throughout the process. Communication skills can be effectively learned through the use of discrete frameworks, some of which are described above. These frameworks are meant to serve as cognitive aids, not as conversation outlines or checklists. When first developing these skills, however, it is not uncommon for early learners to get stuck when trying to apply specific frameworks to various challenging conversations. In those instances, some may prefer a simplified approach involving three focused efforts: assessing; communicating; and empathizing (*Table 10*).

Conclusions

Skilled communication facilitates alignment of treatments with patients' goals and values and is essential to the delivery of high quality cancer care. Emotional reactions to medical information can pose a barrier to a patient's illness understanding. Skilled responses to emotional reactions assure patients they were heard and facilitate purposeful progression of difficult conversations. As yet, the majority of radiation oncologists lack formal training in this area.

Table 9 Example dialogue for discussing goals of care using REMAP

Clinician/patient	Example dialogue	REMAP framework
Radiation oncologist	"*In terms of the cancer, we are in a different place now than we were a year ago. Given all of the changes you've described, I'd like to take a step back and discuss what to do next.*"	Reframe
Juan	"*What we need to do next is to get my strength back.*"	
Radiation Oncologist	"*I hear how worried you are about your weight loss and weakness.*"	Expect emotion
Juan	Sighs	
Radiation Oncologist	"*Given what you know about how your cancer is progressing, what is most important as you look to the future*?"	Map out the patient's goals
Juan	"*I want to be at home with my family. I know I'm going to die. I just don't want to suffer or be asleep all the time.*"	
Radiation Oncologist	"*As I listen, it sounds like the most important things are being at home, spending time with your family, being alert but also being comfortable.*"	Align with the patient's values
Juan	"*That's right.*"	
Radiation Oncologist	"*Based on what you've shared, I worry that brain irradiation will not help you reach these goals. I recommend that that we work towards optimizing your quality of life in other ways that do not include brain radiation, so that you can focus on what's most important to you. If you'd like, I can discuss in more detail what this might look like.*"	Propose a plan based on the patient's values
Juan	"*Yes. That would be helpful.*"	

Table 10 ACE—A general approach to common communication tasks in radiation oncology

Effort of Focus	Assess	Communicate	Empathize
Examples of clinical application	Evaluate the patient's understanding of his/her illness	Establish a shared agenda at the start of the conversation	Recognize verbal expressions of emotion
	Ask the patient what amount and type of information he/she desires	Speak clearly and succinctly	Recognize non-verbal expressions of emotion
	Clarify the patient's expectations of treatment	Be mindful of non-verbal communication cues	Respond to expressions of emotion with empathic statements
	Assess the patient's goals of care and treatment preferences	Avoid medical jargon	Acknowledge the patient's struggles and concerns
	Ask about core values/beliefs	Provide the desired amount of detail	Convey respect for the patient
	Ask about sources of joy and meaning	Ask for permission before sensitive disclosures	Remain present during the patient encounter
	Evaluate psychosocial concerns	Use medical interpreters if there are language barriers	Prioritize listening over speaking
	Evaluate physical concerns	Acknowledge your uncertainty	Practice self-reflection
	Ask about the patient's support systems	Utilize open-ended questions	Align with the patient's goals
	Assess the patient's understanding of the communicated information	Use reflective and summary statements	Convey non-abandonment

Given that evidence affirms that empathic, patient-centered communication improves patient understanding, the patient-provider alliance, quality of life, and the overall quality of cancer care (67) communication skills should be prioritized as a core competency within radiation oncology.

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Footnote

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