THE PATIENT-PHYSICIAN
RELATIONSHIP

Patient-Physician Communication During Outpatient Palliative Treatment Visits
An Observational Study

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The principal goals of palliative cancer treatment are to prolong the patient's life and to alleviate debilitating symptoms of the disease.1-3 In both cases, health-related quality of life (HRQL) issues, defined in terms of the patient's physical, emotional, and social functioning, and well-being4,5 may be of central importance in selecting among available treatment options and in monitoring the effects of such treatments over time. An essential condition for optimal palliative cancer treatment is that physicians communicate effectively with their patients to obtain as complete a picture as possible of the patients' physical and psychosocial health status.

Although, to the best of our knowledge, no studies have been directed at patient-physician communication regarding HRQL in the palliative treatment setting, there is a substantial amount of literature on the content of patient-physician communication in other medical settings.6-11 Results from these studies indicate that a number of elements play a role in the way in which information is exchanged between physicians and their patients. First, the nature of the symptoms themselves can influence patient-physician communication. For example, Funch,10 investigating the symptom-reporting behavior of colorectal cancer patients, found that 54% of experienced symptoms were spontaneously reported, and that chronic, nonspecific, and mild symptoms were less likely to be discussed than more acute, concrete, and severe symptoms.

Context Improving health-related quality of life (HRQL) is an important goal of palliative treatment, but little is known about actual patient-physician communication regarding HRQL topics during palliative treatment.

Objectives To investigate the content of routine communication regarding 4 specific HRQL issues between oncologists and their patients and to identify patient-, physician-, and visit-specific factors significantly associated with discussion of such issues.


Setting Outpatient palliative chemotherapy clinic of a cancer hospital in the Netherlands.

Participants Ten oncologists and 240 of their patients (72% female; mean age, 55 years) who had incurable cancer and were receiving outpatient palliative chemotherapy.

Main Outcome Measures Patient and physician questionnaires and audiotape analysis of communication regarding daily activities, emotional functioning, pain, and fatigue during an outpatient consultation using the Roter Interaction Analysis System.

Results Physicians devoted 64% of their conversation to medical/technical issues and 23% to HRQL issues. Patients’ communication behavior was divided more equally between medical/technical issues (41%) and HRQL topics (48%). Of the independent variables investigated, patients’ self-reported HRQL was the most powerful predictor of discussing HRQL issues. Nevertheless, in 20% to 54% of the consultations in which patients were experiencing serious HRQL problems, no time was devoted to discussion of those problems. In particular, these patients’ emotional functioning and fatigue were unaddressed 54% and 48% of the time, respectively. Discussion of HRQL issues was not more frequent in consultations in which tumor response was evaluated.

Conclusion Despite increasing recognition of the importance of maintaining patients’ HRQL as a goal of palliative treatment, the amount of patient-physician communication devoted to such issues remains limited and appears to make only a modest contribution, at least in an explicit sense, to the evaluation of treatment efficacy in daily clinical practice.

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Second, patients vary in their willingness and ability to talk about their problems and concerns. Female patients tend to ask more questions and to receive more information than their male counterparts.12,13 Similar results have been reported for patients with relatively high levels of education compared with those who are less well-educated.14

Physicians also vary widely in their interest in and their ability to elicit relevant information from their patients.6,11,12 Levinson and Roter11 found that patients disclose significantly more information about their emotional and social functioning when their physician has a positive attitude toward the psychosocial aspects of patient care. Maguire et al15 found that patient disclosure of psychosocial information was inhibited when physicians used closed-ended questions and when they focused their attention on physical health issues.

Finally, structural factors may play a role in the exchange of information. For example, perceived time pressure may decrease the amount of information exchanged.16-18

Taken together, these studies indicate that patient-physician information exchange may not always be optimal. In particular, nonspecific symptoms and psychosocial issues are often left undressed.19-22 Whether this also holds true for the palliative treatment setting is unclear. Particularly in the realm of palliative treatment, there is increasing recognition that HRQL is an outcome that is as important, if not more important, than traditional outcomes such as survival.22,23 Thus, one might expect more discussion about HRQL issues in the palliative treatment setting, and in particular during consultations in which the effect of the treatment is being evaluated.

