

**Effects of Patient-Physician Relationships on Breast Cancer Survivorship**

**by**

**Marisa Reichstein**

**Thesis**

Presented to the Faculty of the Undergraduate School of Liberal Arts

The University of Texas at Austin

in Partial Fulfillment

of the Requirements

for the Degree of

**Bachelor of Arts in Health and Society, College Honors**

**The University of Texas**

**Spring 2024**

Supervisors:

Scott Swearingen, PhD

Marc A. Musick, PhD

## Abstract

Breast cancer refers to a group of diseases that affect breast tissue, typically resulting from an uncontrolled growth of breast cells. Though men and women can get breast cancer, it continues to be the second leading cause of death for women. The diagnosis and treatment of breast cancer pose threats to psychosocial issues that impact the quality-of-life responses of women. Prior research indicates that effective patient-physician relationships can improve patient health-related quality of life, decision-making, treatment adherence, and survivorship outcomes. Furthermore, understanding barriers to physician trust in non-culturally congruent patients can reveal potential interventions to improve health equity and survivorship outcomes across all demographics. These barriers can include access to treatment, loss of patient autonomy, and communication and language differences. Implementing effective health communication and multidisciplinary care, including social workers, primary physicians, and psychologists (in addition to primary oncologists), can pose a solution to combat patient struggles. This thesis analyzes several frameworks for improving health communication and patient-physician relationships in breast cancer oncology, as well as real-world examples of said practices as presented by a panel of physician-interviewees from the field.

## Table of Contents

Abstract .....	2
Table of Contents .....	3
Dedication .....	4
Acknowledgements .....	5
1. Breast Cancer Background.....	6
2. Access to Care and Treatment Outcomes .....	7
3. Ethical Considerations in Oncology .....	9
4. Patient-Physician Relationships and Psychosocial Impacts.....	10
4.1. Time to Treatment and Disparities .....	10
4.2. Communication and Language .....	12
4.3. Cultural Congruence and Patient-Physician Relationships .....	14
5. Treatment Decision Making and Physician Communication .....	16
6. Survivorship and Quality of Life .....	17
7. Multidisciplinary Care and Patient Experience .....	19
8. Theoretical Implications – Social Support Theory .....	21
9. Interviews with Clinical Oncologists.....	22
9.1. Methods .....	22
9.2. Interview Questions and Background .....	24
9.3. Interview Results .....	26
Conclusion .....	28
References .....	30

## **Dedication**

I would like to dedicate this thesis to my cabin of 9-year-old cancer patients from Camp Periwinkle, who were at the forefront of reminding me how essential social support and positive communication are to coping with cancer.

## **Acknowledgments**

I would like to thank my advisors Dr. Scott Swearingen and Dr. Marc Musick for assisting me in the writing of this thesis. I would also like to thank my parents for their continued emotional and financial support towards my education, and personal battle with cancer. I would not be here without them. This paper is a testament to the impact my oncologist, Dr. Kenneth McClain had on me over my years as a Langerhans Cell Histiocytosis patient. Had it not been for his nurturing words, commitment to teaching, and evident love for his profession, I would not have pursued a degree in medicine.

## 1. Breast Cancer Background

Breast cancer encapsulates a wide range of diseases, often determined by genetic and sociological factors — If left untreated, breast cancer can metastasize to other parts of the body resulting in an uncontrolled growth of cells and an increased chance of death (Rahib et al Nead 2021). While screening mammography is positively associated with reduced cancer-specific mortality by 10-20%, screening ability is heavily influenced by access and coverage (citation 6). Breast cancer follows a natural progression that includes symptoms of lumps and pain as well as changes in breast size and shape (Rahib et al Nead 2021). As a result, diagnosis of breast cancer requires a combination of mammograms, imaging tests, and lesion biopsies (Barzaman et al Farahmand 2020).

Over the last decade, the threat of breast cancer diagnosis has increased for black, Asian, and Pacific Islander women, with black women having an increased risk of death from breast cancer (Kanu and Brown 2019). Additionally, research suggests that minority oncology patients report less sufficient patient-physician relationships due to language barriers and bias, thus increasing their risk for delayed diagnosis or breast cancer mortality. Because breast cancer is the leading cancer diagnosis for women and is associated with several psychological and personal stressors (Barzaman et al Farahmand 2020). Understanding sociological factors contributing to morbidity and mortality by breast cancer is crucial for effective health intervention strategies. Additionally, the diagnosis and treatment of breast cancer by surgery pose threats to psychosocial issues that impact the quality-of-life responses of women.

For nearly 100 years, mastectomies, or the surgical removal of one's breast, have been used as a synonymous term for breast cancer surgery. With “varying degrees of painful resignation,” physicians and patients have accepted the necessary mutilation associated with such

a surgery. However, despite the effectiveness of the procedure, many women and their spouses suffer from “depression, anxiety, suicidal thoughts, sexual problems, and family maladjustment” proceeding surgery (Harness, & Harness, J. K. 2021). As a result, assessing patients’ health-related quality of life through the lens of Social Support Theory can further determine the psychological impacts of mastectomies

## **2. Access to Care and Effects of Social Support on Treatment Outcomes**

Access to care remains a critical determinant of treatment outcomes and overall survival rates for individuals diagnosed with breast cancer. Brown et al. (2021) conducted a comprehensive evaluation of access to care issues among breast cancer patients, identifying various barriers such as geographical disparities, financial constraints, and healthcare system inefficiencies. For instance, they highlighted how individuals residing in rural areas often face challenges in accessing specialized oncology services due to limited healthcare infrastructure and long travel distances to urban treatment centers. Similarly, Phippen et al. (2017) demonstrated the profound impact of access to care on quality of life and survival rates among women with advanced epithelial ovarian cancer. The study revealed that patients with limited access to comprehensive cancer care facilities experienced poorer quality of life outcomes and shorter survival durations compared to those with timely access to multidisciplinary treatment teams. Furthermore, Johnson et al. (2021) investigated the temporal aspects of breast cancer care, specifically examining the duration between diagnosis and treatment initiation among participants in Idaho's National Breast and Cervical Cancer Early Detection Program. Their findings illustrated how delays in treatment initiation, whether due to administrative bottlenecks or resource constraints, can adversely affect disease prognosis and patient well-being. These

studies collectively underscore the critical role of equitable access to timely and comprehensive care in optimizing treatment outcomes and enhancing the overall quality of life for breast cancer patients.

