

Reports of Sharing and Withholding Cancer-Related Information by Patients With Gynecologic Cancer and Their Supporters

Maria G. Checton, PhD, Maria K. Venetis, PhD, Danielle Catona, PhD, Allyson C. Bontempo, MA, Kathryn Greene, PhD, Alexandre Buckley de Meritens, MD, and Katie A. Devine, PhD, MPH

PURPOSE: To examine patients' with gynecologic cancer and supporters' reports of sharing and withholding cancer-related information during oncology visits, with a focus on navigating communication encounters more effectively.

PARTICIPANTS & SETTING: 18 women who were recently diagnosed with gynecologic cancer and their supporters (N = 16) were recruited from the Rutgers Cancer Institute of New Jersey in New Brunswick.

METHODOLOGIC APPROACH: Data were collected via audio-recorded semistructured interviews and analyzed to determine the types of information that patients and supporters share or withhold during oncology visits.

FINDINGS: Thematic analyses revealed two major themes: "everything is easy to share" and "nothing is withheld except . . ." Patients and supporters indicated that topics such as treatment side effects are easiest to share, whereas sharing private information is difficult when the other is present.

IMPLICATIONS FOR NURSING: Probing patients and supporters separately on topics that they may not feel comfortable discussing can help nurses to identify unaddressed concerns and better assist patients and their supporters during oncology visits.

KEYWORDS gynecologic cancer; supporters; patient-provider communication; disclosure

ONF, 46(6), 676-685.

DOI 10.1188/19.ONF.676-685

According to the American Cancer Society ([ACS], 2018a), about 76,470 new uterine cancer and 22,240 new ovarian cancer cases will be diagnosed in 2019. Although 67% of uterine cancers are diagnosed at an early stage because of signs and symptoms such as pelvic pain and abnormal bleeding or spotting, particularly in postmenopausal women, ovarian cancer is harder to detect in its early stages because of its vague symptoms (e.g., bloating, abdominal or back pain) (Centers for Disease Control and Prevention, 2017). Depending on the cancer type and stage, treatments for uterine and ovarian cancers may include surgery, chemotherapy, radiation therapy, and/or hormone therapy (ACS, 2018b), which can cause physical and psychological burdens for patients and their support system. The five-year survival rate for women diagnosed with metastatic uterine cancer is 16%, and 29% for those diagnosed with metastatic ovarian cancer (ACS, 2018a). In addition, psychological distress is prevalent among women diagnosed with uterine and ovarian cancers (DellaRipa et al., 2015; Manne et al., 2014). Feelings of isolation are particularly common for patients with ovarian cancer; therefore, access to emotional and psychosocial support is essential (Hill, 2016; Roland, Rodriguez, Patterson, & Trivers, 2013).

Background

Patients with cancer are often accompanied to medical oncology appointments by a spouse, partner, adult child, friend, or another relative. These supporters provide patients with instrumental and emotional support while navigating a cancer diagnosis (Maly, Umezawa, Ratliff, & Leake, 2006; Venetis, Robinson, & Kearney, 2015). Supporters can also provide

coordination, such as assisting with patient and provider understanding (Street & Gordon, 2008), and can be beneficial on many levels (Cloyes, Berry, Reblin, Clayton, & Ellington, 2012), such as facilitating shared decision making between the patient and his or her healthcare provider (HCP), encouraging adherence to treatment recommendations, and helping to reduce delays in care (Arora, 2003; Shin et al., 2013, 2016). To date, no known research has explored the challenges that can result from patients withholding information from HCPs (e.g., nurse practitioners, oncologists, medical technicians) during medical oncology visits when supporters are present (i.e., at initial diagnosis or after surgery, radiation therapy, or chemotherapy). Because patients may choose to share only some cancer-related information with their supporter (Goldsmith & Miller, 2014; Venetis, Magsamen-Conrad, Checton, & Greene, 2014), they may feel conflicted about sharing all relevant information with their HCP and selectively withhold information while supporters are present. Therefore, the presence of supporters may negatively affect the reporting of relevant health information and cancer care.

The patient-provider relationship and overall care decisions are shaped by interaction (i.e., verbal and nonverbal communication) (Roter & Hall, 2011). During oncology appointments, patients may share personal or private health information, such as treatment side effects, with their HCPs. Patients' distress and uncertainty can be exacerbated or reduced based on their interactions with treating HCPs (Clayton, Reblin, Carlisle, & Ellington, 2014). Open communication with HCPs is essential to addressing patient needs and quality of life, particularly during chemotherapy treatments when symptom management is key for the overall well-being of patients and supporters (Clayton et al., 2014).

