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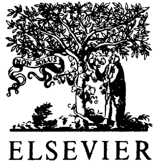

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Patient proactivity enhancing doctor–patient–family communication in cancer prevention and care among the aged

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Abstract

This paper presents a comprehensive conceptual model of health care communication involving three key health care partners: patients, physicians, and significant family members (health significant other, HSOs). A unique feature of this model is its focus on proactive roles played by elderly patients in information gathering and communication with health care partners regarding both cancer prevention and cancer care. We outline how proactive initiatives by health care consumers and involvement of their HSOs can enhance patient outcomes (satisfaction with physician, adherence to preventive and corrective practice recommendations, and quality of life). Finally, we also note primary antecedents of health care partner communication in terms of both medical care context and patient characteristics. We hope that this testable causal model will inform future research in the field of health communication.
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Keywords: Elderly; Cancer communication; Proactivity; Health care consumerism

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1. Introduction

In attempting to improve communication between doctors and patients related to cancer prevention and care, there have been relatively little patient-driven data, particularly based on elderly patients, to help in developing better communication guidelines [1,2]. Present recommendations are largely based on expert (physician) opinions about desirable approaches to communication [3,4]. We present a model that aims to address this gap in knowledge. Our discussion goes beyond the typical focus of the health communication literature on only dyadic interactions, to consideration of interactions among members of a health care triad of physician, patient and health significant other (HSO).

Research has documented that older adults are an underserved population in terms of communication regarding cancer prevention and control [5]. In terms of prevention, doctors are less likely to discuss preventive practices and recommend cancer screening tests to elderly patients than to middle aged individuals [6,7]. In terms of cancer care, physician communication has been found to be largely inadequate in meeting older patients' needs, based on both insufficient information given to patients [4,8] and information presented in a manner too difficult to understand [9]. To better understand factors influencing cancer prevention and care in elderly populations, we propose a comprehensive and testable model of health communication (Fig. 1).

2. Overview of the health care partnership model

The health care partnership (HCP) model we have developed is focused on understanding the influence of communication among health care partners on patient outcomes in both cancer prevention and cancer care. This model considers not only content and relational aspects of doctor–patient communication [10], but also the proactive roles played by patients in information gathering and communication [11]. The role of health significant others in providing advocacy and support is also explored. Communication has been identified as the primary process that can close the gap in power between health care providers and consumers [12]. Thus, we are particularly interested in ways that proactive communication by patients and involvement of HSOs in communication can improve patient outcomes.

The proposed model stops short of including communication between non-physician health care providers (e.g. nurses or social workers) and physicians or patients. Nevertheless, it strives for greater comprehensiveness than typical in empirical research on doctor–patient communication. We recognize that there are both divergences and overlap in the types of variables and causal linkages relevant to communi-