To further investigate these findings, Johnson et al. (2021) examined the time from breast cancer diagnosis to treatment initiation among participants in Idaho's Women's Health Check (WHC) Program, which provides breast and cervical cancer screening to under- and uninsured women. The study, conducted from 2011 to 2017, evaluated differences in treatment initiation between WHC-linked cases and non-linked cases. Interestingly, despite demographic and tumor-related differences, most women in both groups began treatment within 60 days of diagnosis. This suggests that the WHC Program effectively addresses barriers to timely treatment initiation for its participants, even among those residing in poorer census tracts and diagnosed at later stages. The findings highlight the importance of targeted programs like WHC in reducing disparities in breast cancer care and ensuring equitable access to treatment for vulnerable populations.

In a related investigation, Fayanju et al. (2021) explored the impact of patient-reported distress on disparities in time to care after breast cancer diagnosis. By analyzing data from women diagnosed between 2014 and 2016, the study assessed the association between distress levels and delays in evaluation and treatment initiation. While patient-reported stressors predicted delays in time to care, the overall level of distress did not significantly correlate with treatment timing. Moreover, Black patients reported lower levels of distress compared to White patients yet experienced longer times for evaluation and treatment. These findings reveal the complexity of factors influencing disparities in breast cancer care, suggesting that patient-reported distress may serve as a more accurate predictor of delays than overall distress levels.



Addressing these disparities requires culturally responsive strategies and early assessment of logistical and psychosocial challenges to ensure timely access to care for all patients, regardless of race or ethnicity.

### **3. Ethical Considerations in Healthcare**

Ethical considerations play a crucial role in healthcare, especially in complex areas such as oncology where decisions can have profound impacts on patients' lives. This chapter delves into two key ethical analyses within the realm of breast cancer treatment: the debate over immediate breast reconstruction (IBR) in the setting of radiotherapy and the evolving guidelines for cancer treatment during pregnancy. More so, both studies highlight the importance of patient autonomy on quality of life and patient-physician relationships.

During the process of post-mastectomy radiation treatment (PMRT), evidence suggests a tendency for women to lose not only their real breasts but their implant as well; however, several patients desire immediate breast reconstruction (IBR) before radioactive treatment (Hansson, et al Sandman, L. 2020). While IBR may offer significant psychosocial benefits for patients, it poses potential risks and complications, particularly in the context of subsequent radiotherapy. The authors explore the ethical implications of balancing patient autonomy with medical necessity, highlighting the importance of informed decision-making and patient-centered care in navigating these complex treatment decisions. In a similar vein, Linkeviciute, Canario, Peccatori, and Dierickx (2022) examine the evolving ethical guidelines for cancer treatment during pregnancy.

Pregnancy adds an additional layer of complexity to cancer treatment decisions, as clinicians must consider not only the health and well-being of the mother but also the potential

impact of treatment on the developing fetus. The authors discuss the ethical challenges inherent in balancing maternal autonomy and fetal well-being, emphasizing similar ideas of shared decision-making and comprehensive support for pregnant patients facing a cancer diagnosis. Furthermore, provider communication that supports patient autonomy has been associated with numerous positive patient outcomes and can therefore be used to combat discrepancies in care access. For example, a Turkish study evaluated participants to investigate the psychosocial trauma associated with reduced quality of life and ways in which patient-physician relationships (PPR) influence such. The impact of poor PPR on fear of cancer recurrence (FCR) was most significant for young women, with a history of mastectomy (Alkan, et al Şenler, F 2020). However, to date, minimal research has examined the relationship between perceived provider communication style and patient-assessed decision quality in breast cancer.

The above studies underscore the critical role of effective communication and patient-centered care in navigating ethical dilemmas in oncology. By prioritizing patient autonomy, fostering open dialogue, and providing comprehensive support, clinicians can uphold ethical principles while ensuring the best possible outcomes for patients facing breast cancer and pregnancy-related cancer diagnoses. These analyses contribute valuable insights to the ongoing discourse surrounding ethical considerations in healthcare and highlight the need for continued research and guideline development in these complex and nuanced areas.

#### **4. Patient-Physician Relationships and Psychosocial Impacts**

The intricate dynamics of patient-physician relationships and their profound psychosocial impacts on breast cancer care are crucial to consider for effective therapeutic strategies. As access to care and cultural congruence play pivotal roles in shaping these relationships, it is

imperative to explore the multifaceted dimensions of communication, shared decision-making, and trust within the healthcare setting.

#### **4.1 Shared Decision-Making:**

Shared decision-making (SDM) is a cornerstone of patient-centered care, empowering patients to actively participate in treatment decisions alongside their healthcare providers. The Cancer Care study conducted by Williams et al. (2020) sheds light on the discrepancies in SDM perceptions between clinicians and patients, particularly among individuals with metastatic breast cancer. Of the respondents, 95 percent were women (60% with breast cancer), and the highest reports indicated differing perspectives between providers and patients with metastatic breast cancer. Surveys overall indicated that 67% of clinicians reported patient satisfaction with plans before the initiation of treatment, and a significantly smaller (37%) number of patients reported SDM discussions at the same point in treatment (Williams 2020). While clinicians reported high patient satisfaction with treatment plans, fewer patients reported engaging in SDM discussions, indicating potential gaps in communication and decision-making processes. This disparity underscores the importance of fostering collaborative partnerships between patients and providers to ensure informed and personalized treatment decisions.

Similarly, Samuel et al. (2020) explored the impact of patient-physician relationships on health-related quality of life (HRQOL) and pain in cancer patients. Participants reported views on “doctor's respectfulness, time spent with doctors, patient involvement in decision-making, satisfaction with care, and following doctor's advice/treatment plan.” In comparison to the Williams study, minimal statistical correlations between physician relationships and HRQOL were found, likely due to the diversity of patients reporting. Despite insignificant results, the

study underscores the complex interplay between patient satisfaction, physician communication, and treatment outcomes.

