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Patient-Clinician Communication: American Society of Clinical Oncology Consensus Guideline

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Editor's note: This American Society of Clinical Oncology (ASCO) Clinical Practice Guideline provides recommendations, with comprehensive review and analyses of the relevant literature for each recommendation. Additional information, including a Data Supplement, a Methodology Supplement, slide sets, clinical tools and resources, and links to patient information at www.cancer.net, is available at www.asco.org/supportive-care-guidelines and www.asco.org/guidelineswiki.

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ASSOCIATED CONTENT

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ABSTRACT

Purpose
To provide guidance to oncology clinicians on how to use effective communication to optimize the patient-clinician relationship, patient and clinician well-being, and family well-being.

Methods
ASCO convened a multidisciplinary panel of medical oncology, psychiatry, nursing, hospice and palliative medicine, communication skills, health disparities, and advocacy experts to produce recommendations. Guideline development involved a systematic review of the literature and a formal consensus process. The systematic review focused on guidelines, systematic reviews and meta-analyses, and randomized controlled trials published from 2006 through October 1, 2016.

Results
The systematic review included 47 publications. With the exception of clinician training in communication skills, evidence for many of the clinical questions was limited. Draft recommendations underwent two rounds of consensus voting before being finalized.

Recommendations
In addition to providing guidance regarding core communication skills and tasks that apply across the continuum of cancer care, recommendations address specific topics, such as discussion of goals of care and prognosis, treatment selection, end-of-life care, facilitating family involvement in care, and clinician training in communication skills. Recommendations are accompanied by suggested strategies for implementation. Additional information is available at www.asco.org/supportive-care-guidelines and www.asco.org/guidelineswiki.

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INTRODUCTION

Improved health care communication has been associated with improvements in many different objective and subjective health outcomes, including blood pressure control, hemoglobin A1C in diabetes, adherence to medication use, and patient satisfaction.[1-6] Communication in oncology practice (including medical, radiation, and surgical oncology) presents numerous challenges. Clinicians often must share devastating news with patients and families. Cancers are frightening diseases, and patients may react to diagnostic and treatment information with fear, grief, denial, or anger. These strong emotions may make clinicians uncomfortable. Clinicians must learn to support patients and to help them cope and must efficiently build rapport, convey adequate information, and address patient and family concerns within the time constraints of clinical practice. Cancer is also a complicated set of diseases with often complex treatments. Most patients have little in their educational background to help them understand their cancer diagnosis and treatment. Many clinicians have received scant training to prepare them to deliver information about complex health issues in a manner that results in comprehension and retention by patients and other nonexperts.

Good interpersonal skills are not a substitute for strong health care communication skills. This guideline provides guidance to oncology clinicians on how to communicate effectively so as to optimize the patient-clinician relationship, patient care, and the well-being of clinicians, patients, and their loved ones. It also touches on key aspects of effective communication skills training. The guideline presents a framework of specific practices that improve

THE BOTTOM LINE

Patient-Clinician Communication: American Society of Clinical Oncology Consensus Guideline

Guideline Question

What communication skills and tasks can clinicians use to optimize the patient-clinician relationship, patient and clinician well-being, and family well-being?

Target Population and Audience

Clinicians who care for adults with cancer.

Methods

An Expert Panel was convened to develop clinical practice guideline recommendations based on a systematic review of the medical literature and a formal consensus process.

Key Recommendations

1. Core communication skills

(Type of recommendation: formal consensus; Strength of recommendation: strong)

- 1.1. Before each conversation, clinicians should review the patient's medical information, establish goals for the conversation, and anticipate the needs and responses of the patient and family.
- 1.2. At the beginning of conversations with patients, clinicians should explore the patient's understanding of their disease and collaboratively set an agenda with the patient after inquiring what the patient and family wish to address and explaining what the clinician wishes to address.
- 1.3. During patient visits, clinicians should engage in behaviors that actively foster trust, confidence in the clinician, and collaboration.
- 1.4. Clinicians should provide information that is timely and oriented to the patient's concerns and preferences for information. After providing information, clinicians should check for patient understanding and document important discussions in the medical record.
- 1.5. When patients display emotion through verbal or nonverbal behavior, clinicians should respond empathically.

2. Discussing goals of care and prognosis

(Type of recommendation: formal consensus; Strength of recommendation: strong)

- 2.1. Clinicians should provide diagnostic and prognostic information that is tailored to the patient's needs and that provides hope and reassurance without misleading the patient.
- 2.2. Clinicians should reassess a patient's goals, priorities, and desire for information whenever a significant change in the patient's care is being considered.
- 2.3. Clinicians should provide information in simple and direct terms.
- 2.4. When providing bad news, clinicians should take additional steps to address the needs and responses of patients.

3. Discussing treatment options and clinical trials

(Type of recommendation: formal consensus; Strength of recommendation: strong)

- 3.1. Before discussing specific treatment options with the patient, clinicians should clarify the goals of treatment (cure *v* prolongation of survival *v* improved quality of life) so that the patient understands likely outcomes and can relate the goals of treatment to their goals of care.
- 3.2. When reviewing treatment options with patients, clinicians should provide information about the potential benefits and burdens of any treatment (proportionality) and check the patient's understanding of these benefits and burdens.
- 3.3. Clinicians should discuss treatment options in a way that preserves patient hope, promotes autonomy, and facilitates understanding.
- 3.4. Clinicians should make patients aware of all treatment options, including clinical trials and a sole focus on palliative care. When appropriate, clinicians should discuss the option of initiating palliative care simultaneously with other treatment modalities. If clinical trials are available, clinicians should start treatment discussions with standard treatments available off trial and then move to a discussion of applicable clinical trials if the patient is interested.

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4. Discussing end-of-life care

(Type of recommendation: formal consensus; Strength of recommendation: strong)

- 4.1. Clinicians should use an organized framework to guide the bidirectional communication about end-of-life care with patients and families.
- 4.2. Clinicians should initiate conversations about patients' end-of-life preferences early in the course of incurable illness and readdress this topic periodically based on clinical events or patient preferences.
- 4.3. Clinicians should explore how a patient's culture, religion, or spiritual belief system affects their end-of-life decision making or care preferences.
- 4.4. Clinicians should recognize and respond empathically to grief and loss among patients, families, and themselves. Clinicians should refer patients and families to psychosocial team members (eg, social workers, counselors, psychologists, psychiatrists, and clergy) when appropriate.
- 4.5. Clinicians should identify and suggest local resources to provide robust support to patients, families, and loved ones transitioning to end-of-life care.