A study by Manne et al. (2014) examined the role of withholding concerns on emotional expressiveness and quality of life for women newly diagnosed with gynecologic cancer. According to Cloyes et al. (2012), less is known about the role of supporters and how they may serve as an advocate for the patient or interfere with the quality of information that is shared with HCPs. Petronio, Sargent, Andea, Reganis, and Cichocki (2004) evaluated the role of family and friends as healthcare advocates during medical visits. Petronio et al. (2004) found that physicians sometimes directed their questioning toward the caregiver, inadvertently excluding the patient from the dialogue; however, the findings were limited because they only included reports from the supporter and not the

patient. The supporter's role is widely advocated in cancer care but not well studied in health management (Clayton et al., 2014). Potential discrepancies in patients' and supporters' expectations regarding supporter engagement during oncology visits can have significant implications for outcomes on multiple levels. For example, although patient engagement has been related to improved outcomes and quality of life, as well as better coping strategies and better health management (Politi & Street, 2011; Roter & Hall, 2011; Venetis, Robinson, & Kearny, 2013), little is known about the effects of patients and supporters sharing or withholding information on patient engagement and the patient-provider relationship. The purpose of this study was to address a gap in how communication encounters are navigated by examining how patients with gynecologic cancers (e.g., ovarian, uterine) and their supporters share or withhold cancer-related information during oncology visits with HCPs.

Methodologic Approach

Participants and Setting

Patients (N = 18) and supporters (N = 16) were recruited from the Rutgers Cancer Institute of New Jersey (CINJ), a National Cancer Institute (NCI)-designated comprehensive cancer center in New Brunswick. Patients were eligible to participate if they were aged 18 years or older and spoke English. In addition, patients had to be between treatment cycles 2 and 5 for an initial diagnosis of ovarian (n = 9), uterine (n = 2), or endometrial (n = 9) cancer (some patients had multiple cancers) and have a spouse, partner, or other caregiver who regularly attended appointments. Supporters were eligible if they were the primary support person for a patient who met the eligibility criteria and attended some or most cancer-related appointments with the patient. Patients between treatment cycles 2 and 5 were identified so that the patients and supporters would have experience with at least one cycle of cancer treatment and because treatment decision making during this time period is often relevant to how patients and supporters share information.

Research staff provided information on the study to patients and supporters during a routine outpatient visit. If eligible patients were willing to participate, they scheduled a phone interview with one of the researchers (to allow for more privacy during the interview). The researchers identified 38 patients who met the inclusion criteria. Of the patients who were approached, eight did not meet inclusion criteria and five did not agree to participate. Of the 25 patients

who agreed to participate in person, 18 responded to follow-up contact and completed the interview. Two supporters declined participation. The study was approved by the Rutgers University Institutional Review Board and the Rutgers CINJ Scientific Review Board.

Procedures

A total of 34 patients and supporters (n = 32 patient-partner dyads) completed audio-recorded telephone interviews. The patients were all women. Patients ranged from stage I to IV at the time of diagnosis, and 10 patients were diagnosed with advanced-stage cancers. Demographic information is presented in Table 1.

Three trained researchers conducted semistructured interviews with participants via telephone. Consent was obtained prior to participation, and permission was received from all participants to audio record interviews. Patients were asked to focus on one person who attends oncology visits with them; supporters were asked to focus on the patient. In addition to capturing demographic information and disease history, the interview guide questions focused on what cancer-related information is easy to share and what is withheld when the supporter and patient are both present during oncology visits. A series of potential follow-up questions/prompts were established and asked based on the participant's response to each question. Patients and supporters each received a \$50 gift card for their participation.

On average, interviews lasted 40 minutes (SD = 13.69) and ranged in length from 23 to 68 minutes (\bar{X} = 40.15, SD = 13.17) for patients and from 21 to 71 minutes (\bar{X} = 41.61, SD = 14.59) for supporters. Interviews were transcribed verbatim, verified by two other research team members, and deidentified for confidentiality. Transcripts produced 9 to 26 (\bar{X} = 14.38, SD = 4.53) pages of single-spaced text for patients and 10 to 21 (\bar{X} = 14.5, SD = 3.41) pages of single-spaced text for supporters.

Data Analysis

Data were coded using thematic analysis to generate themes that described patients' and supporters' reports of sharing and withholding information during oncology visits. Thematic analysis is a method for identifying, analyzing, and reporting patterns (themes) within data (Braun & Clarke, 2006; Clarke & Braun, 2013). According to Clarke and Braun (2013), the six phases of thematic analysis should not be viewed as a linear model where one cannot proceed to the next phase without completing the prior

phase, but as a recursive process. First, four research team members, who are scholars experienced with disclosure theory (e.g., sharing or withholding health information), became familiar with the data by reading the transcripts, listening to the audio recordings of the interviews, and noting any initial analytical observations. Next, the researchers coded the data by generating labels for important features that were relevant to the broad research questions guiding the analysis (Clarke & Braun, 2013). The researchers completed this phase by collating all codes and relevant data extracts. Researchers then searched for and constructed themes to identify similarities in the data and collated all of the coded data that were relevant to each theme. Themes and extracts were reviewed among the researchers to identify and discuss codes that were repeated throughout the interviews. The researchers modified codes and created larger themes. Data were then sorted again to align with the agreed on coding schemata, and the researchers discussed final codes to identify any discrepancies.

