

Communication preferences and perceptions of cancer patient during their first medical oncology appointment

Rodrigo Santos Vicente^{1,2}  | Ana Rita Freitas¹ | Ricardo Miguel Azevedo Ferreira¹ | Sofia Parada Prada¹ | Telma Sofia Martins¹ | Telma Caleça Martins¹ | Ana Duarte Mendes¹ | Marina Miguel Vitorino¹ | Andreia Filipa Chaves^{1,3} | Catarina Castro Santos⁴ | Diogo Alpuim Costa^{3,4,5}  | Maria Paula Custódio¹ | Miguel Barbosa^{6,7}

¹Hospital Professor Doutor Fernando Fonseca, Medical Oncology, Amadora, Portugal

²Faculty of Medicine, University of Lisbon, Lisbon, Portugal

³CUF Oncologia, Haematology and Medical Oncology, Lisbon, Portugal

⁴Hospital de Cascais Dr. José de Almeida, Medical Oncology, Alcabideche, Portugal

⁵NOVA Medical School, NOVA University Lisbon, Lisbon, Portugal

⁶Faculty of Psychology, ULisboa CICPSI, Lisbon, Portugal

⁷ISAMB, Faculty of Medicine, ISAMB, Lisbon, Portugal

Correspondence

Rodrigo Santos Vicente, Avenida Brasil, n°72, 5 direito, 2700-134 Amadora, Portugal.
Email: rodrigovicente92@gmail.com

Abstract

Background: The first medical oncology appointment serves as a platform for patients to comprehend their diagnosis and prognostic implications of cancer. This study aimed to determine patients' communication preferences during their first medical oncology appointment and to assess the disparities between patients' preferences and perceptions.

Methods: A total of 169 cancer patients participated by completing the Communication in First Medical Oncology Appointment Questionnaire (C-FAQ), a two-section questionnaire designed to assess patients' preferences and perceptions regarding Content (information provided and its extent), Facilitation (timing and location of information delivery), and Support (emotional support) during their first medical oncology appointment. A comparative analysis was conducted to assess the variations between preferences and perceptions.

Results: Content emerged as the most significant dimension compared to Facilitation and Support. The physician's knowledge, honesty, and ability to provide clear information were considered the most important attributes. Patients evaluated most of their preferences as "very important". Patients' perception of the communication dimensions present during their appointment was below preferences for 11 items, indicating significant discrepancies in clinical practice.

Conclusions: Patients highly valued their preferences concerning Content, Facilitation, and Support dimensions of communication. However, patient preferences were more prominently oriented towards the Content dimension. The discrepancies between preferences and perceptions should be viewed as an opportunity for enhancing communication skills through training.

This is an open access article under the terms of the [Creative Commons Attribution](https://creativecommons.org/licenses/by/4.0/) License, which permits use, distribution and reproduction in any medium, provided the original work is properly cited.

© 2023 The Authors. *Psycho-Oncology* published by John Wiley & Sons Ltd.

KEYWORDS

cancer, doctor-patient relationship, health communication, oncology, preferences, psycho-oncology

1 | INTRODUCTION

Effective communication involving the physician, patient, and family is crucial for meeting patient needs and providing safe, high-quality, and patient-centred care.¹ Communication plays a role in regulating patients' emotions, facilitating comprehension of information, and identifying patients' perceptions and expectations.²

In the oncological setting, patients are thrust into a whirlwind of diagnostic tests, invasive procedures and complex treatments, leaving them with little opportunity to process their circumstances.³ Physical, emotional, social, and financial concerns are expected to impact individuals and their families. Indeed, discussions about patients' losses and suffering can be particularly challenging, given the number of potentially unfavourable events over time.⁴ Physicians often struggle to determine how much information to disclose to the patient and acknowledge a lack of expertise in delivering bad news.⁵

Beyond the diagnosis, numerous situations throughout the cancer journey present challenges, encompassing relapses, disease progression, subsequent lines of therapy, toxicities, treatment delays, and the definitive suspension of antineoplastic therapies.^{6–8} The bad news perception correlates with patients' stress and anxiety levels, their ability to manage adverse information, their satisfaction with care, and their adjustment to health outcomes.^{9,10} Inadequate doctor-patient communication skills can lead to psychological distress, including heightened anxiety and depression, and hinder effective psychological adaptation to cancer.¹¹