5. Using communication to facilitate family involvement in care

(Type of recommendation: formal consensus; Strength of recommendation: strong)

- 5.1. Clinicians should suggest family and/or caregiver involvement in discussions (with patient consent) early in the course of the illness for support and discussion about goals of care.
- 5.2. Determine if a formal family meeting in a hospital or outpatient setting is indicated at important junctures in care. When possible, ensure that patients, their designated surrogates, and desired medical professionals are present.

6. Communicating effectively when there are barriers to communication

(Type of recommendation: formal consensus; Strength of recommendation: strong)

- 6.1. For families who do not share a common language with the clinician, use a medical interpreter rather than a family interpreter.
- 6.2. For patients with low health literacy, focus on the most important points, use plain language, and check frequently for understanding.
- 6.3. For patients with low health numeracy, use pictographs or other visual aids when available, and describe absolute risk rather than relative risk.

7. Discussing cost of care

(Type of recommendation: formal consensus; Strength of recommendation: strong)

- 7. Clinicians should explore whether cost of care is a concern for patients with cancer.

8. Meeting the needs of underserved populations

(Type of recommendation: formal consensus; Strength of recommendation: strong)

- 8.1. Enter clinical encounters with a sense of curiosity, aware that any patient and family, regardless of their background, may have beliefs, experiences, understandings, and expectations that are different from the clinician's.
- 8.2. Avoid assumptions about sexual orientation and gender identity and use nonjudgmental language when discussing sexuality and sexual behavior.
- 8.3. Remain aware that members of underserved or marginalized populations have an increased likelihood of having had negative past health care experiences, including feeling disrespected, alienated, or unsafe.

9. Clinician training in communication skills

(Type of recommendation: evidence based; Quality of evidence: intermediate; Strength of recommendation: strong)

- 9.1. Communication skills training should be based on sound educational principles and include and emphasize skills practice and experiential learning using role-play scenarios, direct observation of patient encounters, and other validated techniques.

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THE BOTTOM LINE (CONTINUED)

9.2. For communication skills training to be most effective, it should foster practitioner self-awareness and situational awareness related to emotions, attitudes, and underlying beliefs that may affect communication as well as awareness of implicit biases that may affect decision making.

9.3. Facilitators of communication skills training should have sufficient training and experience to effectively model and teach the desired communication skills and facilitate experiential learning exercises.

Additional Resources

More information, including a Data Supplement with additional evidence tables, a Methodology Supplement with information about evidence quality and strength of recommendations, slide sets, and clinical tools and resources, is available at www.asco.org/supportive-care-guidelines and www.asco.org/guidelineswiki. Patient information is available at www.cancer.net.

ASCO believes that cancer clinical trials are vital to inform medical decisions and improve cancer care and that all patients should have the opportunity to participate.

communication. In the past, communication skills were often viewed as innate or else as something people acquired by mimicry of role models. To a large extent, clinicians were simply expected to figure it out on their own. But research suggests that well-designed training programs can improve clinicians' communication skills and patient experience.[4,7] Challenging conversations in oncology are in many ways akin to complex interventional procedures or operations in that they require careful planning and execution, using well-developed strategies to facilitate optimal communication. This guideline on patient-clinician communication provides recommendations and strategies, based on the literature, for communication with patients and families in the cancer care environment.

GUIDELINE QUESTIONS

This clinical practice guideline addresses nine overarching clinical questions: (1) What core communication skills and tasks apply at every visit, across the cancer continuum? (2) What communication skills and tasks may clinicians use when discussing goals of care and prognosis? (3) What communication skills and tasks may clinicians use when discussing treatment options (including best supportive care) and clinical trials? (4) What communication skills and tasks may clinicians use when discussing end-of-life care? (5) What communication skills and tasks may clinicians use to facilitate family involvement in care? (6) What communication skills and tasks may clinicians use when there are barriers to communication such as language differences and/or low literacy or numeracy? (7) Should clinicians discuss cost of care with patients? (8) What communication skills and tasks may clinicians use to help meet the needs of underserved populations, racial and ethnic minority patients, and other patients from groups that have experienced discrimination historically? (9) What are the most effective ways for clinicians to acquire communication skills?

METHODS

Guideline Development Process

ASCO convened a multidisciplinary Expert Panel to consider the evidence and formulate the recommendations (Appendix Table A1, online only). The Expert Panel met in person and via teleconference and corresponded through e-mail. Based on the consideration of the evidence, clinical experience, and a formal consensus process, the authors were asked to contribute to the development of the guideline, provide critical review, and finalize the guideline recommendations. Members of the Expert Panel were responsible for reviewing and approving the penultimate version of the guideline, which was then circulated for external review and submitted to *Journal of Clinical Oncology* for editorial review and consideration for publication. All ASCO guidelines are ultimately reviewed and approved by the Expert Panel and the ASCO Clinical Practice Guideline Committee before publication.

The systematic review of the literature involved searches of PubMed and the Cochrane Library for the period from January 1, 2006 through October 1, 2016. Searches were limited to guidelines, systematic reviews, meta-analyses, and randomized controlled trials (RCTs). Articles were selected for inclusion if they focused on in-person communication between clinicians and adults with cancer. Articles were excluded if they were (1) meeting abstracts not subsequently published in peer-reviewed journals; (2) editorials, commentaries, letters, news articles, case reports, narrative reviews; (3) published in a non-English language; (4) focused on cancer prevention, risk assessment, or screening; (5) focused on decision aids or specific communication tools; or (6) focused on specific symptoms, such as pain. For the question on clinician training in communication skills, systematic reviews and RCTs were only included if they were published after the 2013 Cochrane review of communication skills training.[8]

Because of the limited evidence available for most of the clinical questions, recommendations were developed using the ASCO modified Delphi formal consensus methodology.[9] This process involved the drafting of recommendations by a subgroup of the Expert Panel using clinical expertise and the available evidence. The Expert Panel met in person to review the recommendations. The Expert Panel was then supplemented by additional experts, who were recruited to rate their agreement with the recommendations. The entire membership of experts is referred to as the Consensus Panel. Each recommendation had to be agreed to by at least

75% of Consensus Panel respondents to be accepted. This methodology is described in further detail elsewhere.[9]

Recommendations are accompanied by strategies for implementation that were developed by the Expert Panel. These strategies were not voted on by the Consensus Panel, but the Consensus Panel was invited to comment on them. The Expert Panel also indicated the strength of each recommendation. For the evidence-based recommendations, the strength of the recommendation was driven by quality of the evidence. For the consensus recommendations, the strength of the recommendation was based on the opinion of the Expert Panel.