Effective SDM can mitigate disparities in patient experiences and enhance treatment adherence, ultimately improving psychosocial well-being and overall outcomes. Furthermore, Elfgren et al. (2022) examined the role of trust in the acceptance of adjuvant endocrine therapy (AET) among breast cancer patients. Their study revealed that higher levels of trust in the treating physician significantly increased the likelihood of accepting AET treatment, highlighting the critical role of trust in treatment decision-making. Establishing a trustful patient-physician relationship fosters open communication and mutual respect, essential components of shared decision-making processes in breast cancer care.

#### **4.2 Communication and Language:**

Language plays a significant role in clinical communication, especially when discussing sensitive topics such as cancer diagnosis. The study by Shirazi and Shekhani (2017) sheds light on the impact of language used by healthcare professionals when disclosing breast cancer diagnoses to patients in Karachi, Pakistan. Through qualitative methods involving interviews with patients and healthcare professionals, the study unveils the intricate dynamics of language within this context. It reveals a prevalent reluctance to use the word "cancer" during disease disclosure, driven by societal fears of death and the desire to maintain hope among patients. Instead, euphemistic terms like "rasoli" (mass) or "this illness" are commonly employed to refer to the disease, often disclosed gradually rather than bluntly. Despite the avoidance of explicit terminology, patients remain aware of their diagnosis, indicating the subtlety with which information is imparted. These findings underscore the need for clinicians in Pakistan to adapt

their communication styles empathetically, especially in the absence of standardized practices for delivering difficult news. It highlights the importance of physicians navigating language sensitively to ensure effective communication with patients grappling with serious illnesses.

Communication barriers, including language and cultural differences, pose significant challenges in patient-physician relationships and contribute to disparities in breast cancer care.

Ashing (2018) demonstrated the impact of language preference on emotional well-being, satisfaction with care, and treatment decisions among African American and Latina cancer patients. Spanish-speaking Latina patients reported the lowest overall emotional well-being and satisfaction with care, highlighting the need for culturally competent communication strategies to address linguistic and cultural diversity in healthcare settings. Similarly, Lauray and Bigatti (2018) emphasized the disparities faced by African American women in breast cancer diagnosis and treatment, attributing these inequities to limited access to screening and treatment services, as well as distrust of healthcare providers.

Effective patient-provider communication, tailored to individual preferences and cultural backgrounds, is essential for building trust and promoting shared decision-making in breast cancer care. Likewise, Krok-Schoen et al. (2019) highlighted the importance of patient-clinician communication during chemotherapy to reduce symptom burden among Hispanic breast cancer patients. The majority of the English-language group shared their experiences while those in the Spanish-language group did not. Additionally, nearly all patients were “unhappy” with the response of clinicians regarding their symptoms including minimal physician time, lack of patient knowledge, timidity, and language (Krok-Schoen et al Post, D. M. 2019). Therefore, language barriers and communication difficulties hindered effective symptom management,

underscoring the need for language-concordant care and culturally sensitive communication approaches.

#### **4.3 Cultural Congruence and Patient-Physician Relationships:**

Cultural congruence in patient-physician relationships is vital for addressing disparities and promoting equitable breast cancer care. Alkan et al. (2020) examined the impact of patient-physician relationships on fear of cancer recurrence (FCR), particularly among young women with a history of mastectomy. Poor patient-physician relationships were associated with increased FCR, highlighting the importance of culturally sensitive communication and supportive provider interactions in alleviating psychosocial distress. The study by Hudson et al. (2016) delves into the experiences of breast and prostate cancer survivors regarding patient-centered cancer follow-up care provided by primary care physicians (PCPs) and oncologists (ONCs). Conducted among 305 early-stage cancer survivors in New Jersey, the research surveyed participants to gauge their perceptions of care coordination, comprehensiveness, and personal relationships with both PCPs and ONCs. The results revealed interesting disparities between the two groups of survivors in their evaluations of care received from PCPs and ONCs. While PCPs received higher ratings for coordination and comprehensive care from all survivors, differences emerged in the strength of personal bonds with physicians. Prostate cancer survivors rated PCPs significantly higher across various aspects, whereas breast cancer survivors rated ONCs higher on specific items related to personal connection, such as having been through a lot together and understanding the patient's medical history and beliefs. These findings underscore the importance of recognizing the distinct experiences of cancer survivors when designing care models and interventions.

Tailoring follow-up care to meet the unique needs and preferences of breast and prostate cancer survivors can enhance the quality of patient-centered care and strengthen the patient-physician relationship, ultimately improving outcomes and satisfaction among cancer survivors. The 2018 study further supported this claim by identifying modifiable determinants of racial/ethnic differences in symptom burdens by demographic. Observed black-white differences in physical well-being (PWB) were slightly attenuated by care surveys, however, all minorities reported lower scores than whites. For example, lower-income black and Hispanic women were more likely than Asian or white women to have an incidence of stage III-IV breast cancer, but the inclusion of survey results was less significant for Hispanic women. This finding was explained by the heavy faith-based community support that influenced cancer care within these groups (Check et al Kushi, L. H. 2018). Moreover, Palmer Kelly et al. (2021) emphasized the need for culturally and linguistically congruent patient-physician relationships to mitigate barriers faced by marginalized cancer patients. Racial and ethnic minority patients often experience discrimination, bias, and mistrust in healthcare settings, underscoring the urgency of addressing systemic inequities and promoting culturally competent care.

In conclusion, effective patient-physician relationships are essential for optimizing breast cancer care outcomes and enhancing psychosocial well-being and quality of life. By prioritizing shared decision-making, promoting effective communication, and fostering cultural congruence in healthcare settings, clinicians can mitigate disparities, build trust, and empower patients to actively participate in their care journey while maintaining patient autonomy.

## 5. Treatment Decision Making and Physician Communication

Effective communication between physicians and patients plays a crucial role in treatment decision-making processes and can be used to improve survivorship outcomes for non-culturally congruent patients. By analyzing patient reports, Martinez et al. (2016) investigated correlations between physician communication styles and perceived decisions. Physician communication styles were shown to impact patients' perceptions of decision quality for breast cancer treatment. This research sheds light on the importance of clear, empathetic communication in facilitating informed decision-making and ensuring patients feel confident in their treatment choices. Furthermore, it reaffirms prior conclusions regarding patient autonomy and ethics in oncology.