In a previous article we described the preferences of cancer patients being treated with palliative chemotherapy and the attitudes and self-reported behavior of their physicians toward discussing HRQL issues.24 In this article, we present results based on actual communication during outpatient consultations. We chose to focus on 4 key HRQL issues affecting the broad spectrum of patients receiving palliative treatment: daily activities, emotional functioning, pain, and fatigue.25

METHODS
Study Sample and Procedures
The patient and physician samples were drawn from the outpatient clinics of the Netherlands Cancer Institute. The physician sample consisted of the physicians working in the department of medical oncology. The patient sample comprised a consecutive series of patients with incurable cancer who were receiving outpatient palliative chemotherapy and who were under the care of one of the participating physicians. Inclusion criteria included the following: older than 18 years, basic proficiency in Dutch, not participating in a concurrent HRQL study, and having received at least 2 cycles of chemotherapy. This latter criterion was applied to increase the likelihood that both the patients' HRQL and, at least in some cases, evaluation of tumor response would be relevant topics for discussion. The institutional review board of the hospital approved the study.

Patients were invited to participate by means of a letter that explained that the study was designed to obtain a better understanding of patient-physician communication during the palliative treatment period. After providing informed consent, patients and physicians were asked to complete several questionnaires. The first subsequent outpatient consultation was audio-taped. The audiotaping procedure was pilot-tested with all physicians and 2 of their patients. The physicians and patients indicated that the audiotaping did not influence their “natural” communication, which is in line with the literature.26 Patients who declined to participate were asked to respond to a brief questionnaire by telephone.

Study Measures
Patients' Characteristics and Self-reported Health Status. Patients' sociodemographic characteristics and their preferences for discussing HRQL issues were obtained by means of a questionnaire.

Preferences were assessed in general terms, rather than in relation to a specific consultation. The response categories were: “No, I would prefer not to discuss this topic”; “Yes, but my physician has to initiate discussion of this topic”; and “Yes, I want to discuss this topic.”

The patients' self-reported HRQL was assessed by means of the COOP/WONCA [Dartmouth Primary Care Cooperative Research Network/World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians] functional health assessment charts assessing physical fitness, emotional functioning, daily and social activities, overall health, and pain.27 Two additional charts assessing fatigue and overall HRQL were also included. The time frame used was the previous 2-week period. Response categories ranged from 1 (excellent) to 5 (very poor). Only the charts assessing patients' daily activities, emotional functioning, pain, and fatigue were used in the current analysis.

Physicians' Characteristics and Attitudes. Questionnaires were used to obtain data on physicians' sociodemographic and professional characteristics and on their perceived responsibility for discussing various HRQL issues with their patients.

Response categories for the latter questions included: “Discussing this topic is completely my task”; “Discussing this topic is partially my task, and partially the task of other health care providers”; and “Discussing this topic is not my task.”

Patient-Physician Communication. Analysis of the audiotaped consultations was conducted by means of an adapted version of the Roter Interaction Analysis System, which places each utterance of the patient and physician into a mutually exclusive category.28,29

The categories are organized into 3 conceptual clusters: process, affective, and content (TABLE 1).

The process cluster includes utterances intended to give direction to the
flow of the visit and facilitate communication. The affective cluster consists primarily of statements that show involvement with the situation. The content cluster includes all statements relating to medical/technical issues, HRQL issues, and administrative issues.

Coding was carried out directly from audiotape by 3 trained raters. All raters coded a random sample of 15% of the audiotapes to assess interrater reliability. The mean interrater reliability was 0.87 (range, 0.66-0.99) for physician categories, and 0.84 (range, 0.64-0.99) for patient categories. These reliability estimates are comparable to those achieved in other studies.30-32

Additionally, a content checklist was used to code whether the selected HRQL topics were discussed at any time during the consultation, regardless of the amount of time devoted to the topic and who had initiated discussion of these topics.

Other Characteristics of the Consultations. The audiotapes were also used to determine if tumor response had been discussed (labeled as an "evaluative" consultation). Also noted were the duration of the consultation and any interruptions that took place. Finally, the waiting time, an indirect indicator of the time pressure under which the consultation took place, was calculated by subtracting the scheduled visit time from the actual time at which the consultation took place.

Data Analysis
Mean percentages of the total utterances devoted to the specific topics of discussion were calculated. Although verbal utterances differed in length, the correlation between the number of utterances and the consultation time was high (r = 0.83). Therefore, the frequency of utterances per topic corresponds approximately to the amount of time dedicated to that topic. To control for differences in consultation time, percentages were used instead of simple frequency counts.