Additional information regarding the methods used to develop this guideline, including the consensus methodology, is available in the Methodology Supplement at www.asco.org/supportive-care-guidelines. The ASCO Expert Panel and guidelines staff will work with co-chairs to keep abreast of any substantive updates to the guideline. Based on formal review of the emerging literature, ASCO will determine the need to update. Information about ASCO's approach to guideline updating is provided in the Methodology Supplement.

This is the most recent information as of the publication date. Visit the ASCO Guidelines Wiki at www.asco.org/guidelineswiki to submit new evidence.

Guideline Disclaimer

The Clinical Practice Guidelines and other guidance published herein are provided by the American Society of Clinical Oncology, Inc. (ASCO) to assist providers in clinical decision making. The information herein should not be relied upon as being complete or accurate, nor should it be considered as inclusive of all proper treatments or methods of care or as a statement of the standard of care. With the rapid development of scientific knowledge, new evidence may emerge between the time information is developed and when it is published or read. The information is not continually updated and may not reflect the most recent evidence. The information addresses only the topics specifically identified therein and is not applicable to other interventions, diseases, or stages of diseases. This information does not mandate any particular course of medical care. Further, the information is not intended to substitute for the independent professional judgment of the treating provider, as the information does not account for individual variation among patients. Recommendations reflect high, moderate, or low confidence that the recommendation reflects the net effect of a given course of action. The use of words like "must," "must not," "should," and "should not" indicates that a course of action is recommended or not recommended for either most or many patients, but there is latitude for the treating physician to select other courses of action in individual cases. In all cases, the selected course of action should be considered by the treating provider in the context of treating the individual patient. Use of the information is voluntary. ASCO provides this information on an "as is" basis and makes no warranty, express or implied, regarding the information. ASCO specifically disclaims any warranties of merchantability or fitness for a particular use or purpose. ASCO assumes no responsibility for any injury or damage to persons or property arising out of or related to any use of this information, or for any errors or omissions.

Guideline and Conflicts of Interest

The Expert Panel was assembled in accordance with ASCO's Conflict of Interest Policy Implementation for Clinical Practice Guidelines ("Policy," found at http://www.asco.org/rwc). All members of the Expert Panel completed ASCO's disclosure form, which requires disclosure of financial and other interests, including relationships with commercial entities that are reasonably likely to experience direct regulatory or commercial impact as a result of promulgation of the guideline. Categories for disclosure include employment; leadership; stock or other ownership; honoraria, consulting or advisory role; speaker's bureau; research funding; patents, royalties, other intellectual property; expert testimony; travel, accommodations, expenses; and other relationships. In accordance with the Policy, the majority of the members of the Expert Panel did not disclose any relationships constituting a conflict under the Policy.

RESULTS

A total of 47 publications met the eligibility criteria of the systematic review.[10-55] Three of the publications precede the search window of the systematic review and were identified by panel members.[10,37,46] Much of the evidence consisted of systematic reviews of observational data, consensus guidelines, and randomized trials, which varied substantially in their populations, interventions, and outcomes of interest. A list of identified publications is provided in the Data Supplement. Because of the limitations of the available evidence, the guideline relied on formal consensus for most recommendations. The only recommendations that were deemed evidence based by the Expert Panel are those for clinician training in communication skills.

During the first round of voting by the Consensus Panel, agreement with individual recommendations ranged from 77% to 100% (N = 23 respondents). Although all the recommendations exceeded the required 75% threshold, the guideline co-chairs chose to revise eight of the recommendations based on comments from the Consensus Panel. These revised recommendations underwent a second round of voting, in which agreement with the recommendations ranged from 79% to 100% (N = 19 respondents). Results for each recommendation and each round of voting are provided in the Data Supplement.

RECOMMENDATIONS

CLINICAL QUESTION 1

What core communication skills and tasks apply at every visit, across the cancer continuum?

Recommendation 1.1

Before each conversation, clinicians should review the patient's medical information, establish goals for the conversation, and anticipate the needs and responses of the patient and family (Type of recommendation: formal consensus; Strength of recommendation: strong).

Strategies for 1.1

a. Arrange for an appropriate location for the conversation and enough time to give the information and answer questions.
b. Have all the information necessary to conduct an effective encounter.
c. Know who should be present for the conversation.
d. Have one to three goals or take-home messages in mind for the conversation.
e. Anticipate the emotional responses of patients and family members.
f. Anticipate questions that might be asked.
g. Inquire if there are family members who are not able to attend meetings in person and ask whether they are informed about clinician/patient conversations. Consider offering a teleconference for people who are important to the patient but cannot be physically present.
h. Explore whether there are financial constraints.

Recommendation 1.2

At the beginning of conversations with patients, clinicians should explore the patient's understanding of their disease and collaboratively set an agenda with the patient after inquiring what the patient and family wish to address and explaining what the clinician wishes to address (Type of recommendation: formal consensus; Strength of recommendation: strong).

Strategies for 1.2

a. Use open-ended questions to encourage patients to share what is important to them.
b. Consider the use of previsit patient-reported outcomes, previsit coaching interventions, and question prompt lists.[56-58]

Recommendation 1.3

During patient visits, clinicians should engage in behaviors that actively foster trust, confidence in the clinician, and collaboration (Type of recommendation: formal consensus; Strength of recommendation: strong).

Strategies for 1.3

a. Introduce oneself and one's role in the patient's care.
b. Sit down.
c. Be friendly but not overly casual.
d. Engage in reflective listening.
e. Make eye contact.
f. Maintain a calm demeanor.
g. Get to know the patient as a person, finding out about what their life was like before their cancer diagnosis, and how the cancer has changed their life.
h. Inquire about how the patient and family are coping and feeling.
i. Be honest, genuine, and respectful.

Recommendation 1.4

Clinicians should provide information that is timely and oriented to the patient's concerns and preferences for information. After providing information, clinicians should check for patient understanding and document important discussions in the medical record (Type of recommendation: formal consensus; Strength of recommendation: strong).