Several protocols outline how physicians should prepare for delivering bad news, the manner in which they should provide the information and the appropriate physical environment for discussions.^{12–14} For the disclosure of negative information to cancer patients about their condition, the SPIKES protocol was outlined by Baile et al.¹³ This acronym denotes (i) Setting up the interview, (ii) assessing the patient's Perception, (iii) obtaining the patient's Invitation, (iv) providing Knowledge and information to the patient, (v) addressing the patient's Emotions, and (vi) Strategy and Summary.¹³ Limited evidence exists regarding adherence to these tools and the impact of their use on patients' satisfaction. Furthermore, evidence suggests differences between doctors' and patients' preferences regarding delivering bad news.⁹

Several studies have aimed to deepen our understanding and evaluate, from the patient's perspective, the communication process required when receiving bad news. The Measure of Patients' Preferences questionnaire (MPP) was developed to assess patient preferences regarding Content, Facilitation, and Support.⁴ The Marburg questionnaire applied the Breaking Bad News Scale, incorporating questions aligned with the six dimensions of the SPIKES protocol.⁹ In this study, only a minority of the interviewed cancer patients expressed satisfaction with the communication process. The SPIKES

protocol did not fully address all the needs of the study population, resulting in a disparity between the information delivered and how it was conveyed, as well as patient preferences.⁹

Beyond the delivery of the diagnosis, the first medical oncology appointment represents a pivotal moment in the trajectory of the oncological disease. Typically, it is a stressful occasion during which the diagnosis and prognosis are discussed or confirmed. Many patients already possess their diagnosis but lack further information regarding the implications of cancer on their lives. Therapeutic strategies, potential side effects, and short- and long-term complications can also be addressed. Furber et al. examined how patients perceived their initial oncology consultation and how the emotional context could impact their informational requirements.¹⁵ Their findings revealed that patients' emotions and anxieties might curtail their inclination to seek more information to obviate distress. Additionally, age, sex, education, and cultural background have influenced communication preferences and truth-telling practices.^{4,9,16}

Social support is important in addressing psychological challenges like anxiety and depression, both prevalent among cancer patients.¹⁷ It could be pertinent to identify patients at heightened risk due to psychosocial vulnerability stemming from inadequate social support. Additionally, comprehending how social factors can impact communication is crucial.¹⁸

It is essential to develop strategies to gather information and meet patients' needs according to their perspective on the first medical oncology appointment. This approach not only aids in mitigating the challenges of the appointment itself but also contributes to enhanced medical care outcomes and knowledge generation.¹⁵

This study aimed to evaluate patients' communication preferences during their first medical oncology appointment. It also assessed patients' perceptions regarding the communication elements present in their first encounter with an oncology appointment. Additionally, it identified disparities between patients' reported perceptions and preferences in this context.

2 | METHODS

2.1 | Participants

A comprehensive survey was conducted on 169 outpatients from the Medical Oncology Department of *Hospital Professor Doutor Fernando Fonseca* (HFF), Portugal. All patients were 18 years or older and had received a cancer diagnosis (whether newly diagnosed, facing relapse, or experiencing disease progression). Moreover, all participants were proficient in the Portuguese language and capable of providing written informed consent. Exclusion criteria included patients with dementia or cognitive impairment.

2.2 | Instruments

Demographical variables such as age, sex, marital status, country of origin, qualifications and occupation were collected. Furthermore, the study encompassed the following clinical variables: tumour location, disease status, intended treatment approach, and the duration from diagnosis to the first appointment.

The C-FAQ (Communication in first oncology appointment questionnaire) was developed within this study to assess patients' communication preferences and perceptions during the first medical oncology appointment. The questionnaire comprises two sections. The first section includes 49 items to assess patients' preferences concerning a range of doctor-patient communication elements, which are derived from the MPP and Marburg Breaking Bad News Scale. The subsequent section includes 40 items, identical to those in the first part, designed to assess patients' perception of the communication elements present during their initial appointment. Participants rated items in both sections using a Likert scale ranging from 0 ('not at all') to 4 ('entirely'). The items in both sections were categorised according to Parker et al. (2001) into Content (the information provided and its extent; $\alpha = 0.93$), Facilitation (contextual variables and setting; $\alpha = 0.92$), and Support (emotional support during the interaction; $\alpha = 0.85$).

