Improving Communication and Support in Cancer Care

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A cancer diagnosis leads to many changes and lessons learned, some painfully enlightening. In the United States, 17 million people are living with these lessons,[1] including me. In 2020, at 38 years of age, I was diagnosed with de novo metastatic breast cancer. I continue to practice outpatient family medicine, and my diagnosis changed my approach to patients with cancer.

As family physicians, we often diagnose cancer and guide patients through early steps, which is one of the most difficult times of treatment. Instead of focusing on all the details of treatment and prognosis, it is better to prepare them for the upcoming mental and physical challenges. Patients also benefit from an overview of the timing and types of appointments to come.

Previously, I strove to reassure patients, trying to "fix it," but I learned that it is more important to hold space for pain and validate suffering. Although initially awkward, this approach leads to a deeper understanding of patients and what they are experiencing.

Cancer rips away any semblance of control over one's future. I benefited from reminders to do basic things, and I now encourage my patients to focus on what they can control, such as diet, hydration, and exercise. Urge them to set boundaries, say no to extra tasks, and conserve energy. Remind them it is okay to ask for and accept help, which was one of the hardest lessons for me. Tell them it is okay to not be okay, and there will be days when getting out of bed is an accomplishment.

Give them permission to enjoy life. Despite the expectation that treatment requires suffering, important trips and activities should still be prioritized—finding moments of joy is extremely valuable after a cancer diagnosis.

A study from the patients' perspectives found that two hallmarks of effective communication are a clinician's assistance in navigating emotional turmoil and allowing for discussion of uncertainty.[2] The time immediately following treatment is especially fraught with uncertainty. Patients often feel anxiety regarding recurrence, apprehension about returning to typical responsibilities, and a sense of loss from the decreased frequency of physician visits.[2,3] Educate patients to anticipate this transition and explain the next steps for surveillance.

Research shows that ineffective communication can lead to emotional distress, anxiety, confusion, and decreased quality of life for patients.[2,3] Participating in support groups taught me painful terms to avoid during discussions with patients with cancer. At the top of that list is the term "good cancer." No matter how treatable a cancer may be, there is nothing "good" about it.

We should also be aware of toxic positivity, an overemphasis on staying positive due to the erroneous belief that mindset controls outcome. Often taking the form of empty platitudes, toxic positivity can cause emotional suppression and feelings of shame and isolation.[4] For example, avoid using rhetoric such as "At least it isn't . . . ." Instead, validate the patient's emotions by saying "I know this is difficult. I am so sorry."[5] Additional language suggestions are provided in *Table 1*.[2-4,6,7] Use caution with language that references a battle because "losing the battle" does not correlate with the patient's effort. Wait for patients to use this type of language first, as some do find strength in it.

I also pay more attention to the many adverse effects of cancer, both short- and long-term. Fatigue, sexual adverse effects, and cognitive impairment ("chemo brain") are difficult to quantify and treat, so they are not always addressed.

Managing mental health is also challenging because of the need to differentiate between a psychiatric disorder and a natural response to a life-threatening diagnosis. Although the rate of suicidal ideation is similar to that of the general population, suicide attempts and completion are higher in patients with cancer, with the highest risk soon after diagnosis or surgery.[8]

The financial and social strain affects all aspects of life; therefore, discussing assistance options can

TABLE 1

Potentially Problematic Phrasing When Discussing Cancer Care

Communication styles to avoid	Examples	Instead, say:	Why it matters
Blame language	"Your weight may have contributed to your cancer." "If you improve your diet, the cancer shouldn't come back."	"Let's talk about ways to decrease the risk of the cancer returning, such as diet and exercise changes."	Patients often hear from family, friends, and self-talk that the cancer is their fault. Lifestyle discussions are important, but consider that patients could be particularly sensitive to implications of blame.
Commenting on appearance	"Did you get a haircut?" "You've lost weight!"	Avoid comments on appearance entirely unless the patient brings it up or you know the patient chose the change.	Comments on appearance may be triggering. Short hair can be the result of treatment and not a choice. Weight changes may be due to pain or treatment effects.
Expressing finality at the end of treatment	"You're all done with cancer treatments!"	"Now that treatments are complete, let's talk about next steps for surveillance and follow-up." "How are you feeling about returning to work?"	Cancer and its effects do not end with treatment. Transition to surveillance and survivorship can cause feelings of abandonment and uncertainty about returning to life after treatment.
False reassurance	"It's going to be okay."	"This is really hard. I am here to support you through this."	Cancer is unpredictable, and the ultimate outcome is unknown.
Hero labeling	"You are such an inspiration."	Be specific about what is inspiring (such as when the patient accomplishes a difficult task). For more general comments: "This is a really difficult time, and you are handling it well."	This type of praise is often given when the patient performs basic activities that are necessary for treatment and survival, but it can pressure them to suppress negative emotions.
Minimizing fertility concerns	"At least you can consider adoption."	"Would you like to discuss how this affects your future fertility?" "Would you like a referral to a fertility specialist for patients with cancer?"	Patients with cancer can have complex fertility issues. A cancer diagnosis may require further documentation on health and prognosis when applying for adoption.
Referencing "good cancer"	"The good news is that you have the good cancer."	"There are excellent treatments for this type of cancer."	All cancer is bad to the person hearing that they have it.
Showing unfamiliarity with the diagnosis	"I've never heard of your type of cancer."	"Although I'm not very familiar with this particular type of cancer, I am referring you to someone who is experienced in managing it."	Although it is impossible to know about all potential diagnoses, it is important to connect patients with knowledgeable health care professionals to provide hope and reassurance.
Toxic positivity	"At least it isn't . . . ." "Try to focus on the positive."	"It's okay to not be okay." "It's important to feel and acknowledge your emotions, both good and bad."	Dismissing fears and worries can lead to emotional suppression and feelings of shame and isolation.

Information from references 2-4, 6, and 7.

be impactful. I encourage asking the patient about their support systems because some people are cut off from close family and friends after diagnosis. As family physicians, we are uniquely positioned to support caregivers.[9]

It is important to remember that your patient's goals for treatment may be different from your own. We need to advocate for their priorities and reflect their goals in our approach to treatment. We can improve cancer care by supporting patients through this difficult process, validating their experience, using appropriate phrasing, advocating for goals, and asking about more subtle adverse effects. These lessons enriched my patient-physician relationships and, ultimately, my own well-being.

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