Strategies for 1.4

a. Avoid unnecessary delays in providing information.
b. Communicate with consultants and others involved in the patient's care so that the patient receives coherent recommendations and information. Different providers may legitimately disagree with each other, but differences of opinion should be explained and providers should actively help patients process and interpret differing recommendations.
c. Consider whether the information is appropriate to provide by phone or mail/e-mail or if an in-person meeting is needed.
d. Orient the patient, if necessary, to make sure they understand what is going to be discussed and why (eg, "I have the results of the CT scans you had done yesterday and I wanted to go over the results with you if that's ok.").
e. Orient yourself to the patient's understanding and concerns: Ask the patient what they know and what they want to know (eg, "Please tell me what you understand [or what you have been told] about why you are in the hospital and what we are doing to help you get better." "What have the other clinicians told you about your cancer?" "What are the things that you want to make sure we discuss today?").
f. Use simple language tailored to the patient's educational level. A patient may be intelligent and well educated but still have low health care literacy.
g. Avoid jargon (eg, "response rate" or "positive test result") and explain in lay language when you must use medical terminology.
h. Provide information that is relevant to what the patient wants to know and to the patient's goals.
i. Avoid information overload by providing information in small doses, stopping frequently, and checking for comprehension.
j. Check for understanding by using a "teach back" or "talk back" method, with a statement such as, "In your own words, what does this mean to you?" or "What will you tell your family about what we discussed?"
k. Assure the patient that you are available to answer questions in the future.

Recommendation 1.5

When patients display emotion through verbal or nonverbal behavior, clinicians should respond empathically (Type of recommendation: formal consensus; Strength of recommendation: strong).

Strategies for 1.5

a. Acknowledge and name the emotions (eg, "You seem sad today." "Help me understand how you're feeling about what we discussed." "This has been a very tough 6 months for you." "I know you had a bad time when you were on chemotherapy previously and that you've been worried about starting it again." "It's stressful coming in for these scans and having to worry about whether there will be bad news.").
b. Use partnership and supporting statements (eg, "I want to make sure we do everything we can to get you the best outcome." "I know this has been a rough time and I want to do what I can to help you feel better." "I'm distressed to hear that you've been suffering so much, and I'm hoping we can work together to improve your quality of life.").
c. Be cautious about providing information when patients are emotional. When in a strongly emotional state, patients often have difficulty absorbing and processing information.
d. Ask patients what they are most concerned about, and explore what is behind strong emotions (eg,"Tell me what you are worried about." "What has been the hardest part of all this for you?" "Help me understand what you are feeling right now.").

Literature review and analysis. A 2009 systematic review and accompanying guideline by Rodin et al[42,43] addressed clinician-patient communication in cancer care, with a focus on alleviating patient distress. The review noted the importance of "open, honest, and timely"[42(p631)] communication but stated that definitive evidence remains limited for many specific strategies. Key recommendations included accounting for patient needs and preferences, including those related to religion or culture; ensuring that significant news is given in a quiet, private place, with adequate uninterrupted time; communicating honestly but in a way that provides room for hope; considering strategies to aid recall and understanding; allowing patients to express their understanding and feelings about information; communicating in clear, simple terms, without the use of medical jargon; and allowing for communication with patients individually and as part of a family unit or support system.[43]

More recent systematic reviews evaluated topics such as patient trust,[25] clinician empathy,[33] and factors that affect treatment decision making among older patients.[40] These reviews point to important limitations of the evidence but suggest that clinician empathy may improve patient satisfaction and reduce patient distress[33] and that the patient's level of trust in the clinician may affect factors such as treatment decision making.[25,40] Interventions to enhance trust were explored in an RCT, which reported that verbal expressions of clinician competence, honesty, and caring (added to video vignettes) were associated with increased patient trust.[26]

CLINICAL QUESTION 2

What communication skills and tasks may clinicians use when discussing goals of care and prognosis?

Recommendation 2.1

Clinicians should provide diagnostic and prognostic information that is tailored to the patient's needs and that provides hope and reassurance without misleading the patient (Type of recommendation: formal consensus; Strength of recommendation: strong).

Strategies for 2.1

a. When discussing the patient's disease status and treatment history, assess the patient's understanding of his/her disease status, prognosis, and the effects of any treatments to date; the patient's goals of care and treatment preferences; and how the patient's goals of care relate to life goals, activities of daily living, and quality of life.
b. Determine whether the patient: is prepared for explicit information, is ambivalent, or does not want information. For ambivalent patients, discuss the pros and cons of knowing. For patients who do not want to know, negotiate (with the patient's permission) a future discussion or discussion with family members.
c. Determine if family members are involved, in agreement, and supportive.
d. An example of providing hope might be assuring the patient that you as their clinician will do everything you can to help them get the best possible outcome. Communication behaviors that facilitate hope include reframing ("Is there something in particular that you are hoping for now?") and nonabandonment ("I will do everything I can to support you.").

Recommendation 2.2

Clinicians should reassess a patient's goals, priorities, and desire for information whenever a significant change in the patient's care is being considered (Type of recommendation: formal consensus; Strength of recommendation: strong).

Strategies for 2.2

a. Triggers for such a discussion include initial diagnosis, relapse or progression, change in treatment approach, change in goals of care, and at patient/family request.
b. To establish a starting point for the conversation, ask the patient to explain what they understand about their illness, including the status of their disease and the treatment plan.
c. After providing patients with test results, it may be helpful to ask them "Would you like to talk about what this means?"[59]

Recommendation 2.3

Clinicians should provide information in simple and direct terms (Type of recommendation: formal consensus; Strength of recommendation: strong).

Strategies for 2.3

a. Use mixed framing (eg, chance of a cure and chance of a relapse, or best/worst/most likely outcome).
b. Provide information in multiple formats (words, numbers, ranges).
c. Provide information in chunks (small discrete units), and check regularly for understanding.

Recommendation 2.4

When providing bad news, clinicians should take additional steps to address the needs and responses of patients (Type of recommendation: formal consensus; Strength of recommendation: strong).

Strategies for 2.4

a. Ensure that the timing and setting are as appropriate and private as possible.
b. Express solidarity (eg, "I wish I had better news.").
c. Give the bad news clearly and succinctly in plain, nontechnical language (eg, "Your cancer unfortunately has spread to your liver.").
d. Pause after delivering the bad news for the patient to absorb what has been said (supportive silence).
e. Wait for the patient to respond before saying anything more. If the patient says nothing, clinicians can ask questions such as "What's going through your mind?" or respond empathically (eg, "You look like you feel overwhelmed.").
f. Respond empathically to patient emotion.
g. Avoid trying to reduce patient distress by minimizing the bad news or changing the subject.
h. Titrate the amount of information to the patient's emotional state.
i. Encourage patients to ask questions ("What questions do you have?") and use silence to create space for patients to express their concerns.
j. Discuss the meaning of the findings and next steps before ending the conversation.
k. Affirm commitment to supporting the patient (eg, "It's my job to help you get the best care possible." or "I'll continue to take care of you whatever happens.") and, if appropriate, help the patient find additional sources of support (eg, family, friends, church, support groups, therapist, or social worker).