The Hospital Anxiety and Depression Scale (HADS) was used to assess psychological morbidity and as a screening tool for anxiety and depression. It includes two subscales that individually measure depression and anxiety, each comprising 7 items rated on a 4-point severity scale.¹⁹

The Social Support Questionnaire–Short Form (SSQ6) is a 6-item measure of social support. Each item poses a question that elicits a two-part response: Part 1 asks participants to indicate the number of individuals (ranging from 0 to 9) available for support in specific circumstances, and Part 2 asks participants to rate their satisfaction (ranging from 0 “not satisfied” to 9 “fully satisfied”) with these individuals. The SSQ6N indicates the perceived support index available, while the SSQ6S represents the satisfaction index concerning that support.²⁰

2.3 | Procedure

A cross-sectional study was designed. Starting from 20th January to 20 November 2022, the research team documented all incoming requests for new medical oncology appointments. After the first appointment, the research team engaged with patients and assessed their eligibility. During this process, the researchers maintained no involvement in the patients' care. The questionnaire was delivered to the patients for completion in their homes, with a stipulated return timeframe of 3 weeks.

The Research Ethics Committee of HFF approved this study (002/2022).

2.4 | Statistical analysis

A descriptive analysis was conducted to describe the demographic and medical characteristics of the sample. A repeated measure t-test was conducted to compare the dimensions of Content, Facilitation, and Support. To compare patients' communication preferences with their perceptions during the first appointment, a paired sample t-test was carried out on the subset of items that garnered the highest ratings of “very important” above the median. An ANOVA test was used to assess differences in preferences according to sex, marital status, tumour location, disease status, treatment approach, country of origin, qualifications, occupation, and HADS scale. Pearson's correlation assessed potential associations among the three dimensions (Content, Facilitation, and Support) and variables such as age, duration from diagnosis to the first appointment, and SSQ6N and SSQ6S. All the statistical analyses were performed using the SPSS software version 27.

3 | RESULTS

A total of 191 questionnaires were distributed, and 169 (88.5%) were returned. Among these, 163 (96.4%) were either fully completed or had less than 10% missing answers. The remaining questionnaires had over 50% of the answers missing, rendering them unsuitable for analysis. The primary reason for non-return was the lack of psychological or emotional capacity required to complete the questionnaire.

Table 1 presents the demographic and medical characteristics of the participants. Participants' ages ranged from 22 to 88 years, averaging 64.5 years ($SD = 12.10$). The most prevalent diagnoses included gastrointestinal cancer, breast cancer, lung cancer, or other thoracic tumours. Among all patients, 89.6% received a recent cancer diagnosis. The average duration since diagnosis was 7.3 months ($SD = 23.10$), with 70.6% of diagnoses occurring within 3 months before their first appointment.

Depression and anxiety scores (assessed through HADS) and social support levels (assess through SSQ6) were measured through patient-reported outcomes. The findings show that 80.4% of the sampled individuals reported a depression score of eight or higher. Over 50% of patients reported an anxiety score of eleven or higher, signifying the presence of severe anxiety symptoms. The averages of the two subscales SSQ6N and SSQ6S showed no statistically significant differences ($p = 0.140$).

3.1 | Patients' preferences concerning content, facilitation and support elements of communication

The C-FAQ items were predominantly assessed as “very important” [Mdn 65.85% (11.525)]. The most highly ranked statements exceeding the median are presented in Table 2 according to the three dimensions of Content, Facilitation, and Support, along with the

TABLE 1 Demographical and medical characteristics of participants ($n = 163$).

Age, mean in years (SD)	64.5 (12.1)
Sex, n (%)	
Male	83 (50.9%)
Female	80 (49.1%)
Marital status, n (%)	
Married or living with partner	112 (68.7%)
Widowed	18 (11%)
Single	18 (11%)
Divorced	15 (9.2%)
Country of origin, n (%)	
Portuguese	134 (82.2%)
Portuguese-speaking African countries	20 (12.3%)
Others	9 (5.5%)
Qualifications, n (%)	
Primary school	95 (58.2%)
High school	44 (27%)
Graduate	18 (11%)
No formal qualifications	6 (3.7%)
Occupation, n (%)	
Retired	77 (47.2%)
Employee or self employed	61 (37.4%)
Unemployed	20 (12.3%)
Unknown	5 (3.1%)
Tumour location, n (%)	
Gastrointestinal	57 (35%)
Breast	36 (22.1%)
Lung and other thoracic locations	31 (19%)
Urological	25 (15.3%)
Gynaecological	10 (6.1%)
Head and neck	4 (2.5%)
Disease status, n (%)	
New diagnosis	146 (89.6%)
Progression	9 (5.5%)
Relapse	7 (4.3%)
Unknown	1 (0.6%)
Curative approach, n (%)	
Yes	87 (53.4%)
No	65 (39.9%)
Unknown	11 (6.7%)
Time from diagnosis to first appointment, n (%)	
<3 months	115 (70.6%)