Univariate statistics (t tests and χ² statistics) were used to assess the association between patient, physician, and consultation characteristics and communication about the selected HRQL issues. For purpose of these analyses, patients’ age was categorized into 2 groups (<60 years and >60 years), the response categories of the COOP/WONCA charts were collapsed into 2 categories (no to limited problems vs moderate to severe problems), and the response categories of patients’ preferences and physicians’ attitude were categorized into 2 groups (wanting to discuss, either self- or physician-initiated, vs not wanting to discuss; full responsibility vs partial or no responsibility, respectively).

Because patients were nested within physicians, we considered the use of multilevel analysis in determining those factors related most strongly to the discussion of the selected HRQL issues. However, multilevel analysis requires a minimum of approximately 30 cases in the highest level.33 With only 10 physicians, the use of these methods can lead to inconsistent parameter estimates. To examine differences between physicians, intraclass correlations were computed for the selected outcome measures. All intraclass correlations were nonsignificant and low (intraclass correlation, <0.05), indicating that the variance components between physicians were very small and thus that regression models for the total patient sample would yield unbiased SEs. Therefore, both linear and logistic regression analyses (forward, stepwise procedures) were used to test the simultaneous effect of the independent variables. Variables were included in the regression models if they were associated with the relevant outcomes at the univariate level (P < .10). For all other statistical tests, the significance level was set at P = .05.

RESULTS
Study Sample
All medical oncologists (n = 12) were invited to participate in the study, and 10 agreed. The 2 oncologists who de-
clined raised objections to having their consultations audiotaped. Of the participating physicians, 4 were female, their mean age was 44 years with, on average, 11 years of work experience in oncology (Table 2).

### Table 2. Demographic and Clinical Characteristics of the Study Sample

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Physicians (n = 10)</th>
<th>Patients (n = 240)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mean age, y (range)</strong></td>
<td>44 (35-53)</td>
<td>55 (24-84)</td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td>Male 60</td>
<td>Female 73</td>
</tr>
<tr>
<td><strong>Work experience in oncology, y (range)</strong></td>
<td>11 (2-24)</td>
<td>11 (2-24)</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td>Single, divorced, widowed 21</td>
<td>Married 79</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td>Primary school/lower-level high school 27</td>
<td>Higher school 10</td>
</tr>
<tr>
<td><strong>Primary cancer diagnosis</strong></td>
<td>Breast 47</td>
<td>Lymphoma 10</td>
</tr>
<tr>
<td><strong>Mean No. of prior visits (range)</strong></td>
<td>9 (5-45)</td>
<td>Other 16</td>
</tr>
<tr>
<td><strong>COOP/WONCA charts, mean (SD) score</strong></td>
<td>Physical fitness 3.2 (1.06)</td>
<td>Overall quality of life 3.1 (0.99)</td>
</tr>
<tr>
<td></td>
<td>Emotional functioning 2.3 (1.08)</td>
<td>fatigue 2.9 (0.96)</td>
</tr>
<tr>
<td></td>
<td>Daily activities 2.9 (1.13)</td>
<td>Emotional functioning 2.9 (0.96)</td>
</tr>
<tr>
<td></td>
<td>Social activities 2.2 (1.18)</td>
<td>Daily activities 2.9 (1.02)</td>
</tr>
<tr>
<td></td>
<td>Overall health 3.4 (0.96)</td>
<td>Overall health 2.5 (1.02)</td>
</tr>
<tr>
<td></td>
<td>Pain 2.5 (1.02)</td>
<td>Pain 2.5 (1.02)</td>
</tr>
<tr>
<td></td>
<td>Fatigue 2.9 (0.96)</td>
<td>Fatigue 2.9 (0.96)</td>
</tr>
<tr>
<td></td>
<td>Overall quality of life 3.1 (0.99)</td>
<td>Overall quality of life 3.1 (0.99)</td>
</tr>
<tr>
<td></td>
<td>Mean No. of prior visits (range) 9 (5-45)</td>
<td>Mean No. of prior visits (range) 9 (5-45)</td>
</tr>
</tbody>
</table>

*Data are presented as percentages unless otherwise indicated. COOP/WONCA indicates Dartmouth Primary Care Cooperative Research Network/World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians.