Precision oncology holds promise for personalized cancer treatment, but there may be discrepancies in understanding and expectations between healthcare providers and patients. To apply patient expectations to modern-day genomic testing, *Current Oncology* distributed self-administered questionnaires for patients with cancer and their physicians. Inconsistencies between the knowledge and expectations regarding the applications of genetic testing on diagnosis and prognosis between patients and their oncologists differed substantially. Like the Williams study, 28% of patients felt they had enough knowledge to make informed decisions, while the majority 68% reported they needed more information from their provider (Dehar, et al Cheung, W. Y. 2022). In identifying potential gaps in knowledge and expectations research frameworks can be better considered.

Ippolito et al. (2020) developed a research framework to explore patient empowerment through the analysis of satisfying physician relationships and patient involvement in healthcare processes. By examining the effects of physician relationships on patient involvement, the study



aimed to uncover how positive interactions between patients and physicians contribute to empowering patients in their healthcare decisions. Through their analysis, they identified a medium-strong positive correlation between satisfying physician relationships and patient involvement, highlighting the key role of effective communication and relational aspects in promoting patient empowerment. This research emphasizes the importance of nurturing quality physician-patient relationships to enhance patient involvement and promote positive healthcare outcomes.

## **6. Survivorship and Quality of Life**

“Quality of life,” or a patient’s ability to cope with their disease, varies across oncology cases and is explored in Fitzpatrick’s “Quality of Life Among Cancer Survivors: Challenges and Strategies for Oncology Professionals and Researchers.” To further understand positive interventions to subside loss of physical capacity and lifestyle experienced by cancer patients, the relationships between effective physician support and quality of life shall be further inquired. Numerous quality-of-life studies have emerged intending to identify effective therapeutic interventions for cancer patients and survivors. Health-related quality of life is a “multidimensional construct” including self-appraisal of mood, coping resources, self-esteem, and emotional, sexual, cognitive, and physical functioning (Fitzpatrick et al Hilcroft 2018). Studying the link between patient-physician relationships and health-related quality of life is important for understanding the impact of ineffective communication between providers and patients.

The patient-physician relationship holds significant implications for health-related quality of life (HRQOL) outcomes among cancer patients. In their study, Mbah et al. (2018) investigated

the associations between various aspects of the patient-physician relationship and HRQOL in breast and lung cancer patients. Analyzing data from the Accountability for Cancer Care through Undoing Racism and Equity study, the researchers examined factors such as physician respectfulness, time spent with doctors, involvement of patients in decision-making, and satisfaction with the quality of care. Findings revealed compelling associations between specific elements of the patient-physician relationship and HRQOL outcomes. Specifically, patients who reported higher levels of physician respect, optimal involvement in their care decisions, and greater satisfaction with the quality of care experienced significantly lower odds of reporting poor to fair HRQOL. These results underscore the critical role of the patient-physician relationship in shaping HRQOL outcomes for cancer patients.

To optimize patient well-being and treatment adherence, it is imperative to prioritize and enhance the quality of communication and interactions within the healthcare setting, emphasizing respect, involvement, and satisfaction with care. Studies also argue that provider communication that supports patient autonomy has been associated with numerous positive patient outcomes and high-level decision-making (Martinez, et al Hawley, S. T. 2016). Net of demographics, physician statistics within oncology by patients signify a recurring theme of inconsistent expectations of oncology providers by their patients. Satisfaction with care was determined to have a short-term effect on HRQOL, however, promoting patient autonomy remained evident six months post-rehabilitation (Farin, & Nagl, M. 2013).

Systematically incorporating positive provider communication and employing methods to reduce bias in the medical field can assist in disentangling the alarming components of the research. It is important to note that access to care, and patient background continues to play a role in patient care, despite a constant diagnosis of breast cancer. While these factors are

somewhat under the political umbrella of healthcare rights, interventions at the clinical level can be made to reduce the stress associated with a cancer diagnosis. During the process of post-mastectomy radiation treatment (PMRT), evidence suggests a tendency for women to lose not only their real breasts but their implants as well; however, several patients desire immediate breast reconstruction (IBR) before radioactive treatment for HRQOL. The patient autonomy, in this case, is violated through the lens of the author as the option for breast reconstruction is elective, while PMRT is needed to reduce the risk of breast cancer (Hansson et al Sandman, L. 2020). But, positive patient-physician communication can reduce the likelihood of reduced autonomy reported, and increase reasonable decision-making by patients.

## **7. Multidisciplinary Care and Patient Experience**

Breast cancer treatment has evolved to encompass multidisciplinary care models, offering patients the opportunity to engage with various specialists in a single visit. Graff et al. (2022) shed light on the patient experience within multidisciplinary breast cancer clinics, revealing both positive aspects and areas for improvement. These findings are crucial for understanding the intersection between healthcare delivery and patient satisfaction in oncology settings.

Multidisciplinary clinics (MDCs) provide a unique care model where patients interact with physicians across specialties and other healthcare professionals during a single appointment. Graff et al. (2022) found that patients valued the convenience and efficiency of MDC visits, with over 89% of respondents regarding it as a convenient approach to care. Furthermore, the ability to see multiple providers in one visit was highlighted as a significant advantage by 80.4% of patients surveyed.

Despite the benefits of multidisciplinary care, concerns were raised regarding the volume of information presented during MDC visits. Approximately 42.9% of patients identified the volume of information as a negative aspect of their experience, indicating a need for improved communication strategies to address patient comprehension and information overload. Additionally, 16.1% of patients reported feeling overwhelmed during MDC visits, underscoring the importance of tailoring information delivery to individual patient needs and preferences. Comparing these findings with previous research by Lansdown et al. (2008) highlights the evolving landscape of patient-physician interactions and the impact on emotional functioning and satisfaction. While Lansdown et al. emphasized the importance of positive patient-physician interactions, Graff et al.'s focus on multidisciplinary care underscores the growing emphasis on collaborative approaches to cancer care.

The implications of these findings extend beyond the clinic setting, with potential practice and policy interventions in breast cancer oncology. Healthcare providers must prioritize effective communication and patient-centered care to optimize the patient experience in multidisciplinary settings. Strategies such as pre-visit preparation, tailored information delivery, and ongoing support for patients experiencing distress are essential components of comprehensive cancer care. By addressing patient concerns and optimizing communication strategies, healthcare providers can enhance the quality of care and improve patient outcomes in breast cancer oncology. Further research and interventions are needed to continually refine and enhance the patient experience in multidisciplinary care settings.