TABLE 1 (Continued)

[3,6] months	29 (17.8%)
[6,12] months	7 (4.3%)
≥12 months	12 (7.4%)
Time from diagnosis to first appointment, mean in months (SD)	7.3 (23.1)
HADS depression scoring, n (%)	
<7/Normal	32 (19.6%)
8–10/Borderline case	113 (69.3%)
11–21/Abnormal case	18 (11%)
HADS anxiety scoring, n (%)	
<7/Normal	10 (6.1%)
8–10/Borderline case	61 (37.4%)
11–21/Abnormal case	92 (56.4%)
SSQ6N, mean (SD)	4.22 (2.3)
SSQ6S, mean (SD)	4.21 (0.91)

Abbreviations: HADS, Hospital Anxiety and Depression Scale; SSQ6N, Index of available support perception in Social Support Questionnaire Short Form; SSQ6S, Index of satisfaction with social support in Social Support Questionnaire Short Form.

frequency of “very important” responses. Of these, 50% pertained to Content items; 30% related to Facilitation; and 20% associated to Support. All percentages obtained regarding communication preferences are available in Appendix 1.

Upon analysing the three dimensions of patient-reported preferences, significant differences were found between Content, Facilitation, and Support. Content ($M = 3.69$, $SD = 0.35$) emerged as the most important component when compared with Facilitation ($M = 3.56$, $SD = 0.39$), ($t(30.13) = 17.38$, $p < 0.001$), and Support ($M = 3.46$, $SD = 0.44$), ($t(24.14) = 7.12$, $p < 0.001$). Facilitation was considered more important than Support ($t(24.14) = 16.42$, $p < 0.001$).

Regarding Content, patients often rated as “very important” physicians' knowledge and honesty, along with receiving clear and comprehensible information about their condition and detailed insights into treatment options.

Within the Facilitation dimension, patients attributed the highest level of importance to the doctor's concern about the clarity and amount of information regarding cancer and treatments. Moreover, patients valued their involvement in treatment decisions and appreciated facilities such as a physical space tailored to their needs, as well as the convenience of posing questions before their next appointment.

In terms of Support, being understood and actively listened to, as well as having the doctor express concerns, were also regarded as highly important. However, fewer patients considered it “very important” to have other healthcare professionals present or to receive assistance in discussing cancer with others.

TABLE 2 Percentage of responses regarding communication preferences relating to Content, Facilitation and Support.

	Very important (%)
Content	
The doctor is up-to-date on research on my type of cancer	79.1
The doctor is honest about the severity of my condition	78.5
I am given information in simple, clear language	77.9
The doctor tells me the best treatment option	77.2
I feel confident about my doctor's skill	75.9
The doctor gives me as much information as possible about my cancer	74.8
I am given detailed information about the results of medical tests	74.6
The doctor explains the impact of treatment options on my daily life	73.5
The doctor talks clearly about the course of my oncological disease, according to the information he or she has	72.8
The doctor lets me know all the different treatment options	70.6
Facilitation	
The doctor asks me what I want to know about my cancer	72.8
The doctor makes sure I understand everything that is said	70.2
The space where the consultation takes place is suitable for my needs	68.1
The doctor lets me know how I can contact them to ask questions or to express my concerns before the next appointment	67.5
The doctor asks what I want to know about treatment options	66.7
The doctor gives me all the information in a logical order	66.3
Support	
The doctor truly listens to me	69.9
The doctor tries to understand my concerns	69.6
The doctor expresses concern for me	69.6
I can have a companion at the consultation	66.3

Note: This table only included the items ranked as "very important" above the median in terms of preferences.

3.2 | Comparison of patients' communication preferences with perceptions

The findings in Table 3 show patients' preferences with the highest ratings alongside their perceptions during the initial medical oncology appointment. A paired-sample *t*-test was used to compare patients' communication preferences and perceptions. Eleven items showed significantly higher 'entirely' ratings on the preferences side. Most of these items were related to the Content dimension (54.5%).