Findings

Two major themes were identified: "everything is easy to share" and "nothing is withheld except . . ." "Everything is easy to share" indicates that patients and supporters operate under a general framework of openness and transparency. Subthemes included discussions about treatment-related information, quality support relationships, and satisfaction with the oncology team as contexts for open sharing. "Nothing is held back except . . ." demonstrates that, although patients and supporters may report that they share information openly, sharing some specific information with HCPs is uncomfortable when the other individual is present. Subthemes included withholding embarrassing or personal cancer-related information, as well as having fears and concerns about the patient's prognosis and the future. Example quotations from patients and supporters are presented in Figure 1.

Everything Is Easy to Share

Overall, patients and supporters reported that they shared all relevant information with their HCP and considered themselves as being very open and transparent during oncology visits. In addition, because supporters are often with the patient during oncology visits, they may perceive more openness. Patient 2 explained the following about her husband:

You know, he's sitting right there. He's in the room. So, if I ask [the oncologist] a question . . .

I'm not trying to hide anything from him because he's always right there He knows everything.

Regarding his wife, one man had a similar response:

I don't feel that I have to talk to the doctor on the side to tell him something. Whatever the situation or whatever is happening to her body, we are very open. And [there are] no secrets. We share everything with the doctor. (Supporter 6)

Supporter 11, who accompanies her mother to oncology appointments, explained,

We usually talk about everything. I don't try to hide anything from her because I don't want her to feel like someone is trying to hide something from her.

Treatment-related information: With further probing, patients reported that it is easier to share treatment-related information and answer their HCP's questions regarding treatment side effects. Patient 17 said that she shares unusual symptoms that she is experiencing (e.g., chest pain, swollen knee). According to Patient 10, the first questions that her HCP asks are how she is doing and whether she had the same reaction to chemotherapy that she had following the previous cycle. Patients also reported that they typically complete a checklist prior to their appointment with the HCP. The checklist includes questions about physical symptoms (e.g., nausea, weight loss or gain, pain) or psychosocial issues (e.g., depression, anxiety, uncertainty) that the patient may be experiencing. Using the information provided on the checklist, HCPs follow up on patient and supporter concerns, allowing for elaboration. As Supporter 8 explained, "The whole issue with the side effects after each chemo . . . that's something [that's] easy to bring up." Similarly, Supporter 7 said that he is comfortable talking about his wife's condition and treatment, and Supporter 5 reported being comfortable bringing up chemotherapy-related side effects that her mother may be experiencing, as well as what tests results are indicating. Some patients and supporters reported drafting a list of questions to ask the HCP before their oncology appointment to ensure that their concerns are addressed.

Quality support relationships: Reports from patients and supporters indicate that having quality support relationships facilitated more effective communication. Many patients and supporters reported a

positive relationship and perceived the ability to share information openly in the other's presence. As Patient 6 explained, "My husband has been great through this whole thing. There's nothing that I'm keeping from him." Patient 15 also said that "my husband is my world." However, although she described her relationship with her husband of 24 years as great and reported that he is giving her support, she also explained that

TABLE 1. Sample Characteristics by Group

Characteristic	Patients (N = 18)		Supporters (N = 16)	
	\bar{X}	SD	\bar{X}	SD
Age (years) ^a	61.33	10.75	57.5	12.76
Time since diagnosis (months) ^b	4.22	3.37	-	-
Characteristic	n		n	
Gender				
Female	18		7	
Male	-		9	
Race or ethnicity				
Caucasian	11		11	
Hispanic	4		2	
African American	3		2	
Mixed race	-		1	
Education				
High school	6		3	
Some college or trade school	6		4	
Undergraduate degree	3		6	
Postgraduate or professional degree	3		3	
Cancer type^c				
Endometrial	9		-	
Ovarian	9		-	
Uterine	2		-	
Relationship to patient				
Spouse or partner	-		7	
Adult child	-		4	
Sister	-		2	
Friend	-		1	
Nephew	-		1	
Parent	-		1	

^aPatient ages ranged from 45 to 88 years; supporter ages ranged from 30 to 72 years.

^bTime since diagnosis ranged from 1 to 16 months.

^cTwo patients were diagnosed with more than one type of cancer.