Literature review and analysis. Several guidelines and systematic reviews address discussions of goals of care and prognosis.[10,11,16,17,19,32,43,44] Many of these focus on patients with advanced disease. Common themes include the identification of triggers that may prompt discussions; the importance of assessing and responding to patients' understanding, values, concerns, and preferences for information; guidance on structuring the conversation; and the role of hope.

CLINICAL QUESTION 3

What communication skills and tasks may clinicians use when discussing treatment options (including best supportive care) and clinical trials?

Recommendation 3.1

Before discussing specific treatment options with the patient, clinicians should clarify the goals of treatment (cure *v* prolongation of survival *v* improved quality of life) so that the patient understands likely outcomes and can relate the goals of treatment to their goals of care (Type of recommendation: formal consensus; Strength of recommendation: strong).

Strategies for 3.1

a. Revisit any previous conversations regarding the patient's values, goals of care, and treatment preferences.
b. Ask whether and how these values and preferences have changed (eg, "In the past you expressed a desire to continue cancer treatment, but I can see this last round of therapy has been hard on you. I'm wondering if your thoughts about treatment have changed?").
c. Include the family or caregiver when possible and acceptable to the patient.

Recommendation 3.2

When reviewing treatment options with patients, clinicians should provide information about the potential benefits and burdens of any treatment (proportionality) and check the patient's understanding of these benefits and burdens (Type of recommendation: formal consensus; Strength of recommendation: strong).

Strategies for 3.2

a. Include a discussion of the frequency and nature of clinic visits and/or hospital stays and adverse effects of treatment.
b. Frame treatment options in the context of the patient's goals and priorities.
c. If appropriate given goals of care and treatment preferences, include the option of a sole focus on palliative care or hospice.

Recommendation 3.3

Clinicians should discuss treatment options in a way that preserves patient hope, promotes autonomy, and facilitates understanding (Type of recommendation: formal consensus; Strength of recommendation: strong).

Strategies for 3.3

a. Focus on what can be done.
b. Reinforce that the patient will not be abandoned, regardless of treatment choice.
c. Acknowledge uncertainty.
d. Normalize patient requests for a second opinion.
e. Present information in small chunks and check in frequently to assess understanding.
f. When available, use published decision aids to prepare patients and to enhance communication and shared decision making during consultations between patients and providers.
g. Whenever possible, include an involved clinic or bedside nurse in discussions. They often have valuable contributions to make and will often be present for patients when questions and emotions arise after the physician has left the room.
h. Document discussions in the medical record.

Recommendation 3.4

Clinicians should make patients aware of all treatment options, including clinical trials and a sole focus on palliative care. When appropriate, clinicians should discuss the option of initiating palliative care simultaneously with other treatment modalities. If clinical trials are available, clinicians should start treatment discussions with standard treatments available off trial and then move to a discussion of applicable clinical trials if the patient is interested (Type of recommendation: formal consensus; Strength of recommendation: strong).

Strategies for 3.4

a. Explain what clinical trials are and why they are conducted.
b. Clearly delineate treatment choices, including available standard treatments and investigational treatments.
c. Explain what is known about the safety and efficacy data of the study treatment(s).
d. Affirm that care will not be compromised if the patient decides not to participate in a clinical trial.
e. Allow patient time to give their reaction to clinical trials in general and the clinical trial presented.
f. Include discussion of symptom- or quality-of-life–directed care, such as palliative care or hospice, in conjunction with or as an alternative to anticancer treatment if consistent with patient's goals or clinical scenario.

Literature review and analysis. The 2009 communication guideline by Rodin et al[43] provides several recommendations regarding discussion of treatment options. In part, clinicians are advised to use lay terms to describe the available options, tailor the information to the needs and preferences of the patient, acknowledge uncertainty, explain the pros and cons of each option, adhere to the patient's preferred role in decision making, and be aware that patient's preferences may change over time. Variability in preferred decision-making roles was highlighted in a 2010 pooled analysis that included 3,491 patients with cancer who completed the two-item Control Preferences Scale.[47] Twenty-six percent of patients preferred an active role, 49% preferred a collaborative role, and 25% preferred a passive role.

CLINICAL QUESTION 4

What communication skills and tasks may clinicians use when discussing end-of-life care?

Recommendation 4.1

Clinicians should use an organized framework to guide the bidirectional communication about end-of-life care with patients and families (Type of recommendation: formal consensus; Strength of recommendation: strong).

Strategies for 4.1

a. Published frameworks include: SPIKES,[10] PREPARED,[17] and the Serious Illness Conversation Guide.[11]
b. Important steps to consider:
    i. Mental preparation: Prepare for discussions by anticipating patient and family member emotions as well as questions about topics such as prognosis.
    ii. Review medical chart for documentation of previous end-of-life discussions.
    iii. Provide information to patient and, with patient's permission, families regarding previous end-of-life discussions.
    iv. Develop rapport with the patient and family or caregivers.
    v. Information preferences: Ask patients and families about their preferences for information sharing.
    vi. Assess understanding: Ask patients and families what they understand about their medical situation.
    vii. Ask permission: Before sharing new medical information, including difficult news, prognostic information, or significant changes in treatment plan, ask permission.
    viii. Provide information: Provide information in small amounts, using language appropriate to the patient's level of education and health literacy, and check understanding frequently.
    ix. Address emotions: Acknowledge and address emotions throughout the conversation.
    x. Define goals: Ask patients and families to define their goals in light of the medical situation. What is most important to them? What are their priorities?
    xi. Align patient goals, values, and care preferences with treatments and services offered.
    xii. Inquire if all appropriate family members are aware of patient's goals.
    xiii. Summarize: Summarize the conversation and establish a plan for the future.
    xiv. Document: Document end-of-life conversations in the medical record.
    xv. Consider spreading out the conversation over two or more visits.

Recommendation 4.2

Clinicians should initiate conversations about patients' end-of-life preferences early in the course of incurable illness and readdress this topic periodically based on clinical events or patient preferences (Type of recommendation: formal consensus; Strength of recommendation: strong).