Between June 1996 and January 1998, a total of 382 patients were asked to participate, of whom 273 (71%) agreed. Of the 109 nonrespondents, 50 declined because they thought the study would be too burdensome, 43 indicated insufficient interest or lack of time, and 16 expressed difficulty with the audiotaping. A nonrespondent analysis indicated that patients who declined to participate had less education ($P<.001$) and rated their overall HRQL as significantly lower (mean = 3.7 vs 3.1, $P<.05$) than the participants.

In 33 cases, the consultation was either not recorded due to logistical reasons or the tape recording was of insufficient quality for analysis. Thus, audiotaped consultations of 240 patients were available (between 19 and 30 per physician). Seventy-three percent of the patients were female, with a mean age of 55 years. Patients had a wide range of cancer diagnoses, with breast cancer being the most prevalent. The patients showed substantial variation in scores on the COOP/WONCA charts. All patients had visited their physician previously (mean = 9 previous visits) (Table 2).

### Content of the Consultations

The mean duration of the consultations was 16.09 minutes (range = 4.10-40.25, SD = 6.82), with the physicians and patients exchanging a mean of 264 utterances (range = 35-711, SD = 117). Overall, the physicians generated slightly more discussion than the patients (53.5% vs 46.5%). Approximately one quarter of the physicians’ and patients’ utterances were coded into the process category, and approximately 13% of utterances conveyed emotional affect and social talk.

Slightly more than 60% of all utterances were substantive and fell into the content category. The focus of interest is on the division of topics within this content category. Approximately two thirds of the physicians’ substantive communication was medical/technical; for patients, this was 41%. Physicians and patients devoted approximately one quarter and one half of their substantive conversation, respectively, to HRQL issues, with symptoms (pain, fatigue, and other symptoms combined) being most often discussed (Table 3).

As indicated in Table 4, patients’ daily functioning was discussed in approximately two thirds of the consultations, most often initiated by the physician. Pain was discussed in approximately three quarters of the consultations, with physicians taking the lead half of the time. Fatigue and emotional problems were brought up in 46% and 35% of the consultations, respectively, primarily by the patients. The mean percentage of the physicians’ substantive utterances devoted to these 4 topics was less than 5% per topic. For the patients, the range was from 2.1% (fatigue) to 10.1% (emotional functioning).

### Patients’ Characteristics and HRQL Communication

Emotional problems and pain were discussed significantly more often during consultations with female than with male patients (38% vs 26% and 76% vs 63%, respectively, $P = .05$). No other significant associations were found between patients’ sociodemographic characteristics and HRQL communication.

Detailed results pertaining to patients’ communication preferences are described elsewhere.24 While the large majority (between 80% and 95%) of the patients expressed a desire to discuss the various HRQL topics, no significant associations were found between patients’ preferences and the frequency of actual discussion.
Table 5 shows the relationship between patients' self-reported HRQL and HRQL communication. Emotional functioning, pain, and fatigue were discussed significantly more frequently in those cases where patients reported serious problems in these areas. Nevertheless, it is noteworthy that among those patients experiencing serious emotional problems or fatigue, these issues were discussed in only about half of the cases.

Physicians' Characteristics and HRQL Communication

No statistically significant associations were observed between physicians' age, sex, or years of work experience, and HRQL communication. However, the physicians' attitude toward discussing their patients' emotional problems was reflected in their actual communication behavior. More time was devoted to discussing patients' emotional functioning by those physicians who felt a strong responsibility to do so compared with those who did not (9% vs 6% of total utterances, respectively, P = .04).

Consultation Characteristics and HRQL Communication

The effect of the treatment on tumor growth was addressed explicitly in 60% of the consultations. No significant differences were found in HRQL communication between consultations with or without such an evaluative component. Forty percent of the patients were seen at their scheduled appointment time. Patients' emotional problems were more likely to be discussed during consultations held at the appointed time than during those that were delayed (49% vs 32%, P = .05). In addition, more time was devoted to this issue during the on-time consultations (9% vs 5.5% of utterances, P = .05). This could not be explained by differences in the duration of on-time vs delayed consultations, which was approximately the same (16.4 minutes vs 15.7 minutes, respectively). The length of the consultation, interruptions, and the number of prior visits had no significant effect on HRQL communication.