“it’s not an easy thing [being diagnosed with stage IV ovarian cancer].” Another patient reported that having her parents with her during oncology visits is “just more supportive . . . but it doesn’t change what I would say to [the oncology team]. Not at all” (Patient 16). One supporter reported that she attended every appointment with her sister (Patient 4), whether it be for blood work, treatment, or routine follow-up. She explained, “My sister and I have had a wonderful relationship all our lives.” Patient 4 shared similar words about her sister: “It’s a fantastic relationship. We’re very close. We’re very close friends, and we rely on each other quite a bit.” Another patient reported that she didn’t have to share anything because her family members (i.e., husband, son, daughter, and daughter-in-law) attend all of her appointments: “They’re right there with me. They don’t leave me alone. They know everything, and they share everything.”

FIGURE 1. Themes and Subthemes Representing Information That Patients and Supporters Share or Withhold During Oncology Visits

Everything Is Easy to Share

Treatment-related information

- “[I’m comfortable with talking about how] the treatment is going well [and] that the side effects have subsided.” (Patient 6)
- “I definitely would feel comfortable [talking about] side effects that she’s having . . . what the results are showing.” (Supporter 5)

Quality support relationships

- “[It’s] fantastic. We’re very close.” (Patient 12)
- I think [we have] a good relationship.” (Supporter 7)

Satisfaction with the oncology team

- “My oncologist . . . she’s an outstanding lady.” (Patient 9)
- “The oncologist is very, very nice. That [oncologist] . . . she’s really nice.” (Supporter 1)

Nothing Is Withheld Except . . .

Embarrassing or personal cancer-related information

- “You know, there [are] things that are sort of more . . . from a woman’s perspective, like, the whole constipation thing was a little bit embarrassing to me.” (Patient 6)

Fears and concerns about prognosis and the future

- “[Future conversations focus on] nothing negative at all . . . just full steam ahead positive.” (Patient 15)
- “You know, my fears . . . my fears or concerns about the type of cancer she has. . . . I wouldn’t bring that up in front of her.” (Supporter 16)

Satisfaction with the oncology team: Patients and supporters also reported that their satisfaction with the oncology team made sharing information easier. Several participants indicated that they had easy access to nurses and received encouragement from the oncology team to contact them with any questions or concerns. For example, after calling the nurse practitioner about vaginal inflammation, Patient 5 described her as “very good and helpful and called me back. She gave me a prescription and I had it that night.” Patient 11 also described the nurses as wonderful, nice, and supportive. Another supporter explained that his wife seems happy with the care she is receiving. Regarding the oncology team, he said, “She likes all of them. But she particularly likes this [specific advanced nurse practitioner]” (Supporter 3). Overall, patients and supporters had positive reports about their oncologists. As Patient 1 explained, “I don’t hold back [anything from] my oncologist. I happen to love her.” Medical oncologists were also described as forthright, phenomenal, and very nice. One supporter described her sister’s oncologist as follows:

[She is] easy to talk to, and easy to listen to, and she’s very kind. You can’t just be a good doctor. You have to be kind and caring and special in this awful field. (Supporter 4)

Patients and supporters reported sharing everything with the oncology team while the other was present, particularly treatment-related information. In addition, perceived quality support relationships and satisfaction with the oncology team provided context for sharing openly. However, additional probing identified topics that participants withhold.

Nothing Is Withheld Except . . .

When asked whether they withhold information during oncology appointments, most patients and supporters reported that they withheld nothing. One patient explained that being diagnosed with endometrial cancer is uncharted territory for her:

This is something I’ve never been through before, so I don’t even know what I’m doing. They ask me questions. “Do you have this? Do you have that?” And I answer. They kind of guide me, and so there isn’t anything I’m holding back because I’m there because I have this problem. I’m not holding back information. I don’t even know what I’m looking for. (Patient 7)

During follow-up, some patients and supporters admitted that they withheld or avoided discussing some issues with HCPs while the other was present. However, the issues that were identified as difficult to discuss varied for patients and supporters. For example, patients withheld embarrassing or personal cancer-related information, particularly about treatment side effects, whereas supporters withheld their fears regarding the patient's prognosis.

Embarrassing or personal cancer-related information: Some patients admitted that they withheld information from HCPs while their supporters were present because it was sensitive in nature. Patient 7 requests that her husband leave the room while her vitals are taken because she doesn't want him to see her weight. Other patients reported avoiding discussing embarrassing physical issues while supporters are present, such as constipation, vaginal discharge, and vaginal bleeding. As one patient explained,

I was bleeding vaginally, and I should've went [to the doctor] sooner. So, the fact that I had to say that in front of my sister was . . . you know, that I probably could have done this quicker. That was difficult to say. (Patient 4)

Although patients initially avoided sharing embarrassing symptoms with HCPs, most reported that they eventually shared their concerns either because it was relevant to their treatment or, as in most cases, they felt comfortable being transparent with their HCPs.