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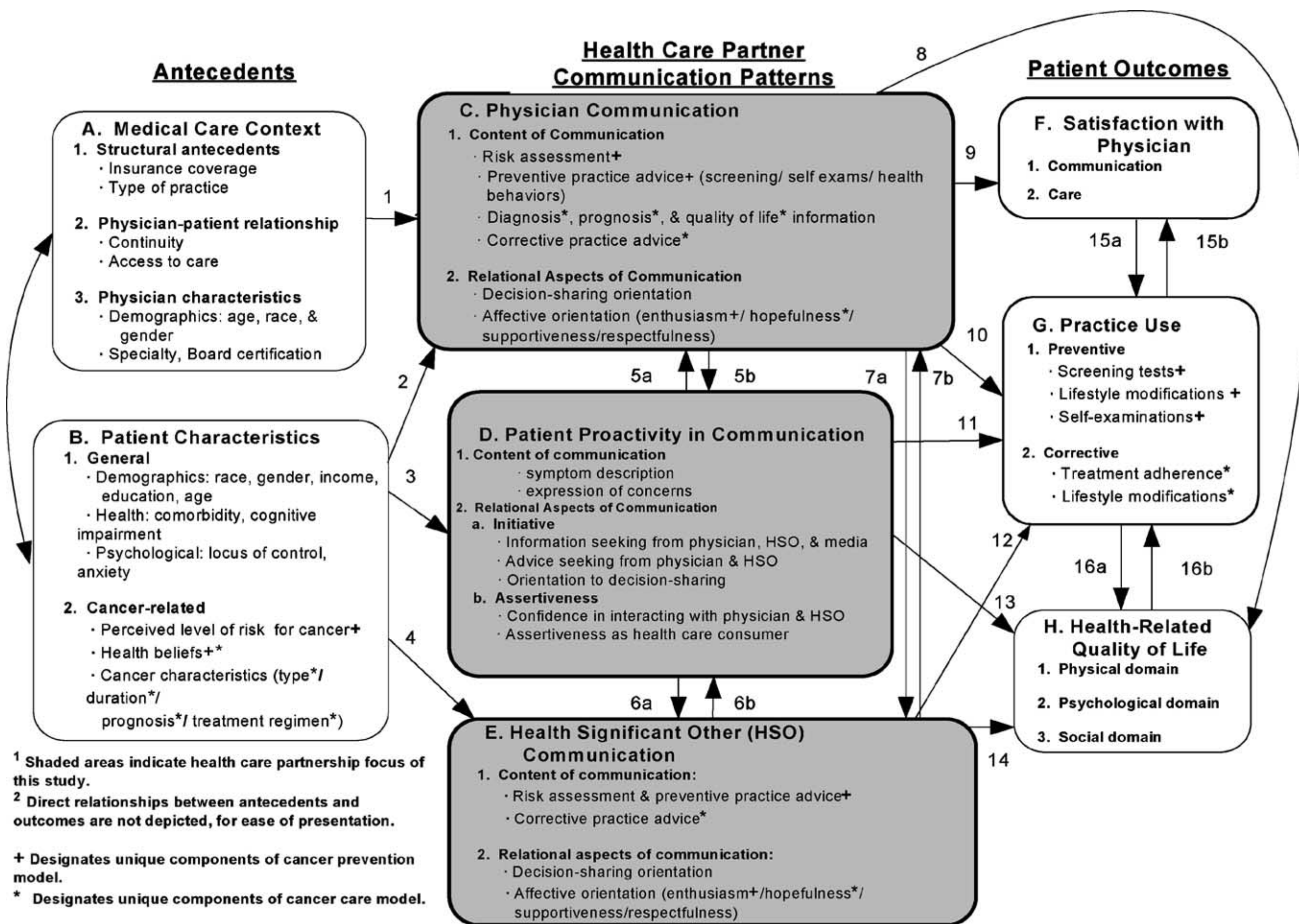

Fig. 1. Health care partnership model of doctor–patient communication with the aged in cancer prevention and care [1,2].

cation in cancer prevention and in cancer care. Our model affords flexibility in considering relationships salient to each of these two areas of communication. At the same time, it maps how communication may span these two distinct areas. Based on longitudinal studies, researchers can test causal sequences proposed in our HCP model of doctor–patient communication (including reciprocal causal relationships).

Our HCP model builds on prior conceptual models. Thus, we incorporate elements from Andersen and Newman's [13] Health Care Utilization model, as we consider the "enabling factors" of continuity and access to medical care and the "need factors" represented by cancer risk or comorbidity. We draw on the Health Belief model [14,15], as we consider the role of patient beliefs in susceptibility to illness and of benefits and deterrents of interventions as they influence adherence to physician's recommendations regarding cancer prevention or cancer care. We also apply Query and Kreps' [16] Relational Health Communication Competence model to older patient provider communication. We focus on two key dimensions proposed in Query and Kreps' [16] communication model: content and relationship. Query and Kreps' [16] model, which posits that the consumer is at the center of the "communication wheel", is further developed in our depiction of the mutual influences among health care partners. Because we visualize older people as crafting strategies to optimize their health that synthesize lay and professional resources [17], we move from a passive model of health care to a participatory, or collaborative, view, which recognizes opportunities for active participation and proactive adaptations by patients [18,19].

2.1. Rationale for model components

Fig. 1 outlines the key causal relationships posited in our model, including reciprocal causal relationships occurring in communication among health care partners. Shaded boxes in the center section of Fig. 1 (boxes C–E) designate central study components representing communication among the three health care partners. The model depicts antecedent as well as sequelae of health care provider communication. However, given space limitations and a desire for ease of presentation, our model does not depict all hypothesized causal linkages and particularly links between antecedents and health outcomes, which are not mediated by communication (e.g. relationships between patient characteristics and health-related quality of life). Moderating relationships and

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expectations of congruence reflecting interaction terms are also not depicted in the model.