## **8. Theoretical Implications – Social Support Theory**

Proceeding cancer diagnosis, reactions such as stress, anxiety, avoidance, confusion, and distress are most reported. The associative stress induced by chronic illness, such as cancer, can be further reduced as argued by the Social Support Theory. The Social Support Theory states that increased social support, both from physicians and family, is directly proportional to the quality of life of patients (Fitzpatrick 2018). By analyzing breast cancer through a conceptual framework, the importance of social support from a psychological perspective can be understood.

Beginning with diagnosis: primary and secondary cognitive appraisals take place resulting in cognitive coping strategies and resources by the patient. Coping resources include social-demographic characteristics, hope, self-efficacy, and social support (Shen et al Chen, Y. 2020). Social Support Theory explored in depth in the second chapter of Fitzpatrick's "Quality of Life" demonstrates correlations between reduced stress and increased social support – that is, these conversations employ patients to validate one's self-esteem while maintaining reinforcement and support through conversation. While the effects of physician-patient relationships are consistent with prior research, the impact on patient autonomy is not... Together, these findings shed light on the possible gaps in medical research impacting oncology patients and raise two important questions for the study of HRQOL in oncology.

### ***What Are the Theoretical Implications of the Findings?***

Associative stress induced by chronic illness, such as cancer, can be further reduced with social support as contended by the Social Support Theory. They conjecture that physician-patient relationships can serve as one form of support for the patient; however,

research indicates oncology providers need to be better at providing such. For example, the average “you have breast cancer,” diagnosis is approximately 15 minutes supporting the paternalistic nature of physicians argued against in the Weitz book (Weitz 2020). In addition, the most effective source of information reported by patients regarding their disease stemmed from physician consultation (84%). Therefore, in alignment with Williams and Weitz's study, participants felt physicians should spend longer explaining and be more involved with patient care.

### ***Do the Findings Have Implications for Future Studies on Breast Cancer Patients?***

Reduced patient time influences shared decision-making, and therefore upkeep of patient autonomy directly affects quality of life. Furthermore, statistics for these interactions yield worse data by demographics, indicating even less provider time for minority patients. Implications of these findings highlight a need for longer physician interactions within oncology to allow for physician support (as argued by the Social Support Theory) and positive decision-making. The proposed multidisciplinary care system is more costly, as it requires more providers; however, its use as a form of social support can improve patient reports of relationships.

## **9. Interviews with Clinical Oncologists**

### **9.1 Methods:**

The research methodology employed a mixed-methods approach, combining a comprehensive literature review (above) with semi-structured interviews with practicing oncological physicians. The literature review encompassed various themes, including effective

communication and shared decision-making between patients and physicians, the significance of building trust and cultural competence in healthcare settings, challenges related to access to care and treatment, and the importance of patient empowerment and multidimensional care. This review provided a comprehensive foundation for understanding the existing body of knowledge and identifying gaps in the literature related to patient-physician relationships in oncology.

The 15-minute phone interviews were conducted with clinical oncologists to gain insights into the applications of the research findings in clinical practice. The interviews were designed to elicit perspectives on various aspects of patient care, focusing on factors influencing patient outcomes, the impact of time spent with patients on treatment outcomes, challenges related to healthcare payment models, the effect of delivering bad news on patient-physician relationships, and trust, and the extent to which marginalized cancer patients face barriers in establishing culturally and linguistically congruent patient-physician relationships. The interview questions were carefully crafted to explore the experiences and perspectives of oncologists regarding patient care and physician-patient relationships, based on Table 1 collected from Lansdown et. al 2008 national online survey and literature review data.

***Table 1: Patient-Physician interactions (including attitudes towards treatment options, consultation time, recurrence and building close patient-physician relationship)***

<b>Relationship with breast cancer doctor (patient's response)</b>	<b>USA</b>	<b>UK</b>	<b>France</b>	<b>Italy</b>	<b>Germany</b>	<b>Overall</b>
Agree, <i>n</i> (%)	<b>(<i>n</i> = 200)</b>	<b>(<i>n</i> = 100)</b>	<b>(<i>n</i> = 200)</b>	<b>(<i>n</i> = 100)</b>	<b>(<i>n</i> = 100)</b>	<b>(<i>n</i> = 600)</b>
I trust my doctor to always recommend the best treatment for me	178 (89)	79 (79)	71 (71)	77 (77)	91 (91)	496 (83)
The trust and confidence I have in my doctor is a vital component of my care	176 (88)	77 (77)	66 (66)	76 (76)	91 (91)	486 (81)
I would be happy to discuss treatment I have heard of elsewhere with my doctor	173 (87)	64 (64)	64 (64)	72 (72)	34 (34)	407 (68)

Following my doctor's orders to the letter is the best way for me to stay healthy	153 (77)	74 (74)	77 (77)	76 (76)	78 (78)	474 (79)
My doctor has told me that my cancer could return	126 (63)	68 (68)	75 (75)	83 (83)	84 (84)	463 (77)
My doctor is the key person to help me find the support and guidance I need to deal with my cancer	178 (89)	55 (55)	72 (72)	76 (76)	82 (82)	411 (69)
My breast cancer nurse is the key person who helps me find the support I need	39 (20)	38 (38)	52 (52)	52 (52)	24 (24)	205 (34)
I wish my doctor had more time during the visit to answer questions	45 (23)	42 (42)	65 (65)	73 (73)	66 (66)	291 (49)
Trust in my doctor would decrease if my cancer returned	23 (12)	28 (28)	75 (75)	79 (79)	39 (39)	244 (41)