3.3 | Correlations between patients' preferences and demographic and medical variables

A significant and negative correlation was found between the 'time from diagnosis to first appointment' and the Support dimension ($r = -0.19$, $p < 0.050$), suggesting that the more time elapsed since diagnosis, the less support is needed during the first appointment. No

significant correlations were observed between age or either of the two subscales SSQ6N and SSQ6S, and patients' communication preferences.

Similarly, no significant differences were observed in means among Content, Facilitation, or Support dimensions concerning the patient's age, sex, marital status, tumour location, disease status, country of origin, qualifications, occupation, treatment approach, or HADS subscales outcomes.

4 | DISCUSSION

This study assessed patients' perceptions of the communication elements related to Content, Facilitation, and Support dimensions that were present during their first medical oncology appointment. Additionally, it aimed to investigate the differences between patients' perceptions and their preferences in this context. The findings indicated that the Content dimension was deemed the most important.

TABLE 3 Comparison of highest-rated patients' communication preferences with perceptions in the first medical oncology appointment.

	Preferences M (SD)	Perception M (SD)	t (160)	p	Cohens' d
The doctor is up-to-date on research on my type of cancer (C)	3.79 (0.41)	3.53 (0.68)	4.70	<0.001	0.73
The doctor is honest about the severity of my condition (C)	3.77 (0.46)	3.66 (0.51)	2.49	0.014	0.57
I am given information in simple, clear language (C)	3.78 (0.42)	3.81 (0.39)	-1	0.319	0.47
I feel confident about my doctor's skill (C)	3.76 (0.43)	3.63 (0.53)	2.7	0.008	0.61
The doctor gives me as much information as possible about my cancer (C)	3.74 (0.45)	3.61 (0.71)	2.13	0.035	0.74
I am given detailed information about the results of medical tests (C)	3.76 (0.44)	3.62 (0.67)	2.43	0.016	0.66
The doctor talks clearly about the course of my oncological disease, according to the information he or she has (C)	3.72 (0.46)	3.65 (0.54)	1.41	0.160	0.62
The doctor asks me what I want to know about my cancer (F)	3.73 (0.45)	3.61 (0.71)	2.146	0.033	0.68
The doctor tells me how my cancer could affect my daily routine (C)	3.69 (0.50)	3.41 (0.79)	3.9	<0.001	0.91
The doctor makes sure I understand everything that is said (F)	3.70 (0.48)	3.58 (0.62)	2.09	0.039	0.67
The doctor truly listens to me (S)	3.70 (0.46)	3.64 (0.5)	1.42	0.158	0.56
The doctor tries to understand my concerns (S)	3.68 (0.49)	3.56 (0.65)	2.64	0.009	0.73
The doctor expresses concern for me (S)	3.69 (0.48)	3.59 (0.58)	1.85	0.067	0.65
The doctor describes my treatment options in detail (C)	3.66 (0.53)	3.57 (0.64)	1.4	0.164	0.76
The reason for the appointment is explained (C)	3.66 (0.56)	3.75 (0.44)	-1.82	0.071	0.61
The space where the consultation takes place is suitable for my needs (F)	3.52 (0.59)	3.70 (0.46)	-3.74	<0.001	0.61
The doctor lets me know how I can contact them to ask questions or to express my concerns before the next appointment (F)	3.66 (0.53)	3.51 (0.78)	2.46	0.015	0.82
The doctor asks what I want to know about treatment options (F)	3.64 (0.58)	3.39 (0.86)	3	0.003	0.90
The appointment takes place in a private place (F)	3.56 (0.59)	3.70 (0.53)	-3.01	0.003	0.58
I can have a companion at the consultation (S)	3.53 (0.82)	3.66 (0.65)	-0.74	0.46	0.56

Note: A paired sample t-test was used to compare patients' communication preferences with perceptions. This analysis only included the items ranked as "very important" above the median regarding preferences.

Abbreviations: C, Content; F, Facilitation; S, Support.

Although both the Facilitation and Support dimensions were ranked lower, patients still considered them important, warranting thorough consideration.