Fears and concerns about prognosis and the future: Patient 6 discussed the side effects that she experienced during chemotherapy treatment and her fears that the treatment was ineffective. Although her husband's presence was not a deterrent, she worried about asking the doctor about a "Plan B." She reported being afraid of the response, saying that "the answer might be, you know, this is all we have." However, some patients reported withholding their fears, or concerns about their prognosis or future from HCPs while their supporter was present. One patient who was recently diagnosed with stage III ovarian and uterine cancer reported that she avoided discussing her children's futures. Because the patient has two children from a previous relationship, she explained that she would not want her current partner in the room if she had a conversation with her nurse about them.

Several supporters also expressed their concerns about discussing the patient's diagnosis or future while attending oncology visits with them.

One supporter who was awaiting test results for her mother said that she would be uncomfortable asking certain questions:

Where to go from here? Like, what [would] the next stage [be] as far as, you know, once we get the [positron-emission tomography] PET scan results. Or is this what [the oncology team] feels is the end? (Supporter 5)

Similarly, another supporter who initially reported being uninhibited about asking questions during oncology visits with his wife later admitted, "There's no conversation [about whether] she going to die . . . that sort of thing." He explained further that he maintains a positive outlook (e.g., "How's the treatment going? Are we making progress?") and avoids negative discussions about end of life: "We're not making funeral arrangements or, you know, writing up a list of testaments and stuff" (Supporter 9). Another husband said that he refrains from asking one question: "How long is she expected to live?" (Supporter 15). Similarly, Supporter 2 agreed that he would be uncomfortable asking the HCP about the long-term prognosis for his partner because her current condition is guarded, at best. Supporter 16 also explained that she would not discuss her fears about her daughter's ovarian cancer diagnosis: "My fears or concerns about the type of cancer she has . . . I wouldn't bring that up in front of her." Another supporter had similar sentiments about her sister's endometrial cancer diagnosis: "I mean, it's a horrible disease. We all know it could have a bad ending. Why would we talk about that?" (Supporter 4).

Discussion

Research exploring how information is shared or withheld between patients and supporters, and how it affects the patient-provider relationship, is limited. The purpose of this study, therefore, was to address a gap in how nurses assist patients, supporters, and HCPs in navigating communication encounters. The findings of this study demonstrate that, although patients and supporters reported sharing everything and withholding nothing from HCPs during appointments, exceptions remain. Information that was easy to share for patients and supporters primarily focused on treatment-related issues, such as chemotherapy side effects, test results, and treatment protocols. This is consistent with the results of a study by Goldsmith and Miller (2014) that examined how couples talk (or avoid talking) about cancer. With further

probing, participants admitted that they withhold specific information from HCPs while the other is present. For example, patients withheld embarrassing or personal cancer-related information (e.g., vaginal bleeding), as well as fears and concerns about their prognosis. Similarly, supporters reported withholding their anxieties about the patient's future. These findings are consistent with the literature on the concerns of patients with gynecologic cancer (Manne et al., 2014) and the difficulties that couples have discussing death (Goldsmith & Miller, 2014).

Little prior research has explored how a supporter's presence may influence patients' reporting of relevant health information during oncology visits. In this study, patients and supporters reported having quality support relationships and being satisfied with the oncology team, which likely facilitated their perception of open communication with the HCP. These findings are consistent with Magsamen-Conrad, Checton, Venetis, and Greene's (2015) study of couples managing one partner's cancer diagnosis. According to Magsamen-Conrad et al. (2015), the quality of the romantic relationship positively influenced the couple's perceived ability to share cancer-related information with each other. In a study of patients recently diagnosed with breast cancer, Venetis et al. (2015) found that when caregivers (e.g., sister, spouse) asked questions during oncology visits, patients experienced a decrease in anxiety. Overall, patients with cancer want family members or other caregivers involved in the cancer treatment decision-making process (Shin et al., 2013).

However, patients may have topics that they want to discuss with their HCP privately, such as one patient with stage III ovarian and uterine cancer who did not want to discuss her concerns about her children's future while her current partner was present. Similarly, supporters reported avoiding discussions about the patient's prognosis, despite their concerns about the future. Although end-of-life discussions are becoming more normalized, the findings of this study indicate that patients and supporters often avoid these difficult topics. Avoiding important discussions about cancer has been associated with less frequent disclosure, withholding more information or concerns, and decreased overall quality of life for patients and supporters (Manne et al., 2014; Shin et al., 2016). As such, the current study's findings support the belief that patients (and caregivers) should be provided with opportunities to speak privately to HCPs, regardless of whether they perceive themselves as communicating openly or not. In addition,

HCPs should be aware of the potential need for privacy during difficult discussions and provide supporters and patients with opportunities to discuss their concerns individually.

Limitations

Because this study only explored the reports of newly diagnosed patients with gynecologic cancer being treated at a hospital-based, NCI-designated cancer center (versus a community practice), generalizability is limited. This study also had a small sample size, and future studies with larger sample sizes can provide more generalizable results. In addition, because responses from patients and supporters were not tracked longitudinally, it is possible that information that is shared or withheld during oncology visits may differ based on treatment stage. Future research that follows participants throughout the disease trajectory can provide more robust data. According to Lee, Teo, and Kanesvaranc (2018), complexities in communication preferences in oncology contexts likely differ for various cultural groups. Participants in this study were primarily Caucasian, and, therefore, the data may not represent the feelings and experiences of patients or supporters of other ethnicities.