## 9.2: Interview Questions and Background

Across various countries, patients consistently expressed high levels of trust in their doctors' treatment recommendations and identified trust as a crucial component of their care. They also demonstrated an openness to discussing treatment options and showed a willingness to adhere closely to their doctors' orders. However, there were variations in the communication regarding cancer recurrence, with some patients reporting less awareness than others. Patients regarded their doctors as key figures in providing support and guidance throughout their cancer journey. Nonetheless, a notable proportion expressed a desire for more time during visits to address their questions. Additionally, while a minority indicated that their trust in their doctor would decrease if their cancer recurred, this underscores the need for continued attention to fostering trust and effective communication in physician-patient relationships, ultimately contributing to optimized patient outcomes and satisfaction. Also taken into consideration Popescu et al. (2016) study in the context of racial/ethnic and socioeconomic disparities, questions regarding the effects of treatment access on patient-physician relationships. By measuring the use of NIH guideline-recommended therapies and employing logistic models, the



relationship between race/ethnicity, socioeconomic status, and cancer quality of care was explored. The findings revealed that minority and low socioeconomic status beneficiaries were less likely to receive recommended treatments compared to whites, indicating disparities in cancer care delivery. Interestingly, between-physician variation accounted for less than 20% of the total variation in the quality of care, suggesting a limited role of individual physicians in explaining disparities. However, after adjusting for between-physician differences, socioeconomic factors such as median household income explained a substantial portion of the variation in treatment utilization (Popescu et al. 2016). This underscores the importance of addressing broader socioeconomic determinants of health in reducing disparities.

***Interview Questions:***

- 1. What do you see in your practice that helps patients survive?*
- 2. Do you find that time spent with patients impacts their outcomes?*
- 3. In your experience, what are the main issues with the way we pay for medical services, and has this impacted any of your patient relationships?*
- 4. In your experience, how does bad news regarding disease impact your patient-physician relationships/trust?*
- 5. How much time do you get to see your patients?*
- 6. Research suggests marginalized cancer patients face significant barriers in establishing culturally and linguistically congruent patient-physician relationships. To what extent do you agree with this finding -- why or why not?*

### 9.3 Interview Results

The interviews with Dr. Jessica Jones (UTMB), Dr. Michael Mitchell (Dell), Dr. Klimberg (UTMB) and Dr. Anthony Conley (MD Anderson) provided insightful perspectives on oncological care and patient-physician relationships. Dr. Jones highlighted the impact of insurance constraints, stating, "because of insurance having such a firm hand on what patients can afford, it does impact what I share with them," emphasizing the challenge of aligning treatment options with patients' financial capabilities. Her agreement with research findings on some cancer patients experiencing delays in diagnosis, and non-culturally congruent relationships was unequivocal: "100% agree with that statement," underscoring the systemic barriers marginalized patients face. Dr. Mitchell emphasized the importance of time spent with patients, noting its role in enhancing coping and understanding: "coping, understanding, confidence in managing symptoms... absolutely." He identified healthcare payment complexities as a challenge, describing them as "unnecessarily complicated" and noting their impact on outpatient and inpatient care. More specifically, he highlighted how he often feels insurance companies and physicians "have different goals." Similarly, Dr. Conley stressed the importance of time in patient interactions, stating, that it "has the potential to" impact outcomes, displaying the significance of discussing patient concerns for treatment adherence. On the contrary, each of the physicians averaged 15-30 minutes of "high impact" patient time for visits, as demonstrated in the literature review. To combat this, and allow for well-rounded social support, I questioned them about multidisciplinary care and its use in their different practices.

Dr. Jones underscored the significance of implementing health coaches and social workers to triage patient needs effectively, ensuring that resources are allocated efficiently to address the diverse challenges patients may face. However, this ideal "health coach" does not

exist in clinical applications offering a potential field to ensure proper allocation of resources with less expenses. Dr. Mitchell emphasized the collaborative nature of oncology care, describing it as a "team sport" and stressing the importance of a multidisciplinary approach in navigating complex treatment pathways. Dr. Conley displayed similar findings, emphasizing the benefits of multidisciplinary care in larger, more well-funded hospitals like MD Anderson. These insights underscore the value of a collaborative, interdisciplinary approach to cancer care, aligning with existing research emphasizing the benefits of coordinated care teams in improving patient outcomes and satisfaction. By leveraging the expertise of various healthcare professionals, multidisciplinary care can address the diverse needs of cancer patients comprehensively, enhancing both the quality and efficiency of care delivery.

Finally, trust in the context of patient-physician relationships emerged as a critical theme across the interviews with all physicians. Specifically, delivering bad news requires a unique trust improved by expressing commitment to patients and their well-being. Dr. Jones recognized the pre-existing challenges marginalized patients face in navigating the healthcare system, highlighting the need to establish trust early on. Dr. Mitchell echoed this sentiment, acknowledging that delivering bad news could initially create distance but emphasizing the value of upfront communication, even when the news is unfavorable, to foster trust and confidence in the physician-patient relationship. Similarly, Dr. Conley emphasized the significance of honesty from the start, noting that being truthful, particularly about prognosis, is essential for building trust, even during the first visit. These insights underscore the critical role of trust in patient-physician relationships, especially when facing challenging circumstances like delivering bad news. Establishing trust through honest and empathetic communication is vital for supporting

patients through difficult times and fostering long-term therapeutic adherence, aligning with existing research on the importance of trust in healthcare interactions.

## **Conclusion**

The findings presented in this comprehensive review underscore the multifaceted nature of breast cancer care, emphasizing the critical importance of patient-centered approaches, effective communication, and interdisciplinary collaboration in optimizing treatment outcomes and enhancing patient well-being. The analysis of patient-physician relationships reveals their pivotal role in shaping health-related quality of life (HRQOL) outcomes among breast cancer patients. Studies have consistently shown that factors such as physician respectfulness, patient involvement in decision-making, and satisfaction with care significantly influence HRQOL. However, disparities in patient experiences persist, particularly among minority and underserved populations, due to communication barriers, bias, and unequal access to care. Addressing these disparities requires a comprehensive approach that prioritizes culturally sensitive communication, shared decision-making, patient autonomy, effective trust, and psychosocial support.

Patient-physician relationships play a central role in breast cancer care, influencing treatment decision-making, psychosocial impacts, and health-related quality-of-life outcomes. Shared decision-making, effective communication, and cultural congruence are vital for fostering trust and empowerment among patients, ultimately enhancing treatment adherence and satisfaction. Multidisciplinary care models offer opportunities to streamline care delivery and address diverse patient needs comprehensively. However, challenges such as information overload and the need for tailored communication strategies underscore the importance of

patient-centered approaches in multidisciplinary settings. Lastly, insights from interviews with clinical oncologists highlight the real-world implications of these findings, emphasizing the importance of addressing systemic barriers, fostering trust, and promoting interdisciplinary collaboration to optimize breast cancer care outcomes.