4.1 | Patient's preferences regarding the content dimension

The physician's knowledge, honesty, and the provision of clear information about cancer and treatment were the most significant areas. Before the first consultation, patients lack a comprehensive understanding of their diagnosis, which explains their eagerness for information. Acquiring appropriate initial information also facilitates better adjustment of expectations throughout the trajectory of the disease.¹⁵ In a 60-item questionnaire assessing the importance and satisfaction with care, the quality of medical care and the technical competence of clinicians were reported as the greatest importance to cancer patients.²¹ Our findings are consistent with other studies where physicians' knowledge, clarity, and

willingness to discuss treatment were deemed highly important by patients.^{4,22,23}

4.2 | Patient's preferences regarding the facilitation dimension

Significant results were observed for C-FAQ items related to the patient's preference to be asked by a doctor about what they wish to know about cancer and to have the assurance that they comprehend the information. Patients value the opportunity to influence the amount of information shared, which supports their sense of empowerment.²⁴ Emotional status and subsequent fear of receiving negative news can influence the perception of medical terminology. Hence, the validation of comprehension is crucial, as indicated by our results. The preference for a consultation environment tailored to the patient's needs emphasises the necessity of specific conditions for effective information assimilation. The absence of these facilitation elements in other studies resulted in a less favourable communication experience.^{4,22,23}

4.3 | Patient's preferences regarding the support dimension

Patients valued the empathy demonstrated by doctors when they displayed concern for patients' emotions and attentively listened to them. Conversely, items concerning interactions with individuals beyond the doctor-patient relationship were rated as "very important" by fewer than 30% of participants. It is likely that if patients feel satisfied with the support provided by their doctor, they may not attribute as much importance to the presence of other professionals. Additionally, patients might prefer to initially receive and understand all information privately, rather than share it immediately.

Patients with a longer duration between diagnosis and their first consultation expressed less preference for Support. This finding could be explained by the establishment of their support network, assimilation and adjustment to the information, clarifications provided by other healthcare practitioners, and the emotional regulation developed during this period.^{25,26}

4.4 | Patients' preferences versus perceptions

When comparing the 20 highest-rated preferences with the perceptions of their first oncology appointment, there were 11 items where perceptions were rated lower than the preferences, revealing significant discrepancies. This suggests that certain patient preferences are not being fulfilled in clinical practice, highlighting an opportunity to improve communication during the first appointment.

All aspects of communication were highly valued, irrespective of patient age, sex, marital status, tumour location, disease status, country of origin, qualifications, occupation or treatment approach. The results concerning anxiety and depression suggest that patients are distressed due to the diagnosis they are facing. More than 50% of participants reported severe anxiety symptoms, and 80.4% reported a depression score of eight or higher. Although no significant differences were found between the HADS subscales outcomes and the three communication dimensions, empathetic patient-centred care might influence patients' psychological well-being, potentially reducing their anxiety and fostering greater trust in their oncologist.²⁷

Having social support networks in oncology is vital for managing crises and aiding patient's physical and psychological adjustment.¹⁸ However, no significant correlations were observed between social support and communication preferences. To validate these findings, it would be important to conduct this study across various centres.

4.5 | Study limitations

This study included patients with diverse types of cancers, disease stages, treatment settings, and backgrounds. Our findings may capture the preferences of a wide spectrum of patients. Conducting a multi-centric study could enhance the robustness of the results and validate their applicability across different contexts. The elevated presence of anxiety and depression might be linked to participant's reduced

emotional capacity for completing the questionnaire, potentially explaining why 11.5% of participants did not return the questionnaires.

An extension of the current study could involve investigating potential variations in individual patient preferences over time. Recording the consultation could enable a supplementary analysis and introduce insights from physicians. Future studies might also explore the possibility of separately assessing perceptions and preferences and determine whether such an approach influences the outcomes.

4.6 | Clinical implications

Understanding patients' communication preferences allows physicians to be more aware and responsive to patients' needs during a vulnerable period of their lives. There should be ongoing discussions about communication strategies, leading to the development of guidelines tailored to this context. Topics such as informing patients about the practical impact of cancer on daily life and determining their informational needs regarding treatment options could be integrated, as these expectations often go unaddressed. The promotion of communication skills training programs for healthcare teams is essential.

Given the substantial number of patients experiencing symptoms of anxiety and depression, identifying signs of pathological distress or depression becomes crucial. This recognition would enable early referrals for psychological assessment and appropriate follow-up care.

5 | CONCLUSIONS

Patients' preferences concerning Content, Facilitation, and Support dimensions of communication were highly valued, with a greater emphasis on Content in patient preferences. Discrepancies between communication preferences and perceptions should be viewed as opportunities to enhance training in communication skills for healthcare teams, enabling them to address patient needs. Further research is needed to explore the complexities of the doctor-patient relationship and how patients' communication needs can be effectively satisfied.