The focus of our model is on communication among health care partners (boxes C–E) and the sequelae of their communication in terms of patient outcomes (boxes F–H). A secondary focus of the model is on antecedents of health care partner communication, but rationale for these linkages will only be briefly touched upon in this article (boxes A and B). Our consideration of patient health outcomes is multidimensional, encompassing patient satisfaction, practice use (also referred to as adherence) [20], and health-related quality of life.

Physician communication is defined by two elements proposed in Query and Kreps' [16] communication model: content and relational aspects of communication. For influencing practice use, the content of communication (i.e. the specific practices recommended by the physician) is most important [29], with relational aspects of communication, such as enthusiasm in recommending a screening test, also playing a role [30].

3. Relationship of health care partnership to patient outcomes

3.1. Physician communication (component C)

3.1.1. Prevention

Efforts at cancer prevention subsume risk assessment, early detection, and preventive practice advice. Early detection may be accomplished by screening practices, recommendations for patient self-examination, and early symptom reporting. Preventive health behaviors refer to protective lifestyles, involving risk avoidance [21,22]. There is consensus about appropriate cancer prevention recommendations for many common cancers, particularly breast, colorectal, and skin cancer [23]. Yet, there is insufficient "evidence-based" information for making recommendations to persons in old age groups to permit clear prevention guidelines for physicians [24]. Nevertheless, studies indicate [25] that even when the scientific basis for using screening tests for older patients is uncertain, the standard of care in US communities includes administration of tests generally recommended by the American Cancer Society.

In making preventive recommendations, physicians must consider potential costs and benefits of cancer screening, as well as values and preferences of the patient [26]. Thus, communication between older patients and physicians assumes particular importance. Risk assessment and patients' health beliefs, as well as patient initiatives in discussing preferences regarding preventive practices, can influence specific preventive recommendations made by the physician and also patient adherence to recommendations [27,28].

Physicians' communications to their patients during medical visits are an important determinant of satisfaction with care (path 9 in Fig. 1) [33]. Physicians who elicit patients' opinions about diagnostic or treatment options receive higher ratings of patient satisfaction with care [34]. Physician communication also impacts on preventive practice use (path 10). Patients are more likely to adhere to instructions and advice from physicians who give clear and enthusiastic communication, and who show emotional support and concern [34,35]. The supportiveness and respectfulness of physicians' communication are also expected to contribute to an improved health-related quality of life among patients [36] (path 8). The type of advice given is likely to differ depending on perceived familial or lifestyle-related risk of a given patient for the type of cancer being considered [31], and based on costs and benefits of screening practices recommended [32].

3.1.2. Care

In the cancer care component of our model, we primarily focus on the patient's experience with three key content areas of physician communication: disclosure about cancer diagnosis and prognosis, and discussions about maintenance of quality of life and decision sharing about treatments. Both content and relational aspects of communication are expected to influence patient outcomes in cancer care (paths 8–10). We consider content of communication in terms of the amount of information disclosed by the physician and types of corrective practice advice provided about treatment and lifestyle modifications. Decision sharing orientation of the physician is reflected in the degree to which the patient and his or her family are involved in decision making about treatment and general patient care. Additionally, relational components of communication are considered in terms of affective components of support, respectfulness, and hopefulness expressed by the physician.

Most patients want to be told about the diagnosis of cancer and the nature of their disease [37]. Most physicians in the US disclose the cancer diagnosis to patients, but there are inconsistencies in the amount and type of information provided to patients about prognosis, treatment options, and quality of life [38]. Because patients diagnosed with cancer are typically in a crisis situation, the content of physicians' communication is anticipated to be more complex than in encounters dealing with prevention [39,40]. Relational components of communication, such as support and reassurance as well as decision sharing orientation, are expected to assume particular importance [38].

Physician communication affects patients' satisfaction with cancer care (path 9). For example, physicians who communicate personal interest, empathy, mutual respect, and honesty, and are not overly pessimistic, are more likely to have satisfied patients [4], and these patients adhere to treatment regimens and lifestyle modifications [41] (path 10).