Implications for Nursing

Patients in this study primarily reported withholding embarrassing information (e.g., constipation, bleeding, weight issues), whereas supporters (and patients to a lesser extent) withheld their concerns and fears about the patient's prognosis and the future. Therefore, few patients or supporters are actively addressing deeper psychosocial issues and reporting that they are avoiding discussions about the future. Patients and supporters discussed the importance of being optimistic about outcomes, taking things one day at a time, and maintaining a sense of positivity. Although patients and supporters reported openness and transparency during oncology visits, they do avoid negatively framed issues or questions (e.g., "We don't discuss funeral arrangements"). It is essential for nurses to understand that patients and supporters may have concerns that they are not voicing while the other is present. Nurses should ensure that all concerns are addressed, whether through additional probing or private one-on-one conversations.

In terms of sharing and withholding, patients often focused on treatment-related symptoms (e.g., hair loss, weight loss, lack of appetite, constipation) and immediate concerns related to their diagnosis and treatment (e.g., "I take it moment to moment,"

“We do what we have to do”). Conversely, the information that supporters shared or withheld focused on prognosis (e.g., “We all know it could have a bad ending”) and the future (e.g., “How long is she expected to live?”). As patients complete their initial treatment cycles and anticipate next steps in the care trajectory, the issues that they and their supporters withhold or feel comfortable sharing are likely to vary. Nurses should be prepared to assist patients and their supporters in navigating communication about sensitive topics during each stage of the disease trajectory. According to Manne et al. (2017), participation in coping and communication interventions significantly decreased depression and cancer-related distress and improved emotional well-being for newly diagnosed patients with gynecologic cancer. Although providing emotional and relational support is essential (Hill, 2016; Roland et al., 2013), equipping patients and supporters with coping and communication tools is equally important.

Because nurses provide primary care and support to patients and their supporters throughout treatment, they are uniquely positioned to facilitate difficult discussions. Effective communication skills are essential for nurses caring for patients with cancer (Baer & Weinstein, 2013). In general, nurses report feeling confident with providing physical care for patients with cancer, but they may find addressing patients’ emotional concerns more challenging (Newman & Helft, 2015; Rask, Jensen, Andersen, & Zachariae, 2009; White & Coyne, 2011). In previous studies, nurses’ confidence in discussing death, dying, and end-of-life goals significantly increased after completing communication skills training (Banerjee, Manna, & Park, 2019; Coyle et al., 2015). Nurses who care for patients with cancer should be provided with opportunities for communication skills training to improve their efficacy in assisting patients and supporters. In the study by Magsamen-Conrad et al. (2015), perceived confidence with discussing cancer-related topics facilitated patients’ and their partners’ ability to cope with the patient’s diagnosis. Improving the efficacy of communication among nurses, patients, and supporters can lead to better health outcomes.

Conclusion

Although patients and supporters in this study reported open communication with HCPs during oncology visits, the findings reveal that patients with gynecologic cancer and their supporters may withhold salient cancer-related information from HCPs.

KNOWLEDGE TRANSLATION

- Because patients and supporters may withhold embarrassing information, fears, or concerns about the patient’s prognosis, nurses should probe these topics with the patient and supporter individually to identify unaddressed concerns.
 - Nurses should be prepared to assist patients and their supporters with managing communication encounters during each stage of the cancer trajectory.
 - Because nurses are uniquely positioned to facilitate difficult cancer-related discussions with patients and their supporters, they should seek potential continuing education opportunities to improve their communication skills.
-

In particular, patients reported withholding embarrassing personal issues, fears, and concerns while their supporter was present, whereas supporters reported withholding concerns about the patient’s prognosis and future when accompanying the patient to oncology visits. The findings of this study also raise awareness for HCPs, particularly nurses who provide care and support to patients, to be vigilant in ensuring that information that may affect the patient’s medical care is not being withheld. Providing continuing education for nurses on navigating difficult communication encounters with patients and supporters can improve dialogue during oncology visits. In addition, presenting opportunities for patients and supporters to voice their concerns and ask questions privately may alleviate some of the physical and psychological burdens experienced by patients and supporters, leading to better health outcomes overall.