Strategies for 4.2

a. Early in terminal illness, within a month of diagnosis of terminal cancer:
    i. Discuss prognosis and advance care planning.
    ii. Document a surrogate decision maker and encourage patients to complete an advance directive early in the course of disease, because many patients with advanced cancer experience altered mental status during the course of their cancer that may limit their ability to designate decision makers or to make health care decisions.
    iii. Explain why advance care planning is important and why patients should discuss their goals, values, and care preferences with their appointed health care agent.
    iv. Explore patient goals and values.
    v. Anticipate that patient goals and preferences may change over time in response to disease- and treatment-related factors as well as physical and emotional changes.
b. Recognize triggers or sentinel events that may prompt end-of-life care conversations with patients in the setting of advanced disease, including:
    i. Cancer progression
    ii. Decline in functional status.
    iii. Increased high-intensity health care use, including multiple emergency department visits, admissions to the hospital, intensive care unit stays, or transition to a nursing facility if previously independent.
    iv. Consideration of a new line of cancer-directed therapies in the setting of progression on or poor tolerance of previous treatments
    v. Consideration of high-risk or high-burden medical or surgical interventions (eg, hemodialysis, palliative surgery, feeding tube placement).
    vi. Requests for care that do not make sense in the patient's clinical scenario.
    vii. Patient or family request for end-of-life care planning conversation

Recommendation 4.3

Clinicians should explore how a patient's culture, religion, or spiritual belief system affects their end-of-life decision making or care preferences (Type of recommendation: formal consensus; Strength of recommendation: strong).

Strategies for 4.3

a. Avoid assumptions about a patient's end-of-life care preferences based on stereotypes related to their race, ethnicity, culture, religion, or spirituality.
b. Ask open-ended questions regarding the impact of a patient's culture and spirituality on their medical decision making.
c. Consider use of a standardized tool such as FICA (Faith and Belief, Importance, Community, Address in Care)[60] to assess a patient's spiritual or religious beliefs.
d. When spiritual distress is identified, offer spiritual support from a medically trained chaplain.

Recommendation 4.4

Clinicians should recognize and respond empathically to grief and loss among patients, families, and themselves. Clinicians should refer patients and families to psychosocial team members (eg, social workers, counselors, psychologists, psychiatrists, and clergy) when appropriate (Type of recommendation: formal consensus; Strength of recommendation: strong).

Strategies for 4.4

a. Recognize different presentations of grief among patients, family members, and colleagues.
b. In response to anticipatory grief (eg, "What do I tell my kids?" "How will my family cope when I'm gone?"), providers should explore patient concerns and refer patients for appropriate psychosocial support.
c. In response to patient descriptions of loss (eg, loss of role, income, identity, and so on), explore meaning with patients,

acknowledge the loss through empathy, and refer for appropriate psychosocial support.

d. Refer bereaved family members for grief counseling; identify local agencies, programs, and hospices that provide this service.

Recommendation 4.5

Clinicians should identify and suggest local resources to provide robust support to patients, families, and loved ones transitioning to end-of-life care (Type of recommendation: formal consensus; Strength of recommendation: strong).

Strategies for 4.5

a. Introduce and describe palliative care services, including simultaneous palliative and oncology care, palliative care alone, and hospice care, early in the course of terminal illness.

b. When a patient is transitioning to end-of-life care or hospice care, explore the patient and family goals and service needs. Introduce hospice by aligning goals and service needs with services provided via hospice care. For example, "I understand that you don't want to spend any more time in the hospital, but you are scared about pain control at home. There's a program called hospice that can help you stay at home and manage your pain and other symptoms."

c. Be aware of cues that the patient might or might not be ready for such a discussion.

d. Address family members, whose openness to hospice may differ from the patient's.

e. When possible and with patient's permission, include key family members by phone if they cannot be present.

Literature review and analysis. A 2016 systematic review explored the evidence for end-of-life communication interventions.[53] The authors highlight the limitations of the available evidence but note there is some evidence for approaches such as educating patients about the importance of end-of-life communication and formal advance care planning, providing family meetings and other communication opportunities to caregivers, and providing communication skills training to clinicians, particularly training that includes delivery of bad news. Previous guidelines and protocols for communication address several of these points, providing recommendations on the timing, content, and structure of conversations.[10,11,17]

CLINICAL QUESTION 5

What communication skills and tasks may clinicians use to facilitate family involvement in care?

Recommendation 5.1

Clinicians should suggest family and/or caregiver involvement in discussions (with patient consent) early in the course of the illness for support and discussion about goals of care (Type of recommendation: formal consensus; Strength of recommendation: strong).

Strategies for 5.1

a. Establish rapport and lines of communication within the family. Identify a spokesperson if appropriate.

b. If a patient lacks decisional capacity, remind the surrogate that their responsibility is to represent the wishes of the patient.

c. Develop proficiency in conducting a family meeting.

d. Document goals of care in medical record.

Recommendation 5.2

Determine if a formal family meeting in a hospital or outpatient setting is indicated at important junctures in care. When possible, ensure that patients, their designated surrogates, and desired medical professionals are present (Type of recommendation: formal consensus; Strength of recommendation: strong).

Strategies for 5.2

a. Before the meeting, designate a medical professional to facilitate the meeting.

b. Review medical record for previous discussions of goals of care and end-of-life directives.

c. Introduce everyone present.

d. Explore a family's agenda for a family meeting and state the provider team's agenda to create a framework for the discussion and to ensure a family's questions are answered directly.

e. Share information about and/or documentation of previous discussions of goals of care and end-of-life directives.

f. Elicit perspectives from all meeting attendees.

g. Identify key issues, disagreements, and perspectives clearly before problem solving.

h. Anticipate that in nonurgent situations, a resolution may not happen in the meeting itself.

i. Pay attention to interactions (eg, who talks, to whom, and who is seen as a decision maker in the family).

j. Set a plan for follow-up.

k. Offer to include absent family members via telecommunications, if appropriate.

Literature review and analysis. Although relatively few end-of-life interventions have targeted caregivers, the important role played by these individuals has been acknowledged in end-of-life care guidelines.[17,23] Clayton et al[17] encourage clinicians to elicit the understanding and preferences of caregivers, to address their emotions and concerns, and to consider whether caregivers have distinct information needs that could warrant a separate meeting (with the consent of the patient).

CLINICAL QUESTION 6

What communication skills and tasks may clinicians use when there are barriers to communication such as language differences and/or low literacy or numeracy?

Recommendation 6.1

For families who do not share a common language with the clinician, use a medical interpreter rather than a family interpreter (Type of recommendation: formal consensus; Strength of recommendation: strong).