Communication of information to patients about their disease and treatment options is important in allowing patients to gain a sense of control and maintain better quality of life (path 8) [41], and maintain psychological well being [42]. Because all cancer patients are expected to ben-

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efit from affective support, positive relational communication is expected to have a “main effect” on outcomes. In contrast, patients differ in their preferences for communication of information, and hence, the latter construct is viewed in “interaction” terms. Multiple physicians, including surgeons, procedural specialists, and oncologists, are likely to be involved in cancer diagnosis and care. We anticipate that the support patients perceive from formal health care partners (e.g. primary care physician and oncologist) should be cumulative in its positive effects on outcomes. In testing the proposed model, studies should ideally incorporate data on health care partner communications including the key treating physicians.

3.2. Patient proactivity in communication (component D)

3.2.1. Prevention

The HCP model of communication is predicated on the understanding that the more actively patients are involved in health communication with their physicians, the better their health outcomes will be [43]. We recognize that content of communication of patients may range widely from symptom description to expressions of concerns about their illness. In terms of patient proactivity, we focus on two key, relational elements of patient’s health communication: initiative and assertiveness. These qualities are reflected in patients seeking out medical information from multiple sources, including HSOs and the media [12]. Additionally, patient proactivity in communication involves assertiveness in acting as health care consumers and in seeking to take an active role in medical decision making [11]. While older patients may be less proactive than their younger counterparts, increasingly educated cohorts of older adults have been assuming more active orientations in their interactions with their doctors [44].

We anticipate that patients’ proactivity in communicating with their physicians and HSOs will affect the communication they receive as well as their satisfaction, practice use, and quality of life. Patients who elicit the active involvement of their physicians are likely to receive encouragement for expressing their screening preferences (paths 5a and 5b). We recognize that the medical sociological and health services literature typically places responsibility on the physician for assessing patients’ preferences [34]. Nevertheless, there is growing evidence about the limited initiatives physicians take to solicit patient input [45]. Consequently, we present a consumer-focused model of patient–physician communication suggesting patient empowerment, proactivity, and initiative as critical facilitators of satisfactory doctor–patient communication and important avenues for enhancing patient-responsive care [11]. Patients who actively solicit opinions from their HSOs are expected to receive more advice on asking physicians the appropriate questions (paths 6a and 6b). Furthermore, patients who are more assertive and involved in communication with their physicians are expected to be more adherent to cancer screening recommendations [46] (path 11). A patient’s proactivity in communication with his/her HSO is likely to play a secondary, but still important, facilitative role in contributing to patient satisfaction with care, adherence to preventive practice recommendations, and a higher quality of life.

Seeking information from the media is an important strategy utilized by proactive patients. The Internet provides ready access to desired information about cancer prevention. In fact, searching for health information or health-related support is among the most frequent reason for older adults’ use of the Internet [47]. Even as we acknowledge the value of information available through the media, it should also be noted that accurate and user-friendly information is not available for many important decisions involved in cancer prevention or cancer care [48].

3.2.2. Care

Proactive information-seeking behavior is also a useful coping strategy for those living with cancer [49] and is generally expected to elicit responsiveness in communication from both physicians and HSOs (paths 5a and 6a). The stressful impact of cancer at times makes it difficult for patients to play proactive roles, so the extent of patient proactivity may change with phases of the illness and of treatments. Major areas of investigation concerning physician–patient communication in cancer care involve information sharing and the treatment decision-making process. While most patients want to be given full information about their condition, people vary in how much they wish to participate in making decisions about their treatment [8,50]. Even though doctors are preferred as a source of information about cancer treatment, information from the media is also widely used [51]. Older adults who have been socialized not to challenge medical authority may be more comfortable in seeking answers to their care-related questions from informal sources, such as self-help groups and the Internet [52]. Information obtained from informal sources may be incorporated into patients’ discussions with their physician (path 5a). Accordingly, the older cancer patient, who is an informed health care partner and who shares the decision-making role with his or her physician, is becoming a more common reality [53]. Such informed patients are also likely to demonstrate greater levels of adherence to treatment regimens [54] (path 11).