Maria G. Cheeton, PhD, is the associate professor of health administration in the School of Professional Studies at the College of Saint Elizabeth in Morristown, NJ; **Maria K. Venetis, PhD**, is an associate professor in the Brian Lamb School of Communication at Purdue University in West Lafayette, IN; **Danielle Catona, PhD**, is an assistant professor in the Department of Global and Community Health at George Mason University in Fairfax, VA; **Allyson C. Bontempo, MA**, is a doctoral student, and **Kathryn Greene, PhD**, is a professor, both in the Department of Communication at Rutgers University in New Brunswick, NJ; and **Alexandre Buckley de Meritens, MD**, is a gynecologic oncologist in the Robert Wood Johnson Medical School and **Katie A. Devine, PhD, MPH**, is an assistant professor in the Department of Medicine, both at Rutgers Cancer Institute of New Jersey in New Brunswick. Cheeton can be reached at mcheeton@cse.edu, with copy to ONFEditor@ons.org. (Submitted January 2019. Accepted March 27, 2019.)

No financial relationships to disclose.

Checton, Venetis, Catona, Greene, Buckley de Meritens, and Devine contributed to the conceptualization and design. Checton, Venetis, Catona, and Greene completed the data collection and provided the analysis. Bontempo provided statistical support. Checton, Venetis, Bontempo, Greene, Buckley de Meritens, and Devine contributed to the manuscript preparation.

REFERENCES

- American Cancer Society. (2018a). *Cancer facts and figures, 2018: Estimated number of new cancer cases and deaths by sex, US, 2018*. Retrieved from <http://bit.ly/2IAHInG>
- American Cancer Society. (2018b). *Cancer facts and figures, 2018. Special section: Ovarian cancer*. Retrieved from <http://bit.ly/2mLo5Q4>
- Arora, N.K. (2003). Interacting with cancer patients: The significance of physicians' communication behavior. *Social Science and Medicine*, 57, 791–806. [https://doi.org/10.1016/s0277-9536\(02\)00449-5](https://doi.org/10.1016/s0277-9536(02)00449-5)
- Baer, L., & Weinstein, E. (2013). Improving oncology nurses' communication skills for difficult conversations [Online exclusive]. *Clinical Journal of Oncology Nursing*, 17, E45–E51. <https://doi.org/10.1188/13.CJON.E45-E51>
- Banerjee, S.C., Manna, R., & Park, P.A. (2019). Communication skills (Comskil) training for oncology nurses to improve patient-centered care. In J.A. Theiss & K. Greene (Eds.), *Contemporary studies on relationships, health, and wellness* (pp. 266–288). Cambridge, UK: Cambridge University.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3, 77–101. <https://doi.org/10.1191/1478088706qp0630a>
- Centers for Disease Control and Prevention. (2017). What are the symptoms of ovarian cancer? Retrieved from https://www.cdc.gov/cancer/ovarian/basic_info/symptoms.htm
- Clarke, V., & Braun, V. (2013). Methods: Teaching thematic analysis. *Psychologist*, 26, 120–123.
- Clayton, M.F., Reblin, M., Carlisle, M., & Ellington, L. (2014). Communication behaviors and patient and caregiver emotional concerns: A description of home hospice communication. *Oncology Nursing Forum*, 41, 311–321. <https://doi.org/10.1188/14.ONF.311-321>
- Cloyes, K.G., Berry, P.H., Reblin, M., Clayton, M., & Ellington, L. (2012). Exploring communication patterns among hospice nurses and family caregivers: A content analysis of in-home speech interactions. *Journal of Hospice and Palliative Nursing*, 14, 426–437. <https://doi.org/10.1097/NJH.0b013e318251598b>
- Coyle, N., Manna, R., Shen, M.J., Banerjee, S.C., Penn, S., Pehrson, C., . . . Bylund, C.L. (2015). Discussing death, dying, and end-of-life goals of care: A communication skills training module for oncology nurses. *Clinical Journal of Oncology Nursing*, 19, 697–702. <https://doi.org/10.1188/15.CJON.697-702>
- DellaRipa, J., Conlon, A., Lyon, D.E., Ameringer, S.A., Lynch Kelly, D., & Menzies, V. (2015). Perceptions of distress in women with ovarian cancer. *Oncology Nursing Forum*, 42, 292–300. <https://doi.org/10.1188/15.ONF.292-300>
- Goldsmith, D.J., & Miller, G.A. (2014). Conceptualizing how couples talk about cancer. *Health Communication*, 29, 51–63. <https://doi.org/10.1080/10410236.2012.717215>
- Hill, E.M. (2016). Quality of life and mental health among women with ovarian cancer: Examining the role of emotional and instrumental social support seeking. *Psychology, Health, and Medicine*, 21, 551–561. <https://doi.org/10.1080/13548506.2015.1109674>
- Lee, G.L., Teo, I., & Kanesvaran, R. (2018). The complexities of doctor–patient–family communication in an Asian oncology setting: Concordance and discordance among patient preferences, family preferences, and perceived and actual communication. *Health Communication*, 33, 95–101. <https://doi.org/10.1080/10410236.2016.1239303>
- Magsamen-Conrad, K., Checton, M.G., Venetis, M.K., & Greene, K. (2015). Communication efficacy and couples' cancer management: Applying a dyadic appraisal model. *Communication Monographs*, 82, 179–200. <https://doi.org/10.1080/03637751.2014.971415>
- Maly, R.C., Umezawa, Y., Ratliff, C.T., & Leake, B. (2006). Racial/ethnic group differences in treatment decision-making and treatment received among older breast carcinoma patients. *Cancer*, 106, 957–965. <https://doi.org/10.1002/cncr.21680>
- Manne, S., Myers, S., Ozga, M., Kissane, D., Kashy, D., Rubin, S., . . . Rosenblum, N. (2014). Holding back sharing concerns, dispositional emotional expressivity, perceived unsupportive responses and distress among women newly diagnosed with gynecological cancers. *General Hospital Psychiatry*, 36, 81–87. <https://doi.org/10.1016/j.genhosppsych.2013.10.001>
- Manne, S.L., Virtue, S.M., Ozga, M., Kashy, D., Heckman, C., . . . Rodriguez, L. (2017). A comparison of two psychological interventions for newly diagnosed gynecological cancer patients. *Gynecologic Oncology*, 144, 354–362. <https://doi.org/10.1016/j.ygyno.2016.11.025>
- Newman, A.R., & Helft, P.R. (2015). Reliability and validity of a tool to assess oncology nurses' experiences with prognosis-related communication. *Oncology Nursing Forum*, 42, 64–73. <https://doi.org/10.1188/15.ONF.64-73>
- Petronio, S., Sargent, S., Andea, L., Reganis, P., & Cichocki, D. (2004). Family and friends as healthcare advocates: Dilemmas of confidentiality and privacy. *Journal of Social and Personal Relationships*, 21, 33–52. <https://doi.org/10.1177/0265407504039838>
- Politi, M., & Street, R.L., Jr. (2011). Patient centered communication during collaborative decision making. In T.L. Thompson, R.L. Parrott, & J.F. Nussbaum (Eds.), *The Routledge handbook of health communication* (2nd ed., pp. 399–413). New York, NY: Routledge.
- Rask, M.T., Jensen, M.L., Andersen, J., & Zachariae, R. (2009).