Multivariate Prediction of HRQL Communication

Multiple linear and logistic regression analyses were performed to test the simultaneous effect of patient-, physician- and consultation-related characteristics on the frequency and duration of communication about each of the 4 selected HRQL issues. Patients' self-reported problems and consultation waiting time emerged as significant predictors of the frequency with which patients' emotional problems were discussed (χ² = 15, P = .009). The percentage of time devoted to discussing emotional problems was related significantly to patients' self-reported problems, consultation waiting time, and the attitude of the physicians (F₅ = 6.7, P < .001) The only variable found to be related significantly at the multivariate level to the discussion of pain and fatigue was the severity of these symptoms as reported by the patients. No variables emerged as significant multivariate predictors of the discussion of patients' daily activities.

COMMENT

The objectives of this study were to describe the content of patient-physician communication during outpatient palliative consultations, and to identify factors that play an important role in the discussion of 4 key HRQL issues: patients' daily activities, emotional functioning, pain, and fatigue.

In general, patients' communication behavior was directed as equally to medical/technical issues (eg, results of blood tests, the dose of the chemotherapy) as it was to HRQL topics. The content of physicians' communication was focused primarily on biomedical/technical issues and, to a lesser degree, on HRQL issues (a ratio of 3:1). This latter finding is in line with results found in other medical settings, suggesting that there is not a substantial difference in HRQL communication.

Table 4. Communication About the Selected Health-Related Quality of Life (HRQL) Issues

<table>
<thead>
<tr>
<th>HRQL Issue</th>
<th>Consultations in Which the Topic Was Discussed, %</th>
<th>Physician Utterances, Mean %</th>
<th>Patient Utterances, Mean %</th>
<th>If Discussed, % in Which the Physician Initiated the Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily activities</td>
<td>64</td>
<td>2.7</td>
<td>7.3</td>
<td>73</td>
</tr>
<tr>
<td>Emotional functioning</td>
<td>35</td>
<td>5.0</td>
<td>10.1</td>
<td>21</td>
</tr>
<tr>
<td>Pain</td>
<td>72</td>
<td>3.7</td>
<td>9.2</td>
<td>52</td>
</tr>
<tr>
<td>Fatigue</td>
<td>46</td>
<td>0.7</td>
<td>2.1</td>
<td>32</td>
</tr>
</tbody>
</table>

Table 5. Relationship Between Self-reported Health-Related Quality of Life (HRQL) and HRQL Communication

<table>
<thead>
<tr>
<th>HRQL Issue (No. of Patients)*</th>
<th>Consultations in Which the Topic Was Discussed, % (P Value)</th>
<th>Utterances Dedicated to the Topic, Mean % (P Value)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited problems (87)</td>
<td>70.5 (.22)</td>
<td>6.0 (.06)</td>
</tr>
<tr>
<td>Severe problems (143)</td>
<td>62.8 (.04)</td>
<td>4.3 (.03)</td>
</tr>
<tr>
<td>Emotional functioning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited problems (151)</td>
<td>30.9 (.04)</td>
<td>6.4 (.03)</td>
</tr>
<tr>
<td>Severe problems (78)</td>
<td>46.3 (.03)</td>
<td>9.5 (.03)</td>
</tr>
<tr>
<td>Pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited problems (139)</td>
<td>66.4 (.03)</td>
<td>4.1 (.04)</td>
</tr>
<tr>
<td>Severe problems (91)</td>
<td>79.6 (.03)</td>
<td>9.2 (.03)</td>
</tr>
<tr>
<td>Fatigue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited problems (83)</td>
<td>34.5 (.01)</td>
<td>1.0 (.20)</td>
</tr>
<tr>
<td>Severe problems (146)</td>
<td>52.0 (.01)</td>
<td>1.4 (.20)</td>
</tr>
</tbody>
</table>

*Number varies due to missing COOP/WONCA chart responses (see Table 2 for expansion of COOP/WONCA). In the first column of data, the association between discussion of HRQL issues ("yes" vs "no") and severity of HRQL problems ("limited" vs "severe") is presented; the χ² statistic was used to generate the P values. In the second column of data, the association between mean percentage of utterances dedicated to a given HRQL topic and severity of HRQL problems ("limited" vs "severe") is presented; the t test was used to generate the P values.
communication between palliative treatment settings and other treatment settings such as primary care and curative treatment.