AUTHOR CONTRIBUTIONS

The present manuscript is the result of the original work by Rodrigo Santos Vicente, Ana Rita Freitas, Ricardo Miguel Azevedo Ferreira, Sofia Parada Prada, Telma Sofia Martins, Telma Caleça Martins, Ana Duarte Mendes, Marina Miguel Vitorino, Andreia Filipa Chaves, Diogo Alpuim Costa, Catarina Castro Santos, Maria Paula Custódio, and Miguel Barbosa. Rodrigo Santos Vicente and Miguel Barbosa conceived and designed the study; Rodrigo Santos Vicente, Miguel Barbosa, Ana Rita Freitas, Ricardo Miguel Azevedo Ferreira, Sofia Parada Prada and Telma Sofia Martins performed the acquisition, analysis, and interpretation of the data; Rodrigo Santos Vicente, Miguel Barbosa, Telma Caleça Martins, Ana Duarte Mendes, Marina Miguel Vitorino, Catarina Castro Santos, Andreia Filipa Chaves, Diogo Alpuim Costa, and Maria Paula Custódio supervised the manuscript. All authors have read and agreed to the published version of the manuscript.

ACKNOWLEDGEMENTS

This study received no external funding.

CONFLICT OF INTEREST STATEMENT

The authors have no conflicts of interest to declare.

DATA AVAILABILITY STATEMENT

The data used to support the findings of this study is included within the article and its Supplementary material.