Effects of an intervention aimed at improving nurse–patient communication in an oncology outpatient clinic. *Cancer Nursing*, 32, E1–E11. <https://doi.org/10.1097/01.NCC.0000343365.13871.12>

Roland, K.B., Rodriguez, J.L., Patterson, J.R., & Trivers, K.F. (2013). A literature review of the social and psychological needs of ovarian cancer survivors. *Psycho-Oncology*, 22,

2408–2418. <https://doi.org/10.1002/pon.3322>

Roter, D.L., & Hall, J.A. (2011). How medical interaction shapes and reflects the physician–patient relationship. In T.L.

Thompson, R.L. Parrott, & J.F. Nussbaum (Eds.), *The Routledge handbook of health communication* (2nd ed., pp. 55–68). New York, NY: Routledge.

Shin, D.W., Cho, J., Roter, D.L., Kim, S.Y., Sohn, S.K., Yoon, M.S., . . . Park, J.H. (2013). Preferences for and experiences of family involvement in cancer treatment decision-making: Patient-caregiver dyads study. *Psycho-Oncology*, 22, 2624–2631. <https://doi.org/10.1002/pon.3339>

Shin, D.W., Shin, J., Kim, S.Y., Yang, H.K., Cho, J., Youm, J.H., . . . Park, J.H. (2016). Family avoidance of communication about

cancer: A dyadic examination. *Cancer Research and Treatment*, 48, 384–392. <https://doi.org/10.4143/crt.2014.280>

Street, R.L., & Gordon, H.S. (2008). Companion participation in cancer consultations. *Psycho-Oncology*, 17, 244–251. <https://doi.org/10.1002/pon.1225>

Venetis, M.K., Magsamen-Conrad, K., Checton, M.G., & Greene, K. (2014). Cancer communication and partner burden: An exploratory study. *Journal of Communication*, 64, 82–102. <https://doi.org/10.1111/jcom.12069>

Venetis, M.K., Robinson, J.D., & Kearney, T. (2013). Consulting with a surgeon before breast cancer surgery: Patient question asking and satisfaction. *Journal of Health Communication*, 18, 943–959. <https://doi.org/10.1080/10810730.2012.757391>

Venetis, M.K., Robinson, J.D., & Kearney, T. (2015). Breast cancer patients' participation behavior and coping during presurgical consultations: A pilot study. *Health Communication*, 30, 19–25. <https://doi.org/10.1080/10410236.2014.943633>

White, K.R., & Coyne, P.J. (2011). Nurses' perceptions of educational gaps in delivering end-of-life care. *Oncology Nursing Forum*, 38, 711–717. <https://doi.org/10.1188/11.ONF.711-717>