Strategies for 6.1

a. Ask the interpreter if they have any concerns about interpreting a conversation about cancer with the patient.

b. Use simple, clear sentences, pausing frequently to allow for interpretation.

c. Ask the patient to state his/her understanding after you have explained something.

d. Be aware of cultural differences, not just language differences.

Recommendation 6.2

For patients with low health literacy, focus on the most important points, use plain language, and check frequently for understanding (Type of recommendation: formal consensus; Strength of recommendation: strong).

Strategies for 6.2

a. Health literacy may be assessed with two questions: How confident are you filling out medical forms by yourself? How often do you have someone help you read hospital materials?
b. Consider allowing the family to audio-record discussions or encourage them to take notes.

Recommendation 6.3

For patients with low health numeracy, use pictographs or other visual aids, when available, and describe absolute risk rather than relative risk (Type of recommendation: formal consensus; Strength of recommendation: strong).

Literature review and analysis. The impact of interpreters on end-of-life care was explored in a 2016 systematic review.[45] The review notes that although a large body of evidence supports the use of professional interpreters, use of ad hoc interpreters appears to be common at the end of life. Failure to use professional interpreters may reduce the quality of care for patients with limited English proficiency.

CLINICAL QUESTION 7

Should clinicians discuss cost of care with patients?

Recommendation 7

Clinicians should explore whether cost of care is a concern for patients with cancer (Type of recommendation: formal consensus; Strength of recommendation: strong).

Strategy for 7

a. For patients who are concerned about cost of care, clinicians should clarify the specific concerns and either address the concern directly or refer the patient and their family to a financial counselor or social worker.

Literature review and analysis. In its 2009 guidance statement on the cost of cancer care, ASCO affirmed the critical role of oncologists in addressing cost of care with patients, noting “ASCO believes that communication with patients about the cost of care is a key component of high-quality care.”[55]

CLINICAL QUESTION 8

What communication skills and tasks may clinicians use to help meet the needs of underserved populations, racial and ethnic minority patients, and other patients from groups that have experienced discrimination historically?

Recommendation 8.1

Enter clinical encounters with a sense of curiosity, aware that any patient and family, regardless of their background, may have beliefs, experiences, understandings, and expectations that are different from the clinician’s (Type of recommendation: formal consensus; Strength of recommendation: strong).

Strategies for 8.1

a. Self-awareness about one’s own experiences and biases can be helpful in providing equitable care.
b. Focus on listening and observing at the beginning of the encounter.

Recommendation 8.2

Avoid assumptions about sexual orientation and gender identity and use nonjudgmental language when discussing sexuality and sexual behavior (Type of recommendation: formal consensus; Strength of recommendation: strong).

Strategy for 8.2

a. Take a comprehensive, sensitive sexual history from patients with life-limiting disease and do not assume that the disease has diminished their desire or interest in sex.

Recommendation 8.3

Remain aware that members of underserved or marginalized populations have an increased likelihood of having had negative past health care experiences, including feeling disrespected, alienated, or unsafe (Type of recommendation: formal consensus; Strength of recommendation: strong).

Strategy for 8.3

a. Inquire about patients’ past experience with the health care system and health care providers.

Literature review and analysis. High-level evidence to guide culturally competent communication remains limited.[13] Nevertheless, the importance of identifying and addressing health care disparities—through improved education, support, policy, training, and research—has been clearly articulated by publications such as ASCO’s position statement on reducing cancer health disparities among sexual and gender minority populations.[61] Improved care will require attention and coordination of efforts by providers, institutions, and the health care system as a whole.

CLINICAL QUESTION 9

What are the most effective ways for clinicians to acquire communication skills?

Recommendation 9.1

Communication skills training should be based on sound educational principles and include and emphasize skills practice and experiential learning using role-play scenarios, direct observation of patient encounters, and other validated techniques (Type of recommendation: evidence based; Quality of evidence: intermediate; Strength of recommendation: strong).

Strategies for 9.1

a. Lectures are an ineffective method of skills training and are not adequate unless paired with supervised skills-practice exercises.
b. Skills-practice exercises may include any of the following:
   i. Role-play sessions conducted by trained facilitators.
   ii. Directly observed or videotaped interviews with real patients or standardized patients.
c. Skills-practice exercises should include structured feedback so that clinicians can learn which of their behaviors are effective and what opportunities exist to improve future performance.
d. Skills-practice exercises benefit from techniques that enhance empathy for the patient and family, such as role reversal.

Recommendation 9.2

For communication skills training to be most effective, it should foster practitioner self-awareness and situational awareness related to emotions, attitudes, and underlying beliefs that may affect communication as well as awareness of implicit biases that may affect decision making (Type of recommendation: evidence based; Quality of evidence: intermediate; Strength of recommendation: strong).

Strategies for 9.2

a. Exercises to increase practitioner self- and situational awareness may include:
   i. Reflection on the types of patient encounters that the clinician finds difficult, challenging, or unpleasant.
   ii. Reflection on the elements of patient care that bring the clinician satisfaction or a sense of meaning. Asking clinicians why they chose to work in health care and what they find meaningful and rewarding in their work is an example.
   iii. Reflection on personal experiences with the health care system as a patient or the loved one of a patient can increase both personal and situational awareness.
   iv. Assuming the role of the patient or family member in role-play exercises to appreciate their perspective and emotional reactions and gain insight into effective communication responses.
   v. Brief mindfulness practices during the work day may help with self-awareness, reactivity, and equanimity in the face of suffering.

Recommendation 9.3

Facilitators of communication skills training should have sufficient training and experience to effectively model and teach the desired communication skills and facilitate experiential learning exercises (Type of recommendation: evidence based; Quality of evidence: intermediate; Strength of recommendation: strong).

Strategies for 9.3

a. Facilitators should be familiar with the various modalities that enhance learner communication skills.
b. Facilitators should be trained to conduct skills-based learning sessions so that participants:
   i. Learn
   ii. Do not feel humiliated
   iii. Are adequately prepared to demonstrate the desired skills
   iv. Receive feedback aimed at improving future performance

Literature review and analysis. For the question on clinician training in communication skills, the systematic review identified one position paper,[48] a 2013 systematic review and meta-analysis,[8] and six RCTs that were published after the systematic review.[15,22,24,31,38,39] The 2010 European position paper, based on a systematic review and meta-analysis and a consensus meeting, notes that although the optimal duration of training remains uncertain, a course of at least 3 days may be necessary to ensure transfer of skills into clinical practice. It also highlights the importance of trained and competent facilitators and role-play with feedback. The 2013 meta-analysis suggested that communication training improved some clinician communication skills, such as empathy (six studies, high-quality evidence) and using open questions (five studies, moderate-quality evidence).[8] Communication skills training was not associated with improved patient outcomes, but few studies assessed these outcomes. The review noted that it remains uncertain whether training benefits are sustained over time and which types of training are best. A majority of the trials involved experienced facilitators, adult learning methods, and small-group learning with role-play. The subsequent RCTs[15,22,24,31,38,39] evaluated a range of different training programs and outcomes, but each reported some benefits of clinician training in communication skills. The duration of the training programs ranged from 7 to 40 hours, and five of the six trials noted that they included opportunities for role-play and/or practice of skills. Evidence tables are provided in the Data Supplement.