The discussion of HRQL issues varied depending on the specific topic under consideration. Whereas patients' daily activities and pain were discussed in the majority of consultations, fatigue was discussed in less than half, and emotional functioning in only one third of the consultations. Importantly, the same variation was observed for those consultations in which patients experienced serious problems in one of these domains. Given that most patients with cancer consider these issues to be of importance and wish to discuss them with their physician,24,34-36 these results suggest that patients' communication needs may often be left unmet.

Physicians' attitudes had an observable impact on HRQL communication. Specifically, when physicians did not feel fully responsible for discussing their patients' emotional functioning, it was significantly less likely to be discussed. Additionally, patients' emotional problems were less frequently discussed during consultations that took place behind schedule, probably reflecting concern that their discussion would be too time-consuming. However, no significant differences were found in the duration of consultations as a function of whether or not emotional issues were discussed. Other studies have also failed to demonstrate an effect of the discussion of psychosocial issues on the length of medical consultations.37,38

Despite its high prevalence, fatigue was discussed relatively infrequently and usually at the initiative of the patient. This finding is not unexpected in that previous research has shown that symptoms of a nonspecific and chronic nature are less likely to be discussed.10 Additionally, until quite recently, few therapeutic options were available for combating fatigue. Physicians may be reluctant to address what is often perceived to be an intransigent problem.39

Consistent with the literature, we found that HRQL issues were discussed significantly more often with female than with male patients. This likely reflects sex differences in symptom awareness and reporting. In general, women are more likely than men to rate themselves as being impaired and to report symptoms.40 This is probably the reason that in the regression analyses, after controlling for the severity of self-reported problems, sex was no longer associated significantly with the discussion of HRQL issues.

Contrary to expectations, the type of consultation (evaluative vs nonevaluative) was not related significantly to HRQL communication. This suggests that HRQL issues may play a lesser role, at least explicitly, in decisions surrounding the (dis)continuation of treatment than one would expect given the importance expressed about such issues by physicians.22,40,41 Efforts directed toward increasing the frequency with which HRQL issues are discussed could enhance patient participation in decision-making, as patients often withdraw from communication that is of a very narrow biomedical and technical nature.32,42

Several strategies have been proposed for increasing the likelihood of HRQL issues being discussed during medical encounters. The effectiveness of training programs to enhance physicians' communication skills and/or to encourage patients to verbalize their needs and concerns has been demonstrated.43-45 Recently, interest has been expressed in introducing formal HRQL assessments into daily clinical practice as a means of triggering patient-physician communication.46,47 Promising results have been obtained from several studies of such procedures, although they have been based on self-report data.48,49

Some caution should be exercised in interpreting the results of the current study. First, the study was conducted in a single hospital and, although the patient sample was large, the number of physicians involved was limited. Second, all patients in the current study were white, reflecting the very low incidence of cancer in the relatively young immigrant population in the Netherlands. As ethnicity and culture can influence the patterns and content of patient-physician communication, future studies are needed that use more culturally diverse patient samples. Third, communication with regard to HRQL issues was observed during a single visit to the outpatient clinic. It is possible that patients and physicians had discussed these issues in one of their earlier contacts and, therefore, may not have found it necessary to discuss them again. However, one could argue that each medical encounter should include at least a minimum amount of question-asking by the physician to track changes in HRQL over time.

In conclusion, our results indicate that the likelihood that HRQL issues will be addressed is greater for patients who experience relatively serious problems, whose physician feels a sense of personal responsibility for discussing such issues, and whose visit takes place at the scheduled time. In general, however, only limited attention was paid to HRQL issues, in particular to patients' emotional problems and fatigue, in these patients-oncologist interviews during outpatient palliative treatment. Importantly, HRQL issues do not appear to play an especially prominent role, at least not in an explicit sense, in the evaluation of treatment efficacy.

### Author Contributions

**Study concept and design:** Detmar, Schornagel, Aaronson.

**Acquisition of data:** Detmar, Wever.

**Analysis and interpretation of data:** Detmar, Muller, Aaronson.

**Drafting of the manuscript:** Detmar, Schornagel.

**Critical revision of the manuscript for important intellectual content:** Wever, Muller, Schornagel.

**Statistical expertise:** Muller.

**Obtained funding:** Aaronson.

**Administrative, technical, or material support:** Detmar, Wever.

**Study supervision:** Aaronson, Schornagel.

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