Overall, this review contributes valuable insights to the ongoing discourse surrounding breast cancer care, highlighting the need for patient-centered, culturally responsive approaches that prioritize effective communication, interdisciplinary collaboration, and equitable access to care for all patients to ensure social support and positive quality of life reports. Further research and practice interventions are needed to address existing gaps and improve the quality of care for individuals affected by breast cancer with new social support systems such as “health coaches.”

## References

- Alkan, Yaşar, A., Güç, Z. G., Gürbüz, M., Başoğlu, T., Sezgin Göksu, S., Buğdaycı Başal, F., Türk, H. M., Özdemir, Ö., Yeşil Çinkır, H., Güven, D. C., Kuş, T., Türker, S., Koral, L., Karakaş, Y., Ak, N., Paydaş, S., Karcı, E., Demiray, A. G., ... Çay Şenler, F. (2020). Worse patient–physician relationship is associated with more fear of cancer recurrence (Deimos Study): A study of the Palliative Care Working Committee of the Turkish Oncology Group (TOG). *European Journal of Cancer Care*, 29(6), e13296–n/a. <https://doi.org/10.1111/ecc.13296>.
- Ashing, George, M., & Jones, V. (2018). *Hflogy* (Chichester, England), 27(4), 1213–1220. <https://doi.org/10.1002/pon.4650>.
- Barzaman, K., Karami, J., Zarei, Z., Hosseinzadeh, A., Kazemi, M. H., Moradi-Kalbolandi, S., Safari, E., & Farahmand, L. (2020). Breast cancer: Biology, biomarkers, and treatments. *International immunopharmacology*, 84, 106535. <https://doi.org/10.1016/j.intimp.2020.10106535>.
- Brown, Richards, K. M., Vohra, Y., Kanu, C., Stevens, L., Sasane, R., Balu, S., & McAneny, B. (2021). Evaluation of access to care issues in patients with breast cancer. *Journal of Medical Economics*, 24(1), 38–45. <https://doi.org/10.1080/13696998.2020.1858580>
- Check, Chawla, N., Kwan, M. L., Pinheiro, L., Roh, J. M., Ergas, I. J., Stewart, A. L., Kolevska, T., Ambrosone, C., & Kushi, L. H. (2018). Understanding racial/ethnic differences in breast cancer-related physical well-being: the role of patient–provider interactions. *Breast Cancer Research and Treatment*, 170(3), 593–603. <https://doi.org/10.1007/s10549-018-4776-0>.

- Constanze, Elfgen, Güth Uwe, Tausch Christoph, Däster Kavitha, Ritter Dominik, Scholz Urte, and Bierbauer Walter. “The Role of Trust in the Acceptance of Adjuvant Endocrine Therapy in Breast Cancer Patients.” *Psycho-oncology* (Chichester, England) 31, no. 12 (2022): 2122–2131.
- Dehar, Abedin, T., Tang, P., Bebb, G., & Cheung, W. Y. (2022). A Comparison of Patients’ and Physicians’ Knowledge and Expectations Regarding Precision Oncology Tests. *Current Oncology* (Toronto), 29(12), 9916–9927. <https://doi.org/10.3390/curroncol29120780>.
- Farin, & Nagl, M. (2013). The patient-physician relationship in patients with breast cancer: influence on changes in quality of life after rehabilitation. *Quality of Life Research*, 22(2), 283–294. <https://doi.org/10.1007/s11136-012-0151-5>.
- Fayanju, Oluwadamilola M., Yi Ren, Ilona Stashko, Steve Power, Madeline J. Thornton, P. Kelly Marcom, Terry Hyslop, and E. Shelley Hwang. “Patient-reported Causes of Distress Predict Disparities in Time to Evaluation and Time to Treatment after Breast Cancer Diagnosis.” *Cancer* 127, no. 5 (2021): 757–768.
- Fitzpatrick. (2018). *Quality of Life Among Cancer Survivors Challenges and Strategies for Oncology Professionals and Researchers* / edited by Tanya R. Fitzpatrick. (Fitzpatrick, Ed.; 1st ed. 2018.). Springer International Publishing. <https://doi.org/10.1007/978-3-319-75223-5>.
- Graff, Stephanie L., Julie Principe, Mary Anne Anne Fenton, Rochelle Strenger, Don S. Dizon, Megan H. Begnoche, and Anne-Marie Galvin. “Patient Experience with Breast Cancer Care Delivered in a Multidisciplinary Clinic.” *Journal of clinical oncology* 40, no. 16\_suppl (2022): e13506–e13506.
- Hansson, Elander, A., Hallberg, H., & Sandman, L. (2020). Should immediate breast

reconstruction be performed in the setting of radiotherapy? An ethical analysis. *Journal of Plastic Surgery and Hand Surgery*, 54(2), 83–88.

[https://doi.org/10.1080/2000656X.2019.](https://doi.org/10.1080/2000656X.2019.1688165)

1688165.

Harness, & Harness, J. K. (Jay K. (2021). *Breast cancer : collaborative management* / edited by Jay K. Harness [and others]. (First edition.). CRC Press. <https://doi.org/10.1201/9781003210542>.

Hudson, Shawna V., Pamela A Ohman-Strickland, Alicja Bator, Denalee O'Malley, Daniel Gundersen, Heather S. Lee, Benjamin F. Crabtree, and Suzanne M. Miller. "Breast and Prostate Cancer Survivors' Experiences of Patient-Centered Cancer Follow-up Care from Primary Care Physicians and Oncologists." *Journal of cancer survivorship* 10, no. 5 (2016): 906–914.

Ippolito, Adelaide, Francesco Smaldone, and Margherita Ruberto. "Exploring Patient Empowerment: The Link between Satisfying Physician Relationship and Patient Involvement." *TQM journal* 32, no. 1 (2020): 92–109.

Johnson, Christopher J., Bożena M. Morawski, Libby Hobbs, Dana Lewis, Charlene Cariou, and Randi K. Rycroft. "Time from Breast Cancer Diagnosis to Treatment among Idaho's National Breast and Cervical Cancer Early Detection Program Population, 2011–2017." *Cancer causes & control* 32, no. 6 (2021): 667–673.