ORCID

Rodrigo Santos Vicente  <https://orcid.org/0000-0001-6780-4271>

Diogo Alpuim Costa  <https://orcid.org/0000-0002-1377-3032>

REFERENCES

- King A, Hoppe RB. Best practice for patient-centered communication: a narrative review. *J Grad Med Educ*. 2013;5(3):385-393. <https://doi.org/10.4300/JGME-D-13-00072.1>
- Ha JF, Longnecker N. Doctor-patient communication: a review. *Ochsner J*. 2010;10(1):38-43.
- Lea Ann Hansen P. Challenges Patients Face in Cancer Care: Implications for the Healthcare Team; 2012. Published online February 9. Accessed 3 December 2022. <https://www.theoncologypharmacist.com/top-issues/issue-archive/14797-top-14797>
- Parker PA, Baile WF, de Moor C, Lenzi R, Kudelka AP, Cohen L. Breaking bad news about cancer: patients' preferences for communication. *J Clin Oncol Off J Am Soc Clin Oncol*. 2001;19(7):2049-2056. <https://doi.org/10.1200/JCO.2001.19.7.2049>
- Lenkiewicz J, Lenkiewicz O, Trzciński M, et al. Delivering bad news: self-assessment and educational preferences of medical students. *Int J Environ Res Public Health*. 2022;19(5):2622. <https://doi.org/10.3390/ijerph19052622>
- Han PKJ, Dieckmann NF, Holt C, Gutheil C, Peters E. Factors affecting physicians' intentions to communicate personalized prognostic information to cancer patients at the end of life: an experimental vignette study. *Med Decis Mak Int J Soc Med Decis Mak*. 2016;36(6):703-713. <https://doi.org/10.1177/0272989X16638321>
- Slort W, Schweitzer BPM, Blankenstein AH, et al. Perceived barriers and facilitators for general practitioner-patient communication in palliative care: a systematic review. *Palliat Med*. 2011;25(6):613-629. <https://doi.org/10.1177/0269216310395987>
- Schmid Mast M, Kindlimann A, Langewitz W. Recipients' perspective on breaking bad news: how you put it really makes a difference. *Patient Educ Couns*. 2005;58(3):244-251. <https://doi.org/10.1016/j.pec.2005.05.005>
- Seifart C, Hofmann M, Bär T, Riera Knorrenschild J, Seifart U, Rief W. Breaking bad news-what patients want and what they get: evaluating the SPIKES protocol in Germany. *Ann Oncol Off J Eur Soc Med Oncol*. 2014;25(3):707-711. <https://doi.org/10.1093/annonc/mdt582>
- Fallowfield L, Jenkins V. Effective communication skills are the key to good cancer care. *Eur J Cancer Oxf Engl*. 1999;35(11):1592-1597. [https://doi.org/10.1016/s0959-8049\(99\)00212-9](https://doi.org/10.1016/s0959-8049(99)00212-9)
- Ellis PM, Tattersall MHN. How should doctors communicate the diagnosis of cancer to patients? *Ann Med*. 1999;31(5):336-341. <https://doi.org/10.3109/07853899908995900>
- Girgis A, Sanson-Fisher RW. Breaking bad news: consensus guidelines for medical practitioners. *J Clin Oncol Off J Am Soc Clin Oncol*. 1995;13(9):2449-2456. <https://doi.org/10.1200/JCO.1995.13.9.2449>
- Baile WF, Buckman R, Lenzi R, Glober G, Beale EA, Kudelka AP. SPIKES-A six-step protocol for delivering bad news: application to the patient with cancer. *Oncol*. 2000;5(4):302-311. <https://doi.org/10.1634/theoncologist.5-4-302>
- Rabow MW, McPhee SJ. Beyond breaking bad news: how to help patients who suffer. *West J Med*. 1999;171(4):260-263.
- Furber L, Bonas S, Murtagh G, Thomas A. Patients' experiences of an initial consultation in oncology: knowing and not knowing. *Br J Health Psychol*. 2015;20(2):261-273. <https://doi.org/10.1111/bjhp.12096>
- Tuckett AG. Truth-telling in clinical practice and the arguments for and against: a review of the literature. *Nurs Ethics*. 2004;11(5):500-513. <https://doi.org/10.1191/0969733004ne7280a>
- Simpson JSA, Carlson LE, Beck CA, Patten S. Effects of a brief intervention on social support and psychiatric morbidity in breast cancer patients. *Psycho Oncol*. 2002;11(4):282-294. <https://doi.org/10.1002/pon.565>
- Usta YY. Importance of social support in cancer patients. *Asian Pac J Cancer Prev*. 2012;13(8):3569-3572. <https://doi.org/10.7314/apjcp.2012.13.8.3569>
- Pais-Ribeiro J, Silva I, Ferreira T, Martins A, Meneses R, Baltar M. Validation study of a Portuguese version of the hospital anxiety and depression scale. *Psychol Health Med*. 2007;12(2):225-237. <https://doi.org/10.1080/13548500500524088>
- Pinheiro M, Ferreira J. O Questionário de Suporte Social: adaptação e validação da versão portuguesa do Social Support Questionnaire (SSQ6). *Psychologica*. 2002;30:315-333.
- Wiggers JH, Donovan KO, Redman S, Sanson-Fisher RW. Cancer patient satisfaction with care. *Cancer*. 1990;66(3):610-616. [https://doi.org/10.1002/1097-0142\(19900801\)66:3<610::aid-cncr2820660335>3.0.co;2-t](https://doi.org/10.1002/1097-0142(19900801)66:3<610::aid-cncr2820660335>3.0.co;2-t)
- Davison BJ, Parker PA, Goldenberg SL. Patients' preferences for communicating a prostate cancer diagnosis and participating in medical decision-making. *BJU Int*. 2004;93(1):47-51. <https://doi.org/10.1111/j.1464-410X.2004.04553.x>
- Jenkins V, Fallowfield L, Saul J. Information needs of patients with cancer: results from a large study in UK cancer centres. *Br J Cancer*. 2001;84(1):48-51. <https://doi.org/10.1054/bjoc.2000.1573>
- McAllister M, Dunn G, Payne K, Davies L, Todd C. Patient empowerment: the need to consider it as a measurable patient-reported outcome for chronic conditions. *BMC Health Serv Res*. 2012;12(1):157. <https://doi.org/10.1186/1472-6963-12-157>
- Conley C, Bishop B, Andersen B. Emotions and emotion regulation in breast cancer survivorship. *Healthcare*. 2016;4(3):56. <https://doi.org/10.3390/healthcare4030056>
- Brandão T, Tavares R, Schulz MS, Matos PM. Measuring emotion regulation and emotional expression in breast cancer patients: a systematic review. *Clin Psychol Rev*. 2016;43:114-127. <https://doi.org/10.1016/j.cpr.2015.10.002>
- Zwingmann J, Baile WF, Schmier JW, Bernhard J, Keller M. Effects of patient-centered communication on anxiety, negative affect, and trust in the physician in delivering a cancer diagnosis: a randomized, experimental study: effects of PCC on Cancer Diagnosis. *Cancer*. 2017;123(16):3167-3175. <https://doi.org/10.1002/cncr.30694>

SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

How to cite this article: Vicente RS, Freitas AR, Ferreira RMA, et al. Communication preferences and perceptions of cancer patient during their first medical oncology appointment. *Psychooncology*. 2023;1-8. <https://doi.org/10.1002/pon.6220>