DISCUSSION AND FUTURE DIRECTIONS

These recommendations have summarized expert consensus on best practices in communication for clinicians caring for patients with cancer. Underlying the specific skills that have been presented are core values of building a stronger relationship with patients with cancer and their families, expressing caring, and creating opportunities to gain a better understanding of who our patients are and what matters to them so that they can be more active partners in their care. When providers understand who their patients are, what they want from their life and their cancer treatment, and how they make decisions, patients are empowered. The other major theme is learning to communicate in such a way that patients understand and retain the information that we give them. This includes both the information they are seeking as well as the information we think they should have.

In the process of undertaking this project, it was clear to the authors that there are many important gaps in our knowledge about health care communication. While there is strong evidence linking improved communication with improved outcomes for some conditions, the literature is heterogeneous. It is not clear specifically which communication behaviors result in better outcomes,[3,8,62] nor is it clear to what extent studies conducted in other patient populations can be generalized to the oncology setting.

There is evidence that skills-based communication training programs can be successful.[4,7,38,63,64] However, while it is clear that lectures and other purely didactic modalities are ineffective in changing communication behavior, oncology fellowship programs still struggle to incorporate meaningful training into their curricula. On the other hand, oncologists are more and more likely to receive patient and family feedback on their clinical communication skills, so that incentives to find ways to incorporate this training into fellowship programs or oncology practice have increased.

Efforts in this direction will be fueled by research. We need a stronger evidence base to enhance our understanding of what to recommend when we try to persuade health care leaders to invest the resources necessary to achieve behavior change related to health care communication. Many important questions need better answers. What, for example, are the most appropriate measures of the effectiveness of communication? If we give a patient distressing news, is measuring patient distress the right focus? When giving bad news, the easiest way to reduce the patient's distress in the short term is to be less forthcoming so that the patient does not know the truth. Similarly, if we aim for improving measures of patient satisfaction, will they be more satisfied if we are excessively optimistic about their prognosis? We risk creating incentives similar to those faced by clinicians asked to satisfy patients with upper respiratory tract infections who are seeking antibiotics. This is not to say that patient satisfaction and distress are not important, only that it is complicated.

Other key issues include refining our understanding of what the most effective education tools and strategies are, scaling educational interventions (eg, using the internet for distance learning) so that more clinicians can benefit within the constraints of available resources, refining our understanding of how best to train health care communication trainers, and learning how best to sustain the improvements that derive from communication skills training so that skills do not diminish over time. Future updates of this guideline will benefit from a more extensive research base. In the meantime, the available evidence, coupled with the experience and training of the Expert Panel, helped to identify a number of best practices as reflected in these recommendations.

HEALTH DISPARITIES

Although ASCO clinical practice guidelines represent expert recommendations on the best practices in disease management to provide the highest level of cancer care, it is important to note that many patients have limited access to medical care. Racial and ethnic disparities in health care contribute significantly to this problem in the United States. Patients with cancer who are members of racial/ethnic minorities suffer disproportionately from comorbidities, experience more substantial obstacles to receiving care, are more likely to be uninsured, and are at greater risk of receiving care of poor quality than other Americans.[65-68] Many other patients lack access to care because of their geographic location and distance from appropriate treatment facilities. Awareness of these disparities in access to care should be considered in the context of this clinical practice guideline, and health care providers should strive to deliver the highest level of cancer care to these vulnerable populations.

MULTIPLE CHRONIC CONDITIONS

Creating evidence-based recommendations to inform treatment of patients with additional chronic conditions, a situation in which the patient may have two or more such conditions—referred to as multiple chronic conditions (MCCs)—is challenging. Patients with MCCs are a complex and heterogeneous population, making it difficult to account for all of the possible permutations to develop specific recommendations for care. In addition, the best available evidence for treating index conditions, such as cancer, is often from clinical trials whose study selection criteria may exclude these patients to avoid potential interaction effects or confounding of results associated with MCCs. As a result, the reliability of outcome data from these studies may be limited, thereby creating constraints for expert groups to make recommendations for care in this heterogeneous patient population.

Because many patients for whom guideline recommendations apply present with MCCs, any treatment plan needs to take into account the complexity and uncertainty created by the presence of MCCs and highlight the importance of shared decision making regarding guideline use and implementation. Therefore, in consideration of recommended care for the target index condition, clinicians should review all other chronic conditions present in the patient and take those conditions into account when formulating the treatment and follow-up plan.

GUIDELINE IMPLEMENTATION

ASCO guidelines are developed for implementation across health settings. Barriers to implementation include the need to increase awareness of the guideline recommendations among front-line practitioners and survivors of cancer and caregivers and also to provide adequate services in the face of limited resources. The guideline Bottom Line Box was designed to facilitate implementation of recommendations. This guideline will be distributed widely through the ASCO Practice Guideline Implementation Network. ASCO guidelines are posted on the ASCO Web site and most often published in *JCO* and *Journal of Oncology Practice*. ASCO believes that cancer clinical trials are vital to inform medical decisions and improve cancer care, and that all patients should have the opportunity to participate.

ADDITIONAL RESOURCES

More information, including Data and Methodology Supplements, slide sets, and clinical tools and resources, is available at www.asco.org/supportive-care-guidelines and www.asco.org/guidelinswiki. Patient information is available at www.cancer.net. Visit www.asco.org/guidelineswiki to provide comments on the guideline or to submit new evidence.

Related ASCO Guidelines

Integration of Palliative Care into Standard Oncology Practice[69]

AUTHORS' DISCLOSURES OF POTENTIAL CONFLICTS OF INTEREST

Disclosures provided by the authors are available with this article at jco.org.

AUTHOR CONTRIBUTIONS

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AUTHORS' DISCLOSURES OF POTENTIAL CONFLICTS OF INTEREST

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Appendix

Table A1. Patient-Clinician Communication Guideline Expert Panel Membership

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