Kanu, & Brown, C. M. (2019). *The relationship between health literacy, patient activation, and health outcomes in breast cancer patients* / by Chisom Nnenna Kanu. [University of Texas].

Krok-Schoen, Fernandez, K., Unzeitig, G. W., Rubio, G., Paskett, E. D., & Post, D. M. (2019).



- Hispanic breast cancer patients' symptom experience and patient-physician communication during chemotherapy. *Supportive Care in Cancer*, 27(2), 697–704. <https://doi.org/10.1007/s00520-018-4375-y>
- Lansdown, M., Martin, L., & Fallowfield, L. (2008). Patient–physician interactions during early breast-cancer treatment: results from an international online survey. *Current Medical Research and Opinion*, 24(7), 1891–1904. <https://doi.org/10.1185/03007990802135042>
- Lauray, Alexandria N., and Silvia Bigatti. “Abstract B69: The Effects of Patient-Physician Relationships on Perceptions of Breast Cancer Treatment in African American Lansdown, M., L. Martin, and L. Fallowfield. “Patient–Physician Interactions during Early Breast-Cancer Treatment: Results from an International Online Survey.” *Current medical research and opinion* 24, no. 7 (2008): 1891–1904.
- Linkeviciute, Canario, R., Peccatori, F. A., & Dierickx, K. (2022). Guidelines for Cancer Treatment during Pregnancy: Ethics-Related Content Evolution and Implications for Clinicians. *Cancers*, 14(17), 4325–. <https://doi.org/10.3390/cancers14174325>.
- Martinez, Resnicow, K., Williams, G. C., Silva, M., Abrahamse, P., Shumway, D. A., Wallner, L. P., Katz, S. J., & Hawley, S. T. (2016). Does physician communication style impact patient report of decision quality for breast cancer treatment? *Patient Education and Counseling*, 99(12), 1947–1954. <https://doi.org/10.1016/j.pec.2016.06.025>
- Mbah, Olive, Jennifer Schaal, Samuel Cykert, Eugenia Eng, Linda Robertson, Stephanie Baker, Kristin Z. Black, et al. “Associations between the Patient-Physician Relationship and Health-Related Quality of Life among Patients with Cancer.” *Journal of clinical oncology* 36, no. 34\_suppl (2018): 162–162.
- Oskay-Özcelik, Lehmacher, W., Könsgen, D., Christ, H., Kaufmann, M., Lichtenegger, W.,

- Bamberg, M., Wallwiener, D., Overkamp, F., Diedrich, K., von Minckwitz, G., Höffken, K., Seeber, S., Mirz, R., & Sehouli, J. (2007). Breast cancer patients' expectations in respect of the physician–patient relationship and treatment management results of a survey of 617 patients. *Annals of Oncology*, 18(3), 479–484.
- Palmer Kelly, Elizabeth, Julia McGee, Samilia Obeng-Gyasi, Chelsea Herbert, Rosevine Azap, Alizeh Abbas, and Timothy M. Pawlik. “Marginalized Patient Identities and the Patient-Physician Relationship in the Cancer Care Context: A Systematic Scoping Review.” *Supportive care in cancer* 29, no. 12 (2021): 7195–7207.
- Phippen, Secord, A. A., Wolf, S., Samsa, G., Davidson, B., Abernethy, A. P., Cella, D., Havrilesky, L. J., Burger, R. A., Monk, B. J., & Leath, C. A. (2017). Quality of life is significantly associated with survival in women with advanced epithelial ovarian cancer: An ancillary data analysis of the NRG Oncology/Gynecologic Oncology Group (GOG-0218) study. *Gynecologic Oncology*, 147(1), 98–103. <https://doi.org/10.1016/j.ygy.2017.07.121>.
- Popescu, Ioana, Deborah Schrag, Alfonso Ang, and Mitchell Wong. “Racial/Ethnic and Socioeconomic Differences in Colorectal and Breast Cancer Treatment Quality: The Role of Physician-Level Variations in Care.” *Medical care* 54, no. 8 (2016): 780–788.
- Rahib, Wehner, M. R., Matrisian, L. M., & Nead, K. T. (2021). Estimated Projection of US Cancer Incidence and Death to 2040. *JAMA Network Open*, 4(4), e214708–e214708. <https://doi.org/10.1001/jamanetworkopen.2021.4708>
- Rautalin, Jahkola, T., & Roine, R. P. (2022). Breast Reconstruction–Prospective Follow-up on Breast Cancer Patients' Health-Related Quality of Life. *World Journal of Surgery*, 46(4), 836–844. <https://doi.org/10.1007/s00268-021-06426-4>.

- Samuel, Mbah, O., Schaal, J., Eng, E., Black, K. Z., Baker, S., Ellis, K. R., Guerrab, F., Jordan, L., Lightfoot, A. F., Robertson, L. B., Yongue, C. M., & Cykert, S. (2020). The role of patient-physician relationship on health-related quality of life and pain in cancer patients. *Supportive Care in Cancer*, 28(6), 2615–2626. <http://doi.org/10.1007/s00520-019-05070-y>.
- Shen, Qiang, W., Wang, Y., & Chen, Y. (2020). Quality of life among breast cancer survivors with triple-negative breast cancer--the role of hope, self-efficacy, and social support. *European Journal of Oncology Nursing : the Official Journal of European Oncology Nursing Society*, 46, 101771–101771. <https://doi.org/10.1016/j.ejon.2020.101771>.
- Shirazi, Bushra, and Sualeha Siddiq Shekhani. “Impact of the Word ‘Cancer’: A Pilot Study on Breast Cancer Patients from Pakistan.” *Asian bioethics review* 9, no. 3 (2017): 229–238.
- Weitz, R. (2020). Health Care Systems, Settings, and Technology. In *The Sociology of Health, Illness, and Health Care: A Critical Approach* (8th ed., pp. 170–246). essay, Cengage Learning Inc.
- Williams, Miller, Sonet, E., Nipp, R. D., Kamal, A. H., Love, S., & Rocque, G. B. (2020). Importance of quality of life priorities and preferences surrounding treatment decision making in patients with cancer and oncology clinicians. *Cancer*, 126(15), 3534–3541. <https://doi.org/10.1002/cncr.32961>.