3.3. HSO communication (component E)

3.3.1. Prevention

Family members and friends serve as powerful influences on the health behaviors of older adults. They provide informational, affective, and instrumental support, which facilitate the pursuit of healthy lifestyles and adherence to the preventive practice recommendations of physicians [55,56]. HSOs may also facilitate proactive consumer roles by patients, by helping them obtain health information from the

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media (path 6b). HSOs advocate during medical visits and make consumerist statements in triadic interactions (path 7b) [43]. The patient may also arrive at the physician's office armed with questions relevant to screening or other preventive services based on suggestions by their HSO. HSOs can also play helpful roles in supporting lifestyle changes that can contribute to prevention of cancer (e.g. using protection in the sun), as well as in secondary prevention activities, such as self-examination and screening (path 12) [57]. HSOs can also influence health beliefs in the efficacy of preventive practices, by recommending for or against such services [25].

3.3.2. Care

When older patients are dealing with cancer diagnosis or treatment, the role of the HSO gains further importance as part of a health care communication triad, comprised of the elder, their physician, and health significant other [58]. The HSO (who may also act as a caregiver) is often an integral part of visits to the physician during discussions of treatment plans (paths 7a and 7b) [59], and may facilitate patient adherence to physician recommendations about treatment and lifestyle modifications [54] (path 12). HSOs often play an important role in influencing patient decision making by encouraging or discouraging adjuvant chemotherapy or radiation therapy [60]. During medical visits, HSOs may act as allies or advocates for the patient (path 7b), and may encourage patient proactivity (path 6b). HSOs also typically accompany patients for radiation and chemotherapy treatments and communicate support, enhancing patients' quality of life (path 14). The involvement of an HSO is generally viewed by patients as facilitative and they often turn to HSO's to consult them on treatment decisions (path 6a). However, at times HSO involvement could also have a negative impact, as it may reinforce patients' feelings of dependency and loss of personal control, and may be perceived as interfering with communication with physicians [61].

4. Antecedents to physician communication and patient proactivity

Structural aspects of the medical care context play an important role in the content of preventive recommendations of physicians (path 1). For example, out-of-pocket costs and lack of supplemental insurance coverage constitute major barriers to obtaining preventive cancer screening, such as mammograms [62]. Structural constraints on physicians' time may limit attention delivered to both content and relational aspects of communication in dealing with patients diagnosed with cancer [63].

Patient characteristics and particularly personal resources influence physician communication about prevention and care (path 2). Minority status, low income, and limited education are thus related to obtaining less extensive communication from physicians [64].

Demographic, health and psychological characteristics of patients are also related to their proactivity in communication (path 3). For example, patients' psychological characteristics are likely to impact their orientation to information seeking and decision making. Specifically, older adults, men, individuals with less education, and those of lower socioeconomic status prefer to receive less information about preventive care, their conditions, or about chance of cure from their physicians [41,65]. Similarly, older adults, men, individuals with less education, and people with multiple co-morbidities prefer to let the doctor decide on the best preventive screenings or treatment options [41,65].

The personal characteristics of older adults are also likely to affect their practice use. The health beliefs of patients about susceptibility to illness and efficacy of screening serve as powerful influences to deter or facilitate patient adherence to preventive recommendations [67].

5. Antecedents to HSO communication

More educated older adults and those with higher incomes tend to be provided with more extensive information by their HSOs and are invited to play more proactive and assertive roles in communicating with their physicians [68] (path 4). Among cancer patients, women, less educated persons [68], patients who are in treatment longer [69], and patients with mental health problems [70] have been shown to be given more support by HSOs.

6. Conclusion

The framework we propose here aims to provide a testable model for describing antecedents, components, and sequelae of communications related to cancer prevention and care among aged patients and their formal and informal health care partners. It is our hope that the availability of such models will facilitate empirical research to enhance scientific understandings of cancer relevant communication in health services research. Although our model is focused on elderly patients and their health care partners, we believe that model components are applicable to cancer patients of all ages. Our ultimate hope is that model development, research, and dialogue among professionals interested in communication about cancer prevention and cancer care will lead to development of guidelines for policy and clinical practice which will further better health and quality of life for patients with cancer.

The focus of this paper has been on previously little-emphasized opportunities that patients have in influencing communication with their health care providers, and particularly, with their physicians. Our interest in highlighting the proactive role of the consumer is not based on a disregard for the critical roles of the physician, of other health care providers, and of family and friends in fostering good com-

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munication. It is clearly seen as desirable for physicians to elicit their patients concerns and respond to them. We urge improvements in health care delivery and physician education, but believe that patients can enhance health communication “deficiencies” through proactive initiatives by soliciting, demanding, and reinforcing patient responsive